Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

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**Public Copy/Copie du rapport public**

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Sep 16, 2020 | 2020_784762_0016 | 002479-20, 003459-20, 004613-20 | Complaint |

**Licensee/Titulaire de permis**

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Bay Ridges
900 Sandy Beach Road PICKERING ON  L1W 1Z4

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

MOSES NEELAM (762)

## 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): August 13-14, 17-21, 2020.**

**The following intakes were inspected up during this Complaint inspection:**

**Log related to housekeeping services, nutrition and hydration**
**Log related to responsive behaviors, short staffing, supplies and pests**
**Log related to responsive behaviors and alleged abuse**

**PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA,2007, c.8, s. 19(1), was identified and has been issued in Inspection Report 2020_784762_0017 dated September 15, 2020, which was conducted concurrently with this inspection.**

**During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Registered Dietitian (RD), Environmental Services Manager (ESM), Registered Practical Nurses (RPN), Housekeeper, Behavioral Supports Ontario Registered Practical Nurse (BSORPN), Personal Support Workers (PSW), Family members and residents.**

**During the course of the inspection, the inspector(s) toured residents' home areas, conducted observations and reviewed clinical records.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Housekeeping**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**

**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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (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 strategies have been developed and implemented to respond to resident #003's specific responsive behaviors.

A complaint was received by the Ministry of Long Term Care (MLTC). The complainant indicated that resident #002 had an incident with resident #003, that resulted in various injuries. During an interview SDM #111, indicated resident #003 had multiple responsive behaviors and the management team of the Long-Term Care Home (LTCH) did not do anything about it. SDM #111 indicated due to the incident with resident #003, resident #002 was found a certain distance from their bed, and that resident #002 could not have done this independently due to their physical limitations.

A review of resident #003's clinical health records, indicated resident had multiple unmanageable responsive behaviors. After multiple interventions, the resident had been sent to an external facility for further treatment.

A review of resident #003's clinical health records at the external facility, indicated resident had responsive behaviors, and had a physical altercation with a co-resident. A note made by a registered staff indicated resident had a responsive behavior directed at co-residents. Additionally, the plan of care from the external facility indicated that the resident can be aggressive and agitated and will require non-pharmacological interventions.

A review of resident 003's clinical records at LTCH, indicated resident had a responsive behavior. Resident #003 was found outside resident #002's room and attempting to stop

staff from entering residents' room by stating "No, it is my room". Resident #002 was found next to the door on the floor.

In separate interviews, PSW #102 and RPN #103, indicated resident #003 was found outside resident room, whilst resident #002, was found on the floor. They stated that resident #002 is unable to move independently, and can only guess as to what happened, however, the incident was not witnessed. RPN #103 indicated, resident #003 was having responsive behaviors, and the plan of care did not have any specific interventions or strategies for managing resident #003's responsive behaviors.

In an interview BSORPN #112, indicated interventions were put in place after the potential incident with resident #002 on specified date. Prior to this, there were no interventions for managing resident #003's responsive behaviors, despite resident #003 exhibiting responsive behaviors with co-residents at the external facility and in the LTCH.

The licensee has failed to ensure that strategies have been developed and implemented to respond to resident #003's specific responsive behaviors. [s. 53. (4) (b)]

2. The licensee has failed to ensure that strategies have been developed and implemented to respond to resident #004's specific responsive behaviors.

A complaint was received by the MLTC. The complainant indicated that resident #004 had an incident with a co-resident, that resulted in various injuries.

A review of resident #004's clinical health records, indicated resident had multiple responsive behaviors, the resident was noted to have significant responsive behaviors towards a co-resident's on multiple days, leading up to the incident that caused injury to resident #005.

A review of resident #004's clinical health records, indicated the involvement of the BSORPN #112. Multiple notes on the review of resident's responsive behaviors were noted. In these notes, it was indicated that the care plan was reviewed with the staff and no new interventions were added. A review of the plan of care indicated that there were no specific interventions or strategies for managing resident #004's specific and significant responsive behaviors.

In an interview, RPN #113 indicated that the resident did have multiple responsive behaviors. RPN #113 indicated, resident #004 had gone into resident #005's room whilst

having a specific responsive behavior, and had caused the incident that lead to an injury for resident #005.

In an interview BSORPN #112, indicated interventions were put in place after the incident with resident #005. Prior to this, there were no specific interventions for managing resident #004’s specific significant responsive behaviors.

The licensee has failed to ensure that strategies have been developed and implemented to respond to resident #004’s specific responsive behaviors. [s. 53. (4) (b)]

***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,***
***for each resident demonstrating responsive behaviours,***

***(a) the behavioural triggers for the resident are identified, where possible;***

***(b) strategies are developed and implemented to respond to these behaviours, where possible; and***

***(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., to be implemented voluntarily.***

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**Issued on this 28th day of September, 2020**

| Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs |
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**Original report signed by the inspector.**