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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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
Mar 5, 2020	2020_689586_0005	018033-19, 018755-19, 018756-19, 000130-20	Critical Incident System

Licensee/Titulaire de permis

Blackadar Continuing Care Centre Inc.
101 Creighton Road DUNDAS ON L9H 3B7

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

Blackadar Continuing Care Centre
101 Creighton Road DUNDAS ON L9H 3B7

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

JESSICA PALADINO (586)

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): February 19, 20, 21 and 24, 2020.

The following Follow Up Inspections were completed concurrently:
018755-20 - Fall's Prevention & Management; and,
018756-20 - Fall's Prevention & Management.

The following Critical Incident System (CIS) Inspections were completed concurrently:
018033-19 - Fall's Prevention & Management; and,
000130-20 - Prevention of Abuse & Neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Quality Manager (QM), Resident Assessment Instrument (RAI) Co-ordinator, Restorative Care Nurse, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW) and residents.

During the course of the inspection, the inspector toured the home, observed resident care and reviewed resident health records, staff training records, audits, internal investigation notes and internal compliance plans.

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2019_549107_0011	586
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2019_549107_0012	586

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provide direct care to the resident.

Resident #003's written plan of care included two sections with activities of daily living (ADL), which were not consistent with each other. This included bed mobility, dressing, eating, locomotion on unit and transfers.

In an interview with the RAI Co-ordinator, they confirmed the inconsistencies in the written plan of care and said that this was due to an error of the previous assessment levels not being omitted when the new levels of assistance were added when the last minimum data set (MDS) assessment was completed. The RAI Co-ordinator confirmed that the plan of care did not include clear directions for staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of the resident.

A. During a tour of the home, resident #002 was observed using a specific mobility device.

In interviews with the Administrator, DOC, RAI Co-ordinator #103 and Restorative Care Worker #104, each person confirmed that the resident was assessed to safely use a specific mobility device, but that they preferred to use another type. The resident would

spend the majority of their time using the preferred mobility device.

Upon review of resident #002's written plan of care, which front line staff used to direct care, it indicated that the resident used only one specific mobility device and did not mention the use of the preferred mobility device.

The DOC and RAI Co-ordinator acknowledged that this was not included in the written plan of care and confirmed that it should have been. The care set out in resident #002's plan of care was not based on the preferences of the resident.

B. According to CIS #2641-000016-19, submitted to the Director on an identified date in 2019, resident #003 experienced a fall resulting in injury.

The resident's written plan of care, which front line staff used to direct care, was reviewed for falls interventions. It included the use of two falls interventions to be used to mitigate the risk of falling.

Observations of the resident on two identified dates during the inspection demonstrated that the two identified falls interventions were not in use. During interviews with RPN #107, RPN #104 and the RAI Co-ordinator, they said that the resident no longer required the use of the two identified falls interventions now that they were using an alternative intervention which was effective. This was confirmed by the QM, who was responsible for reassessing and updating the fall's plan of care, and acknowledged that they assessed the resident to no longer require the use of the two interventions for safety reasons, as the current intervention was effective. The plan of care was not based on an assessment of the resident related to falls interventions. [s. 6. (2)]

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the residents, and to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of the resident, 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 taken to respond to the needs of the resident, including assessments, reassessments and interventions that that the resident's responses were documented.

According to CIS #2641-000001-20, submitted to the Director on an identified date in 2020, resident #007 observed resident #005 demonstrating a responsive behaviour toward resident #004. Resident #007 reported this to PSW #106 who also observed this and separated the residents.

Upon review of resident #005's progress notes, three instances of inappropriate responsive behaviours of the same nature were identified. While interviewed by the LTCH Inspector, resident #005, did not recall these incidents.

Upon review of the resident's plan of care, which front line staff used to direct care, there was no mention of the above behaviours or instances, including triggers, strategies to respond to these, or interventions. In an interview with the DOC, they confirmed this and acknowledged that the resident's history of the identified responsive behaviours should have been included in the resident's written plan of care. [s. 53. (4)]

Issued on this 5th day of March, 2020

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

Original report signed by the inspector.