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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 27, 2021	2021_905683_0018	004858-21, 006354-21, 007032-21, 009565-21, 013504-21, 013527-21	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

LISA BOS (683), EMMY HARTMANN (748)

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): October 12-15 and 18-22, 2021.

This inspection was completed concurrently with complaint inspection #2021_905683_0017.

The following intakes were completed during this critical incident inspection:
Log #004858-21, CIS #2641-000005-21 was related to falls prevention and management;
Log #006354-21, CIS #2641-000007-21 was related to hospitalization and change in condition;
Log #007032-21, CIS #2641-000009-21 was related to falls prevention and management;
Log #009565-21, CIS #2641-000013-21 was related to falls prevention and management;
Log #013504-21, CIS #2641-000019-21 was related to the prevention of abuse and neglect; and
Log #013527-21, CIS #2641-000020-21 was related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), the Dietary/Environmental Manager, the Attending Physician, the Office/Ward Clerk, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Maintenance staff, housekeeping staff and residents.

During the course of the inspection, the Inspector(s) toured the home, observed the provision of care, infection prevention and control practices, meal service, housekeeping practices, and reviewed clinical health records, relevant home policies and procedures, training records and other pertinent documents.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **4 WN(s)**
- **3 VPC(s)**
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was followed for two residents related to falls prevention, and locomotion.

A) A resident was at risk for falls and they had interventions in place to decrease their risk of injury related to falls. They were to be assisted by staff when they ambulated with their mobility device.

i) The resident was observed by staff walking in the hallway without assistance and they sustained an injury.

A Personal Support Worker (PSW) reported that they observed the resident getting up on their own in the dining room and they were not assisted by staff when they left.

The Director of Care (DOC) verified that the resident required the assistance of staff to move around in the home area with a mobility device, but they were not provided this assistance on the date of the incident.

There was actual harm to the resident as they sustained an injury while they were walking unassisted, and without their mobility device.

ii) The resident was observed in bed and they did not have their fall interventions applied, as confirmed by a PSW.

The DOC acknowledged that the resident's plan of care was not followed related to their falls interventions.

There was a risk that the resident’s falls would not be prevented, as their falls risk interventions were not in place.

Sources: Resident observations; a resident’s falls risk assessments, progress notes, care plan; the home's investigation notes, interview with a PSW and DOC.

B) A resident had a fall while they were walking which resulted in an injury. The post-fall assessment for this incident identified that the resident needed to an intervention to decrease their risk of injury from falls.

The resident's fall risk level increased and their plan of care was updated to include two new fall prevention interventions.

The inspector observed the resident and their new fall prevention interventions were not

in place, which was verified by a PSW.

The DOC acknowledged that the resident's plan of care was not followed related to falls interventions.

There was a risk that the resident's falls would not be prevented, as their falls risk interventions were not followed.

Sources: Resident observations; a resident's falls risk assessments, progress notes, care plan; interview with a PSW and DOC. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was protected from sexual abuse by a co-resident.

O. Reg. 79/10 s. 2 (1) defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A resident was observed by a Registered Practical Nurse (RPN) demonstrating an inappropriate behaviour toward another resident without their consent and as a result, the resident was upset.

The resident's clinical record indicated that there were other incidents/allegations of inappropriate behaviour towards co-residents that month. There were no interventions documented in the resident's written plan of care to prevent further incidents.

The Administrator acknowledged that the incident met the definition of sexual abuse.

The home failed to protect a resident from sexual abuse by another resident, who had a known history of inappropriate behaviours towards other residents.

Sources: A Critical Incident (CI) report; resident clinical records; interview with the Administrator and other staff. [s. 19. (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 residents are protected form abuse by anyone, to be implemented voluntarily.

WN #3: 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 they complied with paragraph 2 of section 24. (1) of the LTCHA related to reporting certain matters to the Director.

A) The DOC received a complaint letter regarding an allegation of inappropriate behaviour from an individual towards a resident. The letter requested that the matter be thoroughly investigated as soon as possible.

The DOC initiated an investigation on the home's complaint/concern form. The incident was included in a CI report submitted to the Director, among other incidents of alleged abuse, which was not submitted to the Director until August 24, 2021.

In an interview with the DOC, they acknowledged that the allegation was not immediately reported to the Director.

Sources: A CI report; home's internal investigation notes; a resident’s clinical records; interview with the DOC and other staff.

B) The home submitted a CI report to the Director under the category of resident to resident sexual abuse related to an incident where a resident showed inappropriate behaviour toward another resident. The CI report was not submitted to the Director until three days after the incident occurred.

In an interview with the DOC, they acknowledged that the incident was not immediately reported to the Director and it should have been.

Sources: A CI report; a resident's clinical records; interview with the DOC and other staff. [s. 24. (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 a person who has reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or risk of harm to the resident immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

A resident’s clinical record indicated that on several occasions, they showed inappropriate behaviour toward another resident. Dementia Observation System (DOS) charting was initiated for seven days, and more incidents of inappropriate behaviour were documented.

Later that month, the DOC documented that there was an allegation of inappropriate behaviour by the resident towards another resident. DOS charting was re-initiated and the next day, the resident showed inappropriate behaviour toward another resident, and the resident was upset.

The home's Responsive Behaviours policy directed staff to use DOS charting, among other assessment tools, to allow for a thorough evaluation of any patterns of behaviour to facilitate a comprehensive care plan. DOS was to be evaluated by the interdisciplinary team to determine patterns of behaviours and to plan interventions and update the care plan.

The resident’s written plan of care was not updated to identify their inappropriate behaviours and interventions to prevent inappropriate behaviour towards other residents until several incidents of inappropriate behaviour towards other residents occurred, and after seven days of DOS charting had already been completed.

The DOC and a Registered Nurse (RN) acknowledged that the resident's care plan should have been updated sooner to reflect their behaviours with other residents.

Another resident was harmed, and other residents were placed at risk of harm when the home failed to identify and implement interventions to minimize the risk of altercations to residents when they did not identify or implement any interventions for a resident's known inappropriate behaviour.

Sources: A CI report; Responsive Behaviour policy, last updated December 2020; a resident’s clinical records; interview with the DOC, a RN and other staff. [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between anbd among residents, including identifying and implementing interventions, to be implemented voluntarily.

Issued on this 28th day of October, 2021

[redacted]

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

Original report signed by the inspector.