Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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
Apr 29, 2019	2019_769646_0005	012949-17, 013047-17	Complaint

Licensee/Titulaire de permis

Delcare LTC Inc.
4800 Dufferin Street TORONTO ON M3H 5S9

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

Cawthra Gardens
590 Lolita Gardens MISSISSAUGA ON L5A 4N8

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

IVY LAM (646), GORDANA KRSTEVSKA (600)

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): March 20, 21, 22, 25, 26, 27, 28, 2019; April 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, and 15, 2019.

The following Complaint intakes were inspected during this inspection:
- Log #012949-17 related to resident-to-resident abuse, responsive behaviours, safe transferring, assessment of resident's change in condition, and residents' rights; and
- Log #013047-17 related to continence care, nutrition and hydration, responsive behaviours, and sufficient staffing.

During the course of the inspection, the inspector(s) spoke with the Administrator, the home's previous Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Infection Prevention and Control (IPAC) Lead, Responsive Behaviours Program Lead, Registered Nurse (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), PSW student, Behavioural Support Ontario (BSO) RPN, BSO-PSW, Registered Dietitian (RD), Corporate Registered Dietitian (CRD), Food Service Manager (FSM), Assistant FSM, Social Worker (SW), Physiotherapist (PT), Residents and Family members.

During the course of the inspection, the inspectors observed resident care, observed staff to resident interaction, observed dining service, reviewed resident health records, reviewed home's record, schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Hospitalization and Change in Condition
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

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

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to resident #011 not being protected from resident #012's responsive behaviours. The complaint alleged that resident #012 displayed responsive behaviors toward resident #011 and their family member during an identified meal on an identified date.

Review of resident #012's written plan of care at the time of the incident indicated that resident #012's had identified health conditions which affected their behaviours. Interventions for resident #012 at mealtimes were identified and detailed in the resident's written plan of care. The care plan further indicated that the resident was to be monitored at specified periods of time for their identified behaviours.

Interviews with Registered Practical Nurses (RPN) #109 indicated that on the day of the incident, the staff brought resident #012 to the first identified common area, and had attempted to redirect the resident, but the resident had refused. The RPN stated that once they had the other residents settled, several minutes after resident #012 left the first

identified common area, the RPN went to find the resident and had found resident #012 in the second identified common area where resident #011 and their family member were visiting and where the incident had occurred.

Interview with the Social Worker indicated that on the date of the identified incident, they were walking towards the nursing station across from the second identified common area at the time and came upon the incident and had reported it to the Administrator.

Review of resident #012's progress notes on the day of the incident, and written plan of care after the incident showed that an intervention was initiated for monitoring of resident #012 at specified frequencies of time due to identified responsive behaviours, and continued to be part of the resident's plan of care in the subsequent revision of the resident's written plan of care.

Review of resident #012's observation records identified a number of discrepancies between the resident's written care plan and the documented care provided for the resident. The review showed that for an identified number of shifts in the two-week period after the incident, resident #012 was monitored less frequently than specified in their written plan of care.

Interviews with Personal Support Workers (PSWs) #113, #125, and #126 indicated that the instructions for the times to observe the resident would be from the registered staff at report, in the observation record book and in the care plan and kardex. The PSWs indicated that if the instructions were missing on the observation records, they have access to the kardex or could ask the registered staff. Interview with PSW #113 indicated that some staff documented that they monitored the resident as per the frequency specified in resident #012's written plan of care, and other staff documented that they monitored the resident at a different frequency. The PSW indicated that all PSWs should monitor the resident at the frequency as per their written plan of care and document that the care was done. PSW #126 indicated that they had observed the resident at the frequency as per their written plan of care, but was unsure why they documented a different frequency of monitoring.

Interviews with RPN #127 and Registered Nurse (RN) #103 stated the official instructions for resident's observation record would be in the written plan of care, and the instructions would also be on the face sheet of the observation record binder based on the care plan. They further indicated that the RPN or RN should check the observation records to see if the records were done properly. Interview with RN #103 indicated that the staff made a

mistake by not monitoring the resident at the specified frequency as per their plan of care, and other staff continued to follow the example from the observation record rather than the written plan of care. Interviews with RN #103, the Assistant Director of Care (ADOC) and the Director of Care (DOC) stated that PSWs and registered staff should have collaborated to ensure that resident #012's observation records for responsive behaviours were implemented and documented as per the resident's plan of care, and that this was not done. [s. 6. (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 the staff and others involved in the different aspects of care of the resident collaborate with each other, in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

Issued on this 2nd day of May, 2019

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

Original report signed by the inspector.