Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District
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Waterloo, ON, N2V 1K8
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Original Public Report

Report Issue Date: May 1, 2023

Inspection Number: 2023-1541-0002

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: Corporation of the County of Dufferin

Long Term Care Home and City: Dufferin Oaks, Shelburne

Lead Inspector	**Inspector Digital Signature**
Kim Byberg (729)	Kimberly Byberg Digitally signed by Kimberly Byberg Date: 2023.05.01 15:43:15 -04'00'

Additional Inspector(s)
Gabriella Del Principe (741734)
Yami Salam (000688)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 29-31, 2023, and April 3-5, 12-14, 2023.
The inspection occurred offsite on the following date(s): April 10-11, 2023.

The following intake(s) were completed in this Critical Incident (CI) inspection:
- Intake: #00007052, and Intake #00022371, related to an allegation of staff to resident abuse.
- Intake: # 00017129-22, Intake: #00019711, and Intake: #00016768, related to the home's fall prevention program.

The following intake(s) were completed in this Complaint inspection:
- Intake # 00020632-23, related to the admission process to the Long-Term Care Home

The following intake(s) were completed in this Follow-up inspection:
- Intake: #00015849, Follow-up Compliance Order #01 from inspection #2022-1541-0001 related to O. Reg 246/22 s. 54 (2)

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2022-1541-0001 related to O. Reg. 246/22, s. 54 (2) inspected by Kim Byberg (729)

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management
Admission, Absences and Discharge

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 51 (7) (b)

The licensee has failed to comply with s. 51(7)(b) of the Fixing Long-Term Care Act (FLTCA) whereby the licensee refused the application of applicant #001 for reasons other than provided for in the FLTCA.

Rationale and Summary
The Ministry of Long-Term Care (MLTC) received a complaint on February 13, 2023, related to the home

withholding approval for admission of applicant #001.

The Central West Home and Community Care (CWHCC) submitted an update of health information to the home as the home had a bed vacancy and applicant #001 was being considered for admission to the home.

On February 7, 2023, the Director of Care (DOC) had a conversation with a family member of the applicant that they would not be accepting the applicant for admission due to the home's inability to care for the applicant.

The DOC stated they had the nursing expertise to care for residents that met the bariatric definition but due to the homes history of caring for previous bariatric residents they felt they were not able to manage their care safely.

A review of the homes mechanical lifting equipment and electric bed manufacture guidelines stated that the maximum weight capacity for the equipment exceeded the most recently taken weight of applicant #001. The applicant had a motorized wheelchair that would assist the staff with the mobility of applicant #001.

On March 31, 2023, the DOC stated that they re-evaluated the acceptance of applicant #001 and felt that with the use of specific lifting equipment they would be able to manage applicant #001's care. A letter was sent to CWHCC approving applicant #001 to their waitlist.

Sources: Record review of the home's manufacture guidelines for lifting equipment, and beds/frames, InterRAI assessment dated February 7, 2023, Letters of refusal February 7, 2023, Letter of acceptance dated March 31, 2023, bedroom and bathroom door measurements and wheelchair measurements, elevator weight capacity limits. Interview with DOC #101, CWHCC coordinator, CWHCC manager of placement and complainant.
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Date Remedy Implemented: March 31, 2023

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

A) The licensee has failed to ensure that the Director was immediately informed of an allegation of abuse towards a resident.

In accordance with FLTCA Act s. 154(3) where an inspector finds that a staff member has not complied with subsection 28 (1) or 30 (1), the licensee shall be deemed to have not complied with the relevant subsection and the inspector shall do at least one of the actions set out in subsection (1) as the inspector considers appropriate.

Rationale and Summary
A PSW was witnessed providing improper care to a resident during bathing.

The allegation of abuse was not reported to the Registered Practical Nurse (RPN) until approximately four hours later.

The home's policy titled ""Abuse policy" #GN 3-020, revised January 2017, stated staff were to immediately report the allegation to the Registered Nurse or manager and they would notify the MLTC.

An allegation of abuse towards a resident was not immediately reported to the Director resulting in two subsequent allegations of abuse from a PSW towards other residents on the same day before action was taken and the PSW was asked to leave the home.

Sources: Interview with RPN, PSW, ADOC, Home's policy titled "Abuse policy" #GN 3-020.

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B) The licensee has failed to ensure that the Director was immediately informed of an allegation of abuse towards a resident.

Rationale and Summary
An allegation of improper care of a resident by a PSW was reported to the home.

The allegation of abuse was not reported to the RPN until four hours after the incident occurred.

An allegation of abuse towards a resident was not immediately reported to the Director resulting in a subsequent allegation of abuse from the PSW towards another resident that same day, before action was taken and the PSW was asked to leave the home.

Sources: Interview with RPN, PSW, ADOC, Home's policy titled "Abuse policy" #GN 3-020, [729]

C) The licensee has failed to ensure that verbal abuse of a PSW to a resident was immediately reported to the Director.

Rationale and Summary

The incident occurred on a specified date and was not reported to the Director until the following day.

The DOC recognized that the incident was reported late.

There was low risk to residents when the incident was reported late to the Director delaying prompt follow up by the home related to the allegation.

Sources: Interview with DOC.

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WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that a PSW used safe transferring techniques when assisting a resident.

Rationale and Summary

The DOC reported that a PSW improperly transferred a resident when they transferred the resident on their own without a secondary staff member present.

The resident required two persons to transfer them. The incident was not documented in their clinical record, a physical assessment after the incident or re-evaluation of the resident's care needs was not completed to determine any injuries the resident may have sustained because of the improper transfer.

The PSW confirmed that they were not supposed to transfer the resident by themselves and had to wait for a second staff member to be present.

There was a moderate risk of harm to the resident when they were improperly transferred by one staff instead of two and they were not adequately assessed for injury after the incident.

Sources: Electronic records, interview with DOC, PSW, and RN.

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WRITTEN NOTIFICATION: Responsive Behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

A) The licensee has failed to ensure that a PSW used the strategies and interventions outlined in the residents' the plan of care when a resident exhibited responsive behaviours.

Rationale and Summary
A PSW did not use the gentle persuasive approaches outlined in the residents plan of care when the resident did not wish to have their bath.

The Resident's plan of care had specific interventions when the resident was exhibiting responsive behaviours or refusal of care

The PSW did not implement the strategies and interventions outlined in the plan of care for the resident's responsive behaviours, which escalated their behaviours causing them distress.

Sources: Interview with PSW, and DOC. Review of progress notes, plan of care and the home’s investigation notes.
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B) The licensee has failed to ensure that two PSW's used the strategies and interventions outlined in the residents' plan of care when a resident exhibited responsive behaviours.

Rationale and Summary
An allegation of resident abuse was submitted to the MLTC, when two PSW's were providing continence care to a resident.

The Resident's plan of care had specific interventions when the resident was exhibiting responsive behaviours or refusal of care.

The PSW's did not implement the strategies and interventions outlined in the residents' plan of care for their responsive behaviours. The residents' behaviours escalated, and the staff's actions caused bruising to the resident.

Sources: Interview with PSW, DOC. Review of progress notes, plan of care and the home's investigation notes.
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WRITTEN NOTIFICATION: Notification re incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (a)

The licensee has failed to ensure that the substitute decision-maker (SDM) for a resident was notified immediately after there was an allegation of physical abuse towards a resident.

Rationale and Summary
An allegation of physical abuse from a PSW towards a resident was reported to the RPN on a specified date.

The progress notes indicated that the SDM for the resident was not notified until the following day.

The Assistant Director of Care (ADOC) stated that the SDM was to be notified by the nurse, unit

coordinator, ADOC or DOC responding to the allegation, and they should have been notified immediately.

The SDM was not notified immediately after an allegation of abuse towards a resident which may have impacted communication and decision making when they were not notified immediately.

Sources: Interview with RPN, ADOC, progress notes, home's policy titled "Abuse Investigation" Effective January 2008, revised January 2017, Policy #GN 3-030.
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WRITTEN NOTIFICATION: Notification re incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (b)

The licensee failed to notify the SDM within 12 hours upon becoming aware of an allegation of abuse towards two residents.

Rationale and Summary
An allegation of abuse was reported to the Ministry of Long-Term Care (MLTC) related improper care of two residents by a PSW.

The RPN stated they did not call the SDM's and that it was the responsibility of the DOC. The ADOC stated that the SDM was to be notified by the nurse, unit coordinator, ADOC or DOC responding to the allegation, and they should have been notified within 12 hours as per the home's policy.

The SDM was not notified within 12 hours after an allegation of abuse towards two residents which may have impacted communication and decision making between the home and the SDM.

Sources: Interview with RPN, ADOC, residents progress notes, home's policy titled "Abuse Investigation" Effective January 2008, revised January 2017, Policy #GN 3-030.

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