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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Original Public Report

Report Issue Date: July 7, 2023

Inspection Number: 2023-1541-0003

Inspection Type:
Complaint
Critical Incident System

Licensee: Corporation of the County of Dufferin

Long Term Care Home and City: Dufferin Oaks, Shelburne

Lead Inspector	**Inspector Digital Signature**
Janet Groux (606)	Janet Groux Digitally signed by Janet Groux Date: 2023.07.20 11:31:52 -04'00'

Additional Inspector(s)
Sharon Perry (155)
Kailee Bercowski (000734)
Megan Brodhagen (000738)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: May 31, June 1-2, 5-9, and 12-15, 2023.
The inspection occurred offsite on the following dates: June 13, and 14, 2023.

The following intake(s) were inspected:

- Complaint intake #00088452 regarding concerns about a resident's medical treatment.
- Critical Incidents (CI) intakes #00002811, #00006524, #00011015, #00016728, #00086793, regarding the home's responsive behaviour prevention and management program and the home's resident prevention of abuse and neglect policy; and intakes #00086860, and #00088648, regarding the home's falls prevention and management program.

The following intake was completed in this inspection: CI intake #00001761-22 regarding the home's responsive behaviour prevention and management program.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: COMPLAINTS PROCEDURE - LICENSEE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee has failed to immediately forward a complaint to the Director alleging harm to a resident.

Rationale and Summary
The Administrator received a written letter with concerns alleging a resident had experienced neglect from staff.

The administrator did not report the complaint to the Director.

Sources: a written concern, the home's Complaints Policy and Complaints Log, and interviews with an ADOC and Administrator. [000734]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure that a written policy to promote zero tolerance of abuse and neglect of residents was in place and was complied with.

Rationale and Summary
The home's "Abuse Policy" directed staff who know of or has reasonable grounds to suspect abuse to immediately report it to the Registered Nurse (RN) or Manager.

An incident occurred between two residents in which injury occurred to one of the residents.

The incident between the two residents was discovered by an RN reading the the Personal Support Worker (PSW) communication book for the unit at the end of the shift.

The RN stated that direct care staff should immediately report a resident-to-resident incident.

A Unit Coordinator and the Behavioural Support Officer (BSO) lead stated as per the home's policy the PSW who discovered the incident between the two residents should have notified a registered staff immediately of the incident.

A resident was placed at risk of harm when the PSW failed to immediately notify registered staff of the resident-to-resident incident, that resulted in injury to one of the resident. This delay in notifying registered staff prevented the registered nurse from immediately assessing and managing the incident.

Sources: The home's Abuse Policy, A resident's Behavioural incident assessment, progress notes, Interviews with an RN, a Unit Coordinator, the BSO Lead and other staff. [000738]

WRITTEN NOTIFICATION: GENERAL REQUIREMENTS FOR PROGRAMS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee failed to ensure the volume amount delivered from a medical treatment administered to a resident was regularly documented.

A resident had a physician's order to administer a medical treatment to manage a resident's medical condition.

Staff did not regularly document the volume amount delivered from a medical treatment administered to the resident as ordered by the doctor when they checked the resident's response to the medical treatment. It was not clear to staff what the volume amount to be delivered was required for the resident to manage the resident's medical condition.

Staff not documenting the volume amount delivered from the medical treatment level put the resident at risk, as staff may not know if there was a change in the resident's health status.

Sources: A resident's clinical records, the home's Medication Policy, a specific medical treatment binder, and Interviews with the DOC, and registered staff. [000734]

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)

The licensee has failed to ensure for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of a resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Rationale and Summary
A resident's care plan directed staff to complete safety checks at a specified time.

A resident's care records for a specified date did not showed documentation of the safety checks.

A PSW confirmed in Point of Care (POC) documentation the resident was not on any safety checks.

The BSO Lead acknowledged that the resident was still on the specified safety checks and that direct care staff should have been documenting those safety checks.

Sources: A resident's care plan, documentation survey report, and interviews with the BSO lead, a Unit Coordinator, and other staff. [000738]

WRITTEN NOTIFICATION: ALTERCATIONS AND OTHER INTERACTIONS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between two residents.

Rationale and Summary
An altercation occurred between two residents in which one of the resident sustained an injury and was transferred to the hospital.

The resident who started the incident was identified at a risk level to cause harm to others due to their responsive behaviors. The resident's care plan identified interventions to manage the resident's responsive behaviours.

Staff identified that when the resident displayed responsive behaviours, a specific intervention would have been effective to keep the resident away from having altercations with other residents. However, this intervention was not put in place and the resident had several altercations in a short period of time

The BSO lead said that that a resident at risk of harming other residents and staff due to their responsive behaviours, would be provided additional interventions which included a specific intervention. They acknowledged that the resident should have been provided a specific intervention to address the resident's increased responsive behaviours but was not implemented.

Failure to implement other interventions to address the resident's responsive behaviours resulted in harm to another resident.

Sources: a resident's clinical records, and interviews with staff. [606]