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

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Original Public Report

Report Issue Date: January 3, 2024	
Inspection Number: 2023-1294-0003	
Inspection Type: Critical Incident	
Licensee: Estonian Relief Committee in Canada	
Long Term Care Home and City: Ehatare Nursing Home, Scarborough	
Lead Inspector Chinonye Nwankpa (000715)	**Inspector Digital Signature** Chinonye Nwankpa Digitally signed by Chinonye Nwankpa Date: 2024.01.16 13:08:23 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 4-6, 2023

The following intake was completed during this Critical Incident inspection:

- Intake: #00009077 - 2804-000007-22 related to staff to resident verbal abuse.

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

Plan of care

When reassessment, revision is required

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident was reassessed, and that their plan of care was reviewed and revised when their care needs changed and when care set out in the plan was no longer necessary.

Rationale and Summary

i) A resident exhibited responsive behaviours during personal care and when being transferred with a device.

The home's investigation notes showed that when the resident exhibited specific responsive behaviours, a Personal Support Worker (PSW) allegedly verbally and physically abused the resident. The investigation notes showed that the resident's responsive behaviours were known by the staff providing care before this incident. Upon review of the resident's care plan there was no documentation of these behaviours or applicable interventions.

An interview with two Registered Nurses (RNs) revealed that they failed to assess the behaviour and update the care plan at the time of the incident or afterwards.

Failing to assess the resident and update their care plan placed them at an increased risk of not receiving the appropriate interventions related to responsive behaviors.

Sources: Resident's care plan, home's investigation notes; interviews with RNs. [000715]

ii) A resident was observed without specified fall prevention interventions that were required in their care plan.

In an interview, a RN reported the interventions had been discontinued when the resident no longer required them, however the care plan still stated the interventions were required. A PSW stated they were not aware the interventions had been discontinued as it was still stated in their care plan. The RN acknowledged the resident was not reassessed and their care plan was not updated to remove the discontinued interventions.

Failure of the home to reassess and update the resident's care plan when their needs changed placed them at risk of receiving inconsistent care.

Sources: Observations; resident's care plan; interviews with PSW and RN. [000715]

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

A licensee has failed to ensure that a resident was protected from verbal abuse by staff.

Section 2 (1) of the Ontario Regulation 246/22 defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident."

Rationale and Summary
A Critical Incident (CI) report was submitted to the Director related to an allegation of verbal and physical abuse of a resident.

A PSW reported to a RN that they observed resident being verbally and physically abused by PSW. The home's investigation notes revealed a PSW witnessed another PSW being verbally and physically abusive to the resident.

The investigation records showed the accused PSW had reacted to the resident's responsive behaviour by verbally abusing them. The home's investigation substantiated verbal abuse of the resident.

The Executive Director (ED) confirmed verbal abuse was substantiated following the home's investigation.

There was an increased risk of harm to the resident when they were verbally abused by staff.

Sources: CI report, the home's investigation notes; interviews with RN and ED. [000715]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO THE DIRECTOR

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (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:

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.

The licensee has failed to ensure an alleged incident of verbal and physical abuse was immediately reported to the Director.

Rationale and Summary

A CI report was submitted to the Director on a specified date.

The home's investigation notes showed an agency PSW alleged they witnessed another PSW verbally and physically abuse a resident. The agency RN reported they were not informed of the incident for a period of time after the incident had occurred. The RN proceeded to inform the Director of Care (DOC), however there was no call made to the after-hours mandatory reporting line. The RN stated they were not aware of the mandatory reporting requirements as they had not received any such training.

The DOC who submitted the CI acknowledged that they failed to report the allegation of abuse immediately to the Director. The DOC also confirmed the Home did not previously provide training on Abuse and Neglect as required under the

FLTCA to agency staff, hence there was a delay in reporting the incident to the Director.

Sources: CI report, the home's investigation notes, interview with RN and DOC. [000715]

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)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(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.

The licensee failed to ensure that when a resident demonstrated responsive behaviours, actions were taken to respond to the needs of the resident, including assessments and interventions, and that the resident's responses to interventions were documented.

Rationale and Summary
A resident exhibited specific responsive behaviours during care activities.

The home's Behaviour Management Policy noted that behaviours were to be assessed to identify the cause and to develop strategies to prevent further incidents. The policy directed staff to document the behaviour in the Behaviour Patterns progress notes. Upon review of the resident's records, there was no documented assessment and behaviour interventions, as well as the resident's

response to interventions.

A RN acknowledged they failed to complete and document an assessment of the behaviours as per the home's policy. As a result, the resident's care plan was not updated following the responsive behaviour incidents.

The DOC confirmed the staff failed to document the behaviour assessment and interventions as per their policy.

Failing to complete a behavior assessment and document the resident's response to interventions increased the risk of not properly analyzing the resident's behaviour patterns and not putting the appropriate interventions in place.

Sources: Resident's clinical records, Behaviour Management policy; interviews with RN and DOC. [000715]