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
Feb 20, 2019	2019_782736_0001	031786-18	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Kirkland Lake
155 Government Road East KIRKLAND LAKE ON P2N 3P4

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

AMANDA BELANGER (736), TRACY MUCHMAKER (690)

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): Februray 5-8, 2019.

The following intake was inspected during this Complaint inspection:
-One log related to an allegation of resident to resident verbal and physical abuse.

During the course of the inspection, the inspector(s) spoke with the Regional Director, Administrator, Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and family members.

The Inspector(s) also conducted a daily tour of resident care areas, observed staff to resident interactions, reviewed relevant resident health care records, reviewed relevant internal investigation records, licensee policies, procedures, and programs.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

A complaint was submitted to the Director, related to an incident of alleged physical and verbal resident to resident abuse. The complainant disclosed to the Inspector, that on a specified date in 2018, they witnessed one resident accuse another resident of abuse. The complainant was informed by a staff member that there would be an investigation and follow up, however, the complainant never received a follow up.

A) The Inspector reviewed resident #001's electronic progress notes and identified a progress note dated on a specified date in 2018, which indicated that the resident was to have had documentation of a specified intervention initiated on a particular date for a set amount of days. A second progress note on another date in 2018, indicated that resident #001 was being referred to a specialized service and was to have documentation of a specified intervention initiated on a particular date for a set amount of days to monitor for patterns in behaviours. An additional progress note dated further in 2018, indicated that the documentation of specified intervention would continue for an additional week. A further progress note on a specified date in 2018, indicated that the resident had returned to the home and the documentation of a specified intervention was to be completed.

Inspector #736 reviewed the resident's chart and could not identify the documentation of the specified intervention initiated on the date in 2018, however, the Inspector was able to locate the documentation of the specified intervention for two additional days in 2018. In a review of the documentation of the specified intervention, staff were to complete documentation of the intervention at specific intervals. The Inspector identified that the documentation of the specified intervention was not completed at all on five out of seven days. Sections of the specified intervention were not documented on two out of two days, with no documentation for a length of time on a specific date in 2018.

Inspector #736 reviewed the resident's documentation of the specified intervention from another date in 2018, and identified that the scheduled intervention lacked documentation. Sections of intervention were not documented on 13 out of the 14 days, with the no intervention being documented for a length of time on three separate dates.

Inspector #736 reviewed the resident's documentation of the specified intervention from an additional date in 2018. Sections of intervention were not documented on three out of seven days, with no intervention being documented for a length of time on two separate

dates.

B) The Inspector reviewed resident #003's documentation of the specified intervention from a specified set of dates in 2018, and identified that the scheduled intervention lacked documentation. Sections of intervention were not documented on four out of seven days, with no intervention being documented for a length of time on one date.

C) A review of resident #004's electronic progress notes identified a progress note on a specified date in 2018, that indicated that the resident was being referred to a specialized service and that staff were to initiate documentation of a specified intervention.

Inspector #736 reviewed the resident's documentation of the specified intervention on the specified dates, and identified that the scheduled intervention lacked documentation. Sections of the intervention were not documented on 9 out of 14 days, with no intervention being documented for a period of time on one date.

Inspector #736 reviewed the home's policy titled "Responsive Behaviours" (RC-17-01-04) last updated February 2017. The policy indicated that the documentation of the specified intervention was one of the tools the home used to conduct a more in-depth assessment of the resident throughout the 24 hour period.

The Inspector interviewed Personal Support Worker (PSW) #108, who indicated that the PSW who was responsible for the resident's care, was responsible to complete the documentation of the specified intervention. The PSW indicated that there were codes to indicate if the resident was calm or sleeping, as well as the responsive behaviours demonstrated.

The Inspector interviewed Registered Practical Nurse (RPN) #105, who indicated that PSWs were responsible to fill out the documentation of the specified intervention on a regular basis and that the RPNs were responsible to follow up and ensure that the documentation of the specified intervention was completed in its entirety. The RPN further indicated that the requirement for documentation of the specified intervention was for it to be filled out in its entirety with no missing documentation.

The Inspector interviewed the Behaviour Support System Registered Practical Nurse (BSS RPN) #110, who verified that typically the documentation of the specified intervention had been requested for residents so that the BSS RPN could determine patterns, triggers and interventions to manage behaviours. The BSS RPN further

indicated that there had been ongoing concerns with staff members completing the documentation of the specified intervention as required, and they were happy if they could get three days filled out in its entirety. The BSS RPN indicated that the expectation would be that the documentation of the specified intervention be filled out in its entirety for each resident.

Inspector #736 interviewed the Administrator, who stated that the documentation of the specified intervention should have been filled out completely. Together, Inspector #736 and the Administrator reviewed the documentation identified for resident #001, #003 and #004. The Administrator confirmed that the documentation of the specified intervention was not filled out for these residents in its entirety. [s. 6. (9) 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 all provisions of care, specifically the documentation of the specified intervention, is documented as required for each resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(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. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident who demonstrated responsive behaviours, triggers had been identified where possible and, strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours.

A complaint was submitted to the Director, which alleged resident to resident verbal and physical abuse. Please refer to WN#1 for further details.

A) A review of resident #001's electronic progress notes, identified that the resident had displayed specific responsive behaviours towards co-residents and staff. A further review of resident #001's electronic health record identified a referral to a specialized service on a specific date in 2018, which indicated that the resident was being referred for assistance in managing their specific responsive behaviours. The Inspector also identified an assessment that was completed later in 2018, by the BSS RPN #110 with the staff, which indicated that the resident displayed specific responsive behaviours. The summary statement of the assessment confirmed the specific behaviours.

An additional referral on a specified date in 2018, indicated that the resident had specific responsive behaviours towards other residents and staff. The referral further indicated that the resident had specific triggers that appeared to increase the resident's identified responsive behaviours.

A consultation note dated in 2018, indicated that there was consult with a physician completed on a different date in 2018. The physician recommended at the time of the consult, specific interventions and strategies to manage the identified triggers and responsive behaviours.

Inspector #736 reviewed the resident's electronic health record at the time of the reported concern, and could not identify any behavioural triggers or any strategies to manage the identified responsive behaviours.

In an interview with Inspector #736, PSW #108 indicated that resident's responsive behaviours, triggers and strategies would be located in the electronic care plan. The PSW indicated that resident #001 demonstrated specified responsive behaviours. The PSW further indicated that there were specific strategies that staff utilized to manage the responsive behaviours. The PSW indicated that the responsive behaviours, and strategies should have been in the resident's electronic care plan.

In an interview with Inspector #736, RPN #105 indicated that the staff attempted to determine triggers and strategies for individual residents and that PSW staff would tell registered staff if the strategies were effective in order to update the care plan. The RPN further indicated that resident #001 displayed responsive behaviours. The RPN indicated that the resident was triggered by specific things. The RPN further explained that for resident #001, they had utilized strategies to manage the responsive behaviours. Together, Inspector #736 and RPN #105 reviewed resident #001's care plan and the RPN indicated that the triggers to the responsive behaviours were not on the care plan, nor were the strategies and that they should have been.

B) Inspector #736 reviewed the electronic progress notes for resident #003 and identified a progress note a specified date in 2018, which indicated that the resident had displayed responsive behaviours towards co-residents and staff. A further progress note in 2019, indicated that the resident had another episode of responsive behaviours.

The Inspector reviewed resident #003's electronic health record in effect at the time of the inspection and could not locate any triggers or strategies related to the identified responsive behaviours towards co-residents or staff.

In an interview with Inspector #736, PSW #108 indicated that resident #003 had responsive behaviours towards staff and co-residents, and that the resident had specific triggers. The PSW further indicated that there were specific strategies staff were using to manage the responsive behaviours identified. The PSW stated that those behaviours, triggers and strategies should be included in the care plan.

In an interview Inspector #736, Registered Nurse (RN) #102 indicated that they were aware that resident #003 displayed responsive behaviours at times. The RN further indicated that the triggers and any identified strategies to manage the responsive behaviours would be located in the resident's care plan. Inspector #736 and RN #102 reviewed resident #003's care plan in effect at the time of inspection, and the RN indicated that the care plan did not have any of the triggers for the responsive behaviours or any strategies to manage the responsive behaviours and should have.

C) Inspector #736 reviewed the electronic progress notes for resident #004. A progress note from a specific date in 2018, indicated that the resident was noted to have displayed a specified responsive behaviour towards a co-resident. A further progress note in 2018, indicated that the resident displayed additional specific responsive behaviours towards co-residents and staff members.

The Inspector reviewed the electronic health record for resident #004 in effective at the time of the incident and could not locate any triggers or strategies related to the identified responsive behaviours.

Inspector #736 interviewed PSW #108 who indicated that resident #004 displayed specific repsonsive behaviours towards co-residents and staff members. The PSW further indicated that staff had managed the resident's behaviours by utilizing a specific strategy.

In an interview with Inspector #736, RN #102 indicated that resident #004 had displayed specified responsive behaviours. Inspector #736 and RN #102 reviewed resident #004's care plan, and RN #102 could not locate any triggers or strategies for the resident's specified responsive behaviours. The RN indicated that those behaviours, triggers and strategies should have been in the care plan, and even if the behaviour had resolved, it should still be indicated in the care plan so staff would be aware.

Inspector #736 reviewed the home's policy titled "Responsive Behaviours" (RC-17-01-04) last updated February 2017, that indicated that nurses were to ensure that care plans contain information related to each behaviour observed and at minimum triggers to the behaviour, a description of the behaviour, interventions to deal with the behaviour and what to do if the interventions were not effective.

Inspector #736 interviewed the Administrator, who indicated that the care plans for residents should have included identified responsive behaviours, triggers and strategies. Together, Inspector #736 and the Administrator reviewed the care plans for resident #001, #003 and #004, and could not locate triggers or strategies for the responsive behaviours that had been identified through record review and staff interviews. The Administrator indicated that the responsive behaviours, triggers and strategies were identified during the record review and staff interviews, were not on the care plans, and that they should have been. [s. 53. (4) (a)]

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 all residents who display responsive behaviours have their behaviours, triggers and strategies identified in their plan of care, 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 any person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred that resulted in harm or risk of harm had immediately reported the suspicion and the information upon which it was based to the Director.

A complaint was submitted to the Director, related to an allegation of resident to resident physical and verbal abuse. See WN #1 for further details.

O. Reg. 79/10, s.2 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.

A review of resident #002's electronic progress notes, by Inspector #736, indicated that on a specific date in the fall of 2018, resident #002 had a verbal altercation with a visitor. The progress note further indicated that the visitor was noted to be yelling at the resident in the dining room. An additional progress note later in the evening on same date in 2018, indicated that resident #002 remained upset about the interaction that they had had with the visitor.

A review of resident #001's electronic progress notes, by Inspector #736, indicated that on a specific date in 2018, RN #111 had made Director of Care (DOC) #101, aware of the incident that took place.

In an interview with Inspector #736, resident #002 indicated that they remembered having a verbal altercation with a visitor. The resident stated that on another date, the DOC indicated that the visitor involved would no longer be in the home, and the resident felt relieved by that.

A review of the "Zero Tolerance of Abuse and Neglect: Response & Reporting" policy (RC-02-01-02) last updated April 2017, indicated that any employee who becomes aware of or witnesses an incident of resident abuse will report it immediately to the Administrator/delegate/reporting manager. The policy further stated that in Ontario, when anyone witnesses abuse that causes harm or may cause harm to a resident is required to contact the Ministry of Health and Long Term Care (the Director) through the Action Line.

In an interview with RPN #106, they indicated that they were present on the home area on the evening of the incident on the specified date in 2018, when a visitor approached the RPN and indicated that they had a concern with resident #002. The visitor then proceeded back into the dining room and continued to have a verbal altercation with resident #002. The RPN further indicated that they had recalled that the visitor used profanity while speaking to resident #002 and that resident #002 was upset into the evening by the interaction. The RPN indicated that the interaction between the visitor and resident #002 would have been viewed as verbal abuse of a resident.

Inspector #736 reviewed the Long-Term Care Homes Portal to determine if a Critical Incident System (CIS) report was submitted by the home, related to the visitor to resident verbal abuse. The Inspector was unable to locate a CIS report related to the incident.

In an interview with DOC #101, they indicated that they were made aware of the incident between a visitor and resident #002, but could not recall who had informed them. DOC #101 further stated that they were aware that the visitor had used profanity and yelled at resident #002, which would have fit the definition of verbal abuse. DOC #101 indicated that a CIS report should have been submitted by them, but was not. DOC #101 could not recall why the report was not submitted.

In an interview with the Administrator, they indicated to Inspector #736 that they were unaware of the interaction between the visitor and resident #002 on specific date in 2018, however had read the progress notes at the time of the inspection. The Administrator was unable to locate any investigation notes, or a CIS report related to the alleged verbal abuse of resident #002 on specific date in 2018. Inspector #736 advised the Administrator of what information the staff had provided regarding the incident during the course of the inspection, as well as reviewed the progress notes in resident #002's electronic chart. The Administrator indicated that based on what staff recalled, the incident could have been viewed as verbal abuse and should have been reported immediately to the Director. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that included the nature of each verbal complaint, the date the complaint was received, the type of action taken, the final resolution, every date on which any response was provided to the complainant and a description of the response, and any responses made by the complainant.

A complaint was submitted to the Director, regarding an allegation of resident to resident verbal and physical abuse of a resident. See WN #1 for further details.

During a telephone interview with the complainant, they indicated to Inspector #736 that they had made their concern known to staff members and that the home's staff had indicated that the DOC was to follow up with them after an investigation had been completed. The complainant stated that they never received a follow up call with the outcome of the investigation.

Inspector #736 reviewed the home's complaint binder, and noted that there were no Complaint Investigation Forms in the complaint binder related to the concern that the complainant identified regarding resident #001.

In an interview with Inspector #736, RPN #106 indicated that they were present on the home area, when the complainant had voiced the concerns regarding co-residents targeting resident #001. The RPN indicated the RN on shift was also present during the

conversation and that they stated "they would deal with the documentation" and notify the DOC of the concern.

A progress note on resident #001's chart indicated that the DOC was made aware of the incident with the visitor.

A review of the policy titled Complaints and Customer Service (RC-09-01-04) last updated April 2017, indicated that the home defined a complaint as a verbal or written expression of grievance or dissatisfaction. The policy stated that when a complaint was received, the staff were to complete a concern/complaint investigation form in detail if the complaint could not be resolved within 24hrs, and forward the form to the Administrator/department manager.

In a telephone interview with DOC #101 they indicated that they were aware that the complainant had concerns about the care and other residents' interactions with resident #001 on the home area. DOC #101 further indicated that the concern was investigated but they could not recall if a Complaint Investigation Form was filled out at the time or not. DOC #101 also indicated that based on their recollection of the incident, there should have been a written record of the complaint and investigation.

In an interview with the Administrator, they indicated that they did not have a record of the concern, any investigation notes or any response to the complainant. They further indicated that there should have been a record of the concern and follow up. [s. 101. (2)]

Issued on this 22nd day of February, 2019

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

Original report signed by the inspector.