Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée


**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670


## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 30, 2020 | 2020_617148_0004 | 022915-19 | Critical Incident System |

### 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 West End Villa
2179 Elmira Drive OTTAWA ON K2C 3S1

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

AMANDA NIXON (148)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): January 22 and 23, 2020**

**This inspection included one Critical Incident report #2709-000035-19 related to resident to resident alleged physical abuse.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Clinical Coordinator, Social Worker, Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.**

**In addition, the Inspector reviewed resident health care records and observed resident care and the resident's care environment.**

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

**During the course of this inspection, Non-Compliances were issued.**
- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 O.Reg 79/10, s. 26. Plan of care**

**Specifically failed to comply with the following:**

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

The licensee has failed to ensure that the plan of care for resident #001 and #002 are based on, at a minimum, interdisciplinary assessment of mood and behaviour patterns, including any identified responsive behaviours and any potential behavioural triggers.

As noted in WN #2, resident #001 has exhibited responsive behaviours including verbal and physical aggression when a known trigger is present. The most recent Minimum Data Set (MDS) Assessment generated both Mood and Behavioral Resident Assessment Protocols (RAP). The RAPs described that resident #001 demonstrated verbal aggression, anger and frustration related to the resident's diagnosis and that both mood and behaviour would be care planned to ensure the safety of resident #001 and co-residents with the intent to reduce behaviour.

In review of the health care record, the plan of care for resident #001 did not provide for the resident's physical or verbal aggressions demonstrated towards residents, nor the known potential behavioural trigger.

The most recent MDS Assessment for resident #002, generated the Mood RAP whereby resident #002 was described to have verbal responsive behaviours related to the resident's diagnosis and that mood would be addressed in the resident's plan of care.

RPN #102, RPN #110 and PSW #108, described that the verbal behaviours of resident #002 are frequent and that this can cause distress for co-resident #001.

In review of the health care record, the plan of care for resident #002 did not provide for the resident's verbal responsive behaviours.

***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 plan of care is based on an interdisciplinary assessment of mood and behaviour patterns, including any identified responsive behaviours and any potential behavioural triggers, to be implemented voluntarily.***

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents**
**Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,**
**(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and**
**(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.**

**Findings/Faits saillants :**

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #001 and #002, including, identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations and identifying and implementing interventions.

On a specified date, a progress note written by RN #105 described that resident #001 became physically aggressive toward resident #003. Increased supervision of resident #001 was put in place; there were no injuries sustained by resident #003.

In an interview with RN #105, it was described that it was near the time of this incident that resident #001 began to demonstrate a sensitivity to a specified trigger whereby the resident would become agitated.

As indicated by WN #1 the plan of care was not updated to reflect this new trigger for responsive behaviors.

On a specified date, PSW #108 heard resident #002 calling out from the resident's bedroom. While PSW #108 attended to resident #002, resident #001 entered the bedroom and appeared agitated. PSW #108 described that resident #001 made threats of physical harm to resident #002. PSW #108 described that resident #001 went back to resident #001's bedroom and that the PSW reported the interaction to RPN #103.

As indicated by the health care record and interview with RPN #103 and PSW #108, there was no report of further action taken.

On the same date, PSW #108 heard resident #002 calling out. When PSW #108 entered the room of resident #002, the PSW found the resident with injuries. PSW #108, RPN #103 and RN #104 and #110 responded. At the time of the incident, resident #001 reported having been physically aggressive with resident #002 and resident #002 reported that resident #001 had been physically aggressive.

Progress notes written by RN #110 indicated that resident #001 was placed on 1:1 monitoring. In an interview with RN #110 it could not be determined if this monitoring was implemented. In an interview with Clinical Manager #101, it was reported that upon learning of the incident, three days after, the Clinical Manager implemented 1:1 monitoring. As reported by the Clinical Manager there was no indication that 1:1 monitoring was in place until three days after the incident.

In addition, on a subsequent date, a progress note written by RPN #111 described that while resident #002 was calling out from the resident's bedroom, resident #001 was observed to be approaching resident #002’s bedroom. RPN #111 was able to intervene and when asked by the RPN, resident #001 reported that resident #001 was going to the room of resident #002 to to shut the resident up. RPN directed resident #001 away from the bedroom of resident #002 and indicated the need to frequently monitor resident #001.

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #001 and #002.

***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 steps are taken to minimize the risk of altercations between residents including identifying factors that could potentially trigger such altercations and identifying and implementing interventions, to be implemented voluntarily.***

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**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.**
**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.**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident.**
**4. Misuse or misappropriation of a resident's money.**
**5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.**

**Findings/Faits saillants :**

The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

In accordance with section 2 of O. Regulations 79/10, “physical abuse” means, the use of physical force by a resident that causes physical injury to another resident.

On a specified date, a Critical Incident Report was submitted to the Director describing that three days prior, resident #002 was found with identified injuries. Resident #002 reported that resident #001 had entered the bedroom and hit and pushed resident #002. RN #104 indicated that during an interview with resident #001, shortly after resident #002 was found, that resident #001 admitted to having pushed resident #002.

As indicted by the progress notes and through interviews, the on-call Manager #109, RN #104, RN #110, RPN #103 and PSW #108 were aware of the incident on the date the incident occurred; however, none of the identified staff reported the alleged physical abuse immediately to the Director.

The licensee failed to ensure that physical abuse of resident #002 on a specified date was reported immediately to the Director.

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**Issued on this 4th day of February, 2020**

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

**Original report signed by the inspector.**