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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 23, 2019	2019_694166_0009	004531-17, 005749-17, 012931-17, 018550-17, 024422-17, 029119-17, 005732-18, 030544-18, 001990-19, 005598-19, 006619-19, 006701-19	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Fosterbrooke
330 King Street West NEWCASTLE ON L1B 1G9

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

CAROLINE TOMPKINS (166)

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): April 8, 9,10,11,12, 2019.

Logs #029119-17, 005749-17, 024422-17, 005732-17, related to falls; log #001855-17, 004531-17, 012931-17, 001990-17, 006701-19, 030544-18, 006619-19 and 005598-19, related to allegations of abuse were inspected concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Behaviourial Support Ontario (BSO) team member, Recreation Manager, Assistant Director of Nursing (ADOC), Corporate Nursing Consultant and the Executive Director (ED).

During the course of this inspection the inspector observed staff to resident interactions, resident to resident interactions, reviewed clinical health records, the licensee's investigation documentation and the licensee's policy related to the reporting of resident abuse.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Related to log #005732-17:

A Critical Incident Report(CIR) was submitted to the Director, reporting that a resident was transferred to the hospital for an injury that resulted in a significant change to the resident's health status. Review of the CIR documentation by Inspector #166, indicated that on a specified date, resident #007 sustained a fall. The report indicated at the time that the resident sustained the fall, resident #007's monitoring device was not functioning. Resident #007 was assessed and denied having any discomfort.

Review of resident #007's clinical records by Inspector #166, indicated at a later time, on the same specified date, resident #007 complained of discomfort and was transferred to the hospital for further assessment and treatment.

Review of resident #007's plan of care by Inspector #166, indicated interventions which included a monitoring device that had been put into place to mitigate injury to resident #007.

During an interview with Inspector #166, the Executive Director (ED) and the Assistant Director of Care (ADOC) confirmed that when resident #007 fell, the resident's monitoring device was not functioning.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #007 as specified in the plan, related to use and function of the monitoring device.

Related to log #006619-19:

A Critical Incident Report (CIR) was submitted to the Director reporting an allegation of staff to resident abuse. Review of the CIR and the licensee's documentation by Inspector #166, indicated resident #011 displayed a specified responsive behaviour when PSW #100 and PSW #109 were attempting to prepare the resident for transfer. Due to the resident's identified responsive behaviour, the two PSWs left and later re-approached the resident. Resident #011 continued to display the specified responsive behaviour when the PSWs re-approached the resident. PSW #100 suggested they re-approach the resident again at a later time and continued to work in the same room, however PSW #109 continued to prepare resident #011 for the transfer.

Review of the licensee's documentation by Inspector #166, indicated it was during the time PSW #109 continued preparing the resident for the transfer that PSW #100 overheard an interaction between PSW #109 and the resident. The licensee's documentation indicated that PSW #100 did not witness the incident but heard sounds. PSW #100 reported the incident to the Charge Nurse, who in turn reported the incident to the Manager on call. Resident #011 was assessed.

The licensee's documentation included two documented interviews with co- resident #012. During the licensee's documented second interview with resident #012, the information related to observing the interaction between PSW #109 and resident #011 was deemed by the licensee to be inconclusive. The licensee through their investigation found the allegation of staff to resident abuse unsubstantiated.

Inspector #166, reviewed resident #011's plan of care related to responsive behaviours towards receiving care. The plan of care indicated that staff are directed when the resident is refusing care to leave the resident and reattempt.

Review of the licensee's documentation, resident #001's clinical records and during an interview with Inspector #166, the Assistant Director of Care (ADOC) indicated that on the date of the incident, resident #011 had displayed a specified responsive behaviour. Despite the resident's identified behaviour, PSW #109 continued to provide care to the resident, contrary to the interventions outlined in resident #011's plan of care.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #011, as specified in the resident's plan related to re-approaching the resident when the resident displays responsive behaviours. [s. 6. (7)]

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 care set out in the plan of care is provided to residents as specified in the plan, 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 demonstrating responsive behaviours, the behavioural triggers for the resident are identified, where possible.

Related to logs #004531-17, #018550-17, #001990-19 and log #006701-19:

Log #004531-17

A Critical Incident Report (CIR) was submitted to the Director reporting an allegation of resident to resident abuse. Review of the CIR documentation, indicated that on a specified date and time, resident #001 displayed a specified responsive behaviour directed towards resident #002. There had been no previous history of this specified responsive behaviour by resident #001 directed towards co- residents at the time of this incident. The Substitute Decision Makers (SDM) for both residents were notified, as were the police, the physician and the Director.

Review of of the CIR documentation and the clinical records for both residents by Inspector #166, indicated resident #002 was assessed and emotionally supported. Increased monitoring of Resident #001 was put into place. A medication review for resident #001 was completed by the physician. A room changed was offered to both residents but the SDM for both residents declined the move.

Log #018550-17

A Critical Incident Report (CIR) was submitted to the Director reporting an incident of

resident to resident abuse.

Review of the CIR and clinical documentation by Inspector #166 indicated, that on a specified date and time resident #001 displayed an identified specified responsive behaviour directed towards #003. Resident #003 did not consent to the identified behaviour and expressed being concerned that it would happen again. Both residents were separated immediately. A Personal Support Worker (PSW) was assigned one to one monitoring of resident #001.The SDM for both residents were notified as were the police, the physician and the Director.

Review of resident #001's plan of care related to responsive behaviours, indicated interventions were in place to mitigate resident #001's behaviour.

Log #001990-19

A CIR was submitted to the Director, reporting that resident #004 was passing resident #001, when resident #001 displayed a specified responsive behaviour directed towards resident #004.

Review of the CIR and clinical documentation for both residents by Inspector #166, indicated resident #001 and resident #004 were separated immediately, both residents were placed on frequent monitoring. The Substitute Decision Makers (SDM) for both residents were notified as were the police, physician and the Director.

Review of Behavioural Support Ontario (BSO) documentation by Inspector #166, indicated that the current interventions in resident #001's plan of care were to remain in place and additional interventions to mitigate resident #001's responsive behaviour were added to the resident's plan of care.

Log #006701-19

A CIR was submitted to the Director reporting that on another specified date and time, when resident #004 passed by resident #001, resident #001 displayed an identified responsive behaviour directed towards resident #004. The residents were immediately separated. Review of clinical documentation for both residents indicated resident #004 was assessed and displayed no indication of distress. One to one staff monitoring of resident #001 was initiated.

During an interview with Inspector #166, the Activity Manager indicated that resident #001 does not participate in group activities. One to one social activities were provided, however resident #001 preferred to stay in their room.

During an interview with Inspector #166, RN #103, indicated there had been a medication change for resident #001.

During an interview with Inspector #166, RPN #104, indicated resident #001's, identified responsive behaviours were more directed at staff, however some residents will respond when resident #001 calls out to them. The resident had one to one monitoring for twelve hours daily put into place. Resident #001 had new seating arrangement so that the resident could not be in close contact with other residents.

During separate interviews with Inspector #166, RPN #104, RN #103, ADOC, the Activity Manager, PSW #100 and review of resident #001's clinical records which included the interventions to mitigate the resident's identified behaviour did not provide any evidence that behaviourial triggers had been identified within resident #001's plan of care.

The licensee shall ensure that for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, where possible. [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, for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, where possible, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported is immediately investigated.

Related to log #030544-18:

A Critical Incident Report (CIR) was submitted to the Director reporting an alleged incident of staff to resident abuse.

Review of the CIR documentation indicated resident #013 was very upset with co-resident #014.

Review of the licensee's documentation and resident #013's clinical records by Inspector #166, indicated resident #013 displayed a specified responsive behaviour directed towards resident #014. The documentation indicated resident #014 was taking apart the bed covers of another resident's bed. Resident #013 used the nurse call system to call for assistance and then attempted to stop resident #014.

PSW #100, went to the resident's room and overheard PSW #010, involved in a specified behaviour directed towards resident #013. PSW #110 then told resident #013, that resident #013's SDM had been called and was upset with resident #013's behaviour. PSW #110's comments increased the resident's responsive behaviour.

Review of the licensee's documentation and in separate interviews with the ADOC, the Executive Director (ED) and PSW #100, by Inspector #166, indicated PSW #100 had immediately informed the registered staff of the incident and the registered staff then immediately notified the Director of Care. The investigation into the incident was initiated two days after the allegation of staff to resident abuse was reported.

The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated. [s. 23. (1) (a)]

WN #4: 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 the person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

Related to log #005598-19:

A Critical Incident Report (CIR) was submitted to the Director related to an allegation of staff to resident abuse.

Review of the CIR documentation by Inspector #166, indicated the SDM for resident #010 noticed a minor injury on resident #010. When the SDM asked the resident how the injury had occurred, the resident replied that two staff members had caused the injury. The SDM recounted the matter to the RPN, who then reported the incident to RN #108. The RN immediately questioned the resident related to the incident. Resident #010 was unable to identify the staff members or how the injury had occurred.

Review of clinical documentation related to the incident by Inspector #166, indicated the RPN had reported to RN #108, that the SDM of resident #010 communicated that resident #010 had an injury and had complained of discomfort. Resident #010 was assessed and it was found that the resident had sustained an injury over an identified

area of the body, no other injures were observed at the time. Range of Motion (ROM) was decreased but the resident was still moving well. A Head to Toe assessment was completed and no other abnormality was seen. An analgesic was administered to the resident for the complaint of discomfort. Pain tracking was initiated. The Manager on call was notified. The resident's physician was also notified of the injury. Results of a diagnostic test indicated no evidence of further injury.

Review of the licensee's documentation by Inspector #166, indicated the ADOC, had initiated an investigation into the incident. All psws and registered staff, who provided care to resident #010 on the identified dates were interviewed. Due to the inability of the resident to identify the staff or to recollect how the injury had occurred, the licensee was not able to substantiate the allegation of staff to resident abuse.

Review of the licensee's documentation and in separate interviews with the ADOC and the ED by Inspector #166 indicated, the Director was not notified of the alleged staff to resident abuse until two days after the incident had occurred.

Related to log #030544-18:

A Critical Incident Report (CIR) was submitted to the Director reporting an alleged incident of staff to resident abuse. The Substitute Decision Maker (SDM) and the police were notified of the incident.

Review of the CIR documentation indicated, resident #013 was very upset with co-resident #014.

Review of the licensee's documentation by Inspector #166, indicated resident #014 was taking apart the bed covers of another resident's bed. Resident #013 used the nurse call system to call for assistance and then attempted stop resident #014, but was unsuccessful. Resident #013, then displayed an identified responsive behaviour directed towards resident #014. PSW #100 went to the residents' room and overheard PSW #010, interacting with resident #013. PSW #110, then told resident #013, their SDM was called and was upset with resident #013's behaviour. PSW #110's comments increased the resident's responsive behaviours. The documented statement, indicated PSW #100, informed the registered staff of the incident and the registered staff notified the Director of Care.

Review of the licensee's investigation notes, critical incident documentation and

interviews with the ADOC and the ED by Inspector #166, indicated, the Director was not notified of the alleged staff to resident verbal abuse until two days after the incident had occurred.

The licensee failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director. [s. 24. (1)]

Issued on this 6th day of June, 2019

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

Original report signed by the inspector.