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 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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 30, 2017	2017_601532_0010	017311-17	Critical Incident System

Licensee/Titulaire de permis

GOLDEN YEARS NURSING HOMES (CAMBRIDGE) INC
704 EAGLE STREET NORTH P.O. BOX 3277 CAMBRIDGE ON N3H 4T3

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

GOLDEN YEARS NURSING HOME
704 EAGLE STREET NORTH P.O. BOX 3277 CAMBRIDGE ON N3H 4T3

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

NUZHAT UDDIN (532)

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): August 2 and 3, 2017.

Critical Incident System (CIS) inspection #1033-000011-17, log # 017311-17, and CIS # 1033-000010-17 log # 016864-17 related to resident to resident abuse was completed.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurses (RN), Behaviour Support Ontario Staff (BSO), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and Residents.

The inspector also toured the resident home areas, reviewed clinical records, observed the provision of care and interaction between staff and residents, reviewed relevant policies and procedures.

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.
- **2 WN(s)**
- **1 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	Legendé 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 O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents.

Record review indicated that an identified resident had responsive behaviours.

Record review indicated that there were interventions documented in the plan of care related to the responsive behaviours.

Record review for responsive behaviours demonstrated that there was an escalation in the behaviours since a trigger was presented and the progression of responsive behaviours were documented in the electronic documentation.

On the day of the incident, progress note indicated that the identified resident was involved in a physical altercation with another resident. With further investigation it was discovered that the altercation was related to the identified trigger.

Clinical record review indicated that as a result of the altercation the identified resident sustained injuries.

Clinical record review stated that that physical responsive behaviours were documented on a specified dates.

BSO-RPN shared that the identified resident was not presently part of the BSO case load as they were discharged.

BSO RPN explained the process for BSO referral for a new admission and indicated that new residents were not seen upon admission until there was a referral made by a registered staff or it was noted on the application from Community Care Access Centre (CCAC) that resident had behaviors. Once the referral was made, the BSO team would follow-up with the resident until the goal for the resident was met and then they would be discharged from the case load. BSO RPN was asked about the referral process for the

current resident residing in the home. They said that a referral was made by a manager or a unit registered staff, however, the PSWs were to go through the registered staff to make a referral as the home liked to have paper trail.

BSO RPN said that they identified the resident as having responsive behaviours due to certain identified triggers and both incidents related to physical responsive behaviours involved a trigger.

The RPN said that the BSO team addressed one behavior at a time. They shared that registered staff were to make a new referral for each behavior as it was hard for the BSO team and the resident if they were to address all behaviors at once. They said that residents had to be referred back to them for any new or changed behaviours. BSO RPN shared that they were not aware of physical responsive behaviour for the identified resident and there was no referral made from the registered staff to notify the BSO team regarding physical behaviour. BSO RPN was shown behavior documentation that indicated responsive behaviors –physical, however, they shared that they were not aware.

The ADOC was informed that the identified resident's physical behaviour was not assessed by the BSO team as the team was not aware that the resident had displayed physical behavior and the ADOC was also made aware regarding BSO practice of assessing one behaviour at a time. The ADOC shared that they were not aware of the current practice and acknowledged that the BSO team should address all behaviours once the resident was referred to them. They said that the home could have been more proactive in addressing these behaviours, however, the procedures and interventions were not developed to assist residents and staff until after the altercation.

The licensee has failed to ensure that triggers were identified and that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of the identified resident escalating responsive behaviours.

The severity of this area of non-compliance was actual harm. The scope was determined to be a pattern and there was a compliance history related to this legislation being issued on June 7, 2017, in a Resident Quality Inspection 2017_600568_0007 as a Voluntary Plan of Correction (VPC). [s. 55. (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 procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and ensure that residents were not neglected by the licensee or staff.

The following is further evidence to support Compliance Order #001 issued April 11, 2017, in a Resident Quality Inspection (RQI)) 2017_600568_0007 with a compliance due date of August 31, 2017.

Ontario Regulation 79/10 s.2 (1) defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident."

The Critical Incident (CI) report submitted to the Ministry of Health and Long-Term Care (MOHLTC) reported a resident to resident physical abuse.

Clinical record reviewed indicated that as a result of this altercation there was an injury to the specified resident.

Record review further showed that there was a multi-disciplinary team meeting where the team collaborated and discussed options.

On a specified date another Critical Incident (CI) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) indicating a resident to resident physical abuse, and an injury related to this incident.

Record review showed that there was another multi-disciplinary team meeting to discuss options.

The ED acknowledged that there was lack of interventions in place and shared that the identified resident was very difficult to manage and was not easily re-directed.

In an interview ADOC shared that there were interventions discussed but they were never carried out as the identified resident was not in the home.

The licensee has failed to ensure that interventions for specified resident were in place to protect other residents from abuse.

The severity was determined to be a level three as there was actual harm. The scope of this issue was a pattern and there was a compliance history of this legislation being issued in the home on June 7, 2017, in a Resident Quality Inspection 2017_600568_0007 as a Compliance Order with the due date of August 31, 2017. [s. 19. (1)]

Issued on this 6th day of November, 2017

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

Original report signed by the inspector.