Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Jul 19, 2019	2019_767643_0019	003628-17, 010351-17, 020144-17, 020995-17, 022578-17, 026127-17, 011515-18, 011950-18, 004089-19, 005251-19, 009567-19	Complaint

Licensee/Titulaire de permis

The Governing Council of the Salvation Army in Canada
2 Overlea Blvd TORONTO ON M4H 1P4

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

Isabel and Arthur Meighen Manor
155 Millwood Road TORONTO ON M4S 1J6

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

ADAM DICKEY (643), IVY LAM (646)

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): June 17-21 and 24-27, 2019.

The following Complaint intakes were inspected during this inspection:

Log #020995-17 and Log #022578-17 - related to responsive behaviours;
Log #005251-19 and Log #011515-18 - related to alleged abuse and neglect;
Log #009567-19 - related to safe and secure home;
Log #010351-17 - related to falls prevention and management; and
Log #026127-17 - related to rejection of application for admission.

The following Critical Incident System (CIS) intakes were inspected concurrently during this inspection:
Log #011950-18, CIS C603-000018-18 - related to alleged abuse;
Log #010351-17, CIS C603-000012-17 and Log #003628-17, CIS C603-000007-17 - related to falls prevention and management; and
Log #004089-19; CIS C603-000003-19 - related to injury with cause unknown.

A Written Notification (WN) and Voluntary Plan of Correction (VPC) under O. Reg. 79/10, s. 8. (1) (b), identified in this inspection (Log #005251-19) will be issued under CIS inspection #2019_767643_0020 concurrently inspected during this inspection.

A WN and VPC under LTCHA, 2007, S.O. 2007, c.8, s. 22. (1), identified in this inspection (Log #005251-19) will be issued under CIS inspection #2019_767643_0020 concurrently inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Physiotherapist (PT), Social Worker (SW), Administrative Manager, Manager of Performance and Capacity Toronto Central LHIN, Behavioural Supports Ontario (BSO) Program Lead, Environmental Services Manager (ESM), Personal Support Workers (PSW), private companions and residents.

During the course of the inspection, the inspector(s) conducted observations of staff and resident interactions and the provision of care, reviewed resident health records, internal complaints records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

- **2 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for resident #016 set out the planned care for the resident to manage identified responsive behaviours.

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date which alleged abuse of resident #016 by RPN #106. The home submitted a CIS report on the same date indicating private companion (PC) #134 alleged abuse of resident #016 by RPN #106 while providing treatment at a specified time of day.

In an interview, PC #134 indicated that on the above identified date, they were in resident #016's room when RPN #106 entered the room, woke resident #016 and attempted to administer a specified treatment. PC #134 indicated that resident #016 demonstrated identified responsive behaviours toward RPN #106. PC #134 indicated that RPN #106 applied specified physical force and attempted to provide the specified treatment twice. Resident #016 was not able to answer questions regarding the incident at the time of the inspection.

In an interview, RPN #106 indicated that they had gone to resident #016's room on the above identified date, and the resident was awake and had consented to the specified treatment. The RPN indicated that they began to carry out the treatment and resident #016 exhibited identified responsive behaviours toward the RPN and the RPN stopped the treatment at that time. Review of the home's investigation notes showed RPN #106 denied being rough with or using force toward resident #016 in order to provide the above mentioned treatment.

In interviews, RPN's #102, #104 and #106 indicated that resident #016 could at times demonstrate identified responsive behaviours when the staff would provide the above specified treatment and administer a specified medication. The RPNs indicated that they would leave the resident and come back and re-attempt or to talk to the resident to distract them and attempt to provide treatment after the resident calmed. The RPNs indicated that resident #016 was exhibiting this behaviour on an ongoing basis.

Review of resident #016's care plan did not show interventions for staff to manage the identified responsive behaviours in response to the specified treatment and medication administration.

In an interview, the DOC indicated that staff were re-approaching resident #016 and were approaching with a second staff member to distract the resident while carrying out the specified treatment. The DOC indicated staff needed to use a gentle approach and if exhibiting the identified responsive behaviours and the resident would accept the treatment. The DOC indicated that this planned intervention should have been included in resident #016's written plan of care and had not been. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

A complaint was submitted to the MOHLTC related to the effectiveness of resident #013's falls prevention and management interventions. The complainant had reported that the resident had multiple falls over an identified six-month period.

Review of resident #013's current care plan showed that the resident was at risk for falls as evidenced by previous injury from fall. Interventions were care planned for the resident to prevent falls and minimize injury.

Observation of resident by the inspector showed that the resident had an identified piece of equipment to minimize injury in place, however the equipment was not properly applied. Further observation by the inspector showed that the above identified equipment was not in good repair and could not be applied correctly.

Review of the manufacturer's instructions for the above identified equipment, which was provided by the PT, showed that the equipment must be properly applied in order to be effective in minimizing injury from fall.

Observation by the inspector on two occasions showed a second specified falls prevention intervention was in place for resident #013, but was not properly applied to function effectively. Two additional observations by the inspector showed resident #013's specified falls prevention intervention was not properly applied to function effectively. A subsequent observation by the inspector showed the above specified falls prevention intervention was not in a state of good repair.

Interviews with PSW #119, and RPN #108 indicated that when they noticed that something is broken or worn out, the PSWs should inform the registered staff. They further stated that the registered staff would inform the falls lead if the above specified falls prevention intervention was broken and would inform the PT if the identified equipment to minimize injury was broken or worn out. PSW #119 stated that they had seen the resident with the identified equipment to minimize injury in place but not properly applied previously, but they had not reported this to the registered staff.

Interview with RPN #108 showed that, according to the progress notes, the above identified equipment to minimize injury from falls was provided for resident #013 on an identified date and had been part of the resident's falls prevention and management interventions daily since then. RPN #108 stated that no staff had reported to them regarding any issues with either falls prevention and management interventions. Review

of resident #013's progress notes did not indicate any issues identified with either falls prevention and management interventions since the above mentioned identified date. RPN #108 indicated that they were not aware how long the identified equipment to minimize injury from falls had been in poor repair and was not being applied properly. RPN #108 further stated that above specified falls prevention intervention was broken and the PSWs may have fixed it on their own instead of reporting it to the registered staff, so the falls lead (RN #122) could provide a replacement.

Interview with the PT stated that it was the home's expectation that the above mentioned identified equipment to minimize injury from falls should be applied according to the manufacturer's instructions. The PT also stated that the specified falls prevention intervention should be applied in a specific way in order to function properly. The PT further stated that no staff had mentioned to them that there were any issues with either of resident #013's falls prevention and management interventions.

Interview with the falls lead (RN #122) showed that the staff were expected to notify the falls lead if the above specified falls prevention intervention was broken, and the falls lead would provide a replacement. The falls lead stated that no staff member had notified them about issues with resident #013's specified falls prevention intervention.

Interview with the DOC showed that the PSWs were expected to inform the registered staff if a resident's falls prevention interventions and equipment are broken down, and the registered staff should inform the PT or the falls lead, and that this was not done for resident #013 when either of the above falls prevention and management interventions were broken or worn out. The DOC further stated that it was the home's expectation for staff and others involved in residents' care to collaborate in providing each resident's care, and there was a lack of collaboration in the implementation of the falls prevention interventions for resident #013. [s. 6. (4) (b)]

3. 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.

Review of resident #013's current care plan showed that the resident was at risk for falls as evidenced by injury from a previous fall. Interventions were included in the plan of care to prevent the occurrence of falls and to minimize injury.

Observations were conducted by the inspector which showed that one of the interventions that were in place for falls prevention and management for resident #013

was not in place as specified in the resident's care plan. The inspector observed that an identified falls prevention and management intervention was not in place for resident #013 on two occasions during the inspection.

Interview with PSW #120, who was assigned to provide care to resident #013 on an identified date, stated that it was their first time working with the resident and they had not read the resident's care plan prior to providing care, and was not aware that the above identified falls prevention and management intervention was to be in place for the resident.

Interview with PSWs #119 and #120, and RPN #108, indicated that the PSWs did not have access to the electronic medical record, but had access to resident care plans in the care plan binder. Review of the care plan binder with PSW #120 showed that resident #013 had falls prevention and management interventions care planned, including the above identified intervention.

Interview with the DOC stated that staff members are expected to provide residents with the care set out in their plan of care, and the staff had not applied the above identified falls prevention and management intervention as was specified in the resident's plan of care. [s. 6. (7)]

4. The licensee has failed to ensure that resident #015 was reassessed and the plan of care reviewed and revised when care set out in the plan had not been effective to manage identified responsive behaviours.

Complaints were submitted to the MOHLTC by a family member of resident #015 concerning the home's management of the resident's responsive behaviour. In an interview, resident #015's family member indicated that the staff of the home told them they could not manage resident #015's behaviour without use of additional pharmacological intervention.

Review of resident #015's health records showed they were admitted to the home with an identified diagnosis. Resident #015's quarterly minimum data set (MDS) assessment records for the five quarters following the resident's admission showed the resident exhibited several identified types of responsive behaviours daily during the assessment observation periods.

In interviews, RPN #112 and RPN #130 indicated that interventions which were care

planned for resident #015 were at times ineffective, though behaviours were managed by staff of the home. The RPNs indicated that the resident would exhibit identified responsive behaviours. The RPNs indicated resident #015 would be provided with additional specified behavioural management interventions which were at times effective.

In an interview, PSW #129 indicated resident #015 was challenging to care for due to the responsive behaviours that the resident exhibited on a regular basis. PSW #129 indicated specified strategies were used with resident #013 to eliminate triggers to their behaviours or calm them once behaviours were being exhibited. PSW #129 indicated later interventions were initiated by BSO RPN #113 which were more effective in managing the behaviours.

Review of resident #015's plan of care showed several identified behavioural management strategies had been put into place 10 days following admission to the home. No revisions were made to the resident's plan of care related to the identified behavioural management interventions, despite exhibiting the above identified responsive behaviours on an ongoing basis during the five consecutive quarters as evidenced by the above MDS assessments.

In an interview, BSO RPN #113 indicated that resident #015 was challenging to manage, and that different interventions were implemented after they began in the role more than one year after resident #015's admission. RPN #113 indicated that they established interventions to manage behaviours based on resident #015's previous life experiences. RPN #113 indicated interventions were communicated to unit staff verbally or by notes in the nursing station. RPN #113 acknowledged these interventions were not included in resident #015's plan of care.

In an interview, DOC indicated that the resident's behaviour upon admission was difficult for staff of the home to manage. The DOC acknowledged that resident #015's behaviours were not managed well by the interventions that were included in the plan of care. The DOC indicated that it would be the expectation of registered staff on the unit to review and revise resident care plans quarterly, and if the interventions were ineffective. The DOC indicated that resident #015's plan of care had not been revised when the behavioural interventions were not working. [s. 6. (10) (c)]

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 with ensuring:
- that the staff and others involved in the different aspects of care of a resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other;
- that the care set out in the plan of care is provided to residents as specified in the plan; and
- that residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, when the resident has fallen, that the resident had been assessed and, if required, a post-fall assessment had been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A complaint was submitted to the MOHLTC related to the effectiveness of resident #013's falls prevention and management interventions. The complainant had reported that the resident had multiple falls over an identified six-month period.

Two Critical Incident System (CIS) reports were also submitted related to resident #013

on two identified dates during the above six-month period when the resident was transferred to hospital which resulted in a significant change in their health condition.

Interview with RPNs #104 and #108, and the falls lead (RN #122) stated that the when a resident has fallen, risk management for falls is completed after each fall, and a fall risk assessment post fall is also completed in the electronic medical record.

Review of resident #013's fall history over the above identified six-month period showed that the resident had falls on five identified dates.

Review of the risk management on the home's electronic medical record system for the above mentioned falls identified that the risk assessment was not completed for resident #013's fall on fourth above mentioned identified date in which resulted in injury and transfer to hospital for treatment. Further, the fall risk assessment post fall was initiated but not signed and locked for the fall incident.

Interview with the falls lead (RN #122) stated that the information entered on the incomplete fall risk assessment post fall for the above identified fall incident, was not correct, as the assessment had documented that the resident only had one to two falls in the past six months, but the resident had more than two falls.

Interview with RPN #135 who had assessed the resident and documented after the fourth identified fall incident on the above mentioned date, stated that they had completed the progress note and an incident note at the time, and had not completed the risk assessment for falls. RPN #135 could not recall why they had not completed the fall risk assessment form for resident #013 for the identified date.

In an interview, the DOC stated that the post-fall assessment was not completed for resident #013 using the assessment form specifically designed for falls following the resident's fourth fall incident on the above identified date. [s. 49. (2)]

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 with ensuring that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 23rd day of July, 2019

[redacted]

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

Original report signed by the inspector.