Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: March 13, 2023	
Inspection Number: 2023-1222-0001	
Inspection Type: Complaint Critical Incident System	
Licensee: Kingsway Nursing Homes Limited	
Long Term Care Home and City: Kingsway Lodge Nursing Home, St Marys	
Lead Inspector Cassandra Aleksic (689)	**Inspector Digital Signature** Cassandra N Aleksic Digitally signed by Cassandra N Aleksic Date: 2023.03.14 17:37:26 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 7, 8, 9, 13, 14 and 21, 2023 onsite and February 22 and 23, 2023 conducted offsite.

The following intake(s) were inspected:

- Intake #00003194 / CI: 2726-000022-22; and Intake #00006925 / CI: 2726-000021-22] related to falls prevention and management
- Intake #00004771 / CI: 2726-000004-22; and Intake #00012258 – Complaint related to prevention of abuse and responsive behaviours
- Intake #00012645 / CI: 2726-000026-22 related to prevention of abuse and neglect
- Intake #00020828 - Complaint related to resident care and support services

The following intake(s) were completed in this inspection:

- Intake #00002970 / CI: 2726-000020-22 related to falls prevention and management

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

COMPLIANCE ORDER CO #001 - Licensee must investigate, respond and act

NC #001 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with FLTCA, 2021 s. 27 (1) (a) (i).

Specifically, the licensee must:

A) Ensure that every alleged, suspected or witnessed incident of abuse of a resident by resident #003 is immediately investigated and the home's resident abuse policy specific to investigation procedures is followed.
B) For every alleged, suspected or witnessed incident of abuse as per part A), complete and maintain a record of the investigation per the home's "Investigation of an Alleged Report of Abuse" document as mentioned under procedures in the home's resident abuse policy.
C) Provide training for all management staff responsible for completing investigations in the home.
D) Maintain a record of staff names, dates, trainers name, and training content to ensure that that the training was completed.

Grounds
The licensee had failed to ensure that every alleged, suspected or witnessed incident of abuse towards resident #002 by resident #003 was immediately investigated.

Rationale and Summary
A complaint was submitted to the Ministry of Long-Term Care which documented ongoing abuse between resident #002 and #003. There were two critical incident reports submitted to the Critical Incident Reporting System with the Ministry of Long-Term Care related to the physical altercations resulting in harm between the residents.

The Ontario Regulations 246/22 defines "physical abuse" subject to subsection (2) (c) as the use of physical force by a resident that causes physical injury to another resident.

The home's Resident Assault/Abuse policy stated that a person who had reasonable grounds to suspect that abuse or neglect had occurred or may occur shall immediately report the suspicion and the information, and an investigation would take place immediately. Included with the policy was a document to record the "Investigation of an Alleged Report of Abuse".

The plans of care for both residents were reviewed, and the inspector identified multiple incidents of verbal and physical altercations towards resident #002 by resident #003 resulting in harm or risk of harm. There were no incident reports completed and no documentation to demonstrate that resident #003 was assessed for injury or required treatment. There were no completed "Investigation of an Alleged Report of Abuse" reports provided to the inspector related to the physical altercations between resident #002 and #003 during this timeframe.

The Director of Care (DOC) stated that a progress note and incident report was to be completed in Point Click Care (PCC) in order for staff to document the monitoring of the resident and whether the resident had sustained injuries or required treatment. When asked, the DOC stated that they were not sure if the resident would have been assessed for injury if no risk management report or documentation had been completed. The DOC stated that if the incident was not reported by staff into the risk management report, then it would not have prompted management to complete an investigation into the incident. The DOC stated no altercations or incidents of abuse between the two residents were reported to them prior to an email received from a staff member on a specific date, therefore incidents occurring prior to this time were not reviewed or investigated on.

The lack of investigation into the physical abuse with potential injury, led to recurring incidents, which may have posed an increased risk of physical harm to resident #002 by resident #003.

Sources: Plans of care for resident #002 and #003; interview with the DOC, the home's resident abuse policy [689]

This order must be complied with by April 30, 2023

COMPLIANCE ORDER CO #002 - Policy to promote zero tolerance

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee has failed to comply with FLTCA, 2021 s. 25 (1)

Specifically, the licensee must:

A) Retrain all staff on mandatory reporting of alleged resident to resident abuse.
B) Maintain records of the training provided including, but not limited to, dates, times, attendees, trainer, and materials taught.
C) Ensure that for every suspected, alleged or witnessed abuse towards resident #002 or by resident #003 that results in harm, or risk of harm, the home's resident abuse/assault policy is followed, including but not limited to, immediate reporting to the Director, conducting an investigation, documentation, and ongoing monitoring.

Grounds
The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary
A complaint was submitted to the Ministry of Long-Term Care which documented that abuse between resident #002 and #003 had been ongoing and they were not sure if critical incidents had been reported. On a specific date, a Critical Incident (CI) Report was submitted to the Ministry of Long-Term Care related to an incident of abuse towards resident #002 that resulted in harm or a risk of harm to the resident. A review of the CI report documented that resident #003 was physically aggressive with co-resident #002 which resulted in injury.

The home's resident assault/abuse policy stated that a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm, shall immediately report to the registered staff, managerial staff/administrator and an investigation would take place immediately. The policy stated that if an investigation results in a probable case of abuse, the matter would be reported to the Ministry of [Health] Long-Term Care.

Progress notes in Point Click Care (PCC) were reviewed and there were multiple incidents of

physical harm documented towards resident #002 by resident #003 that were not reported to the Director via the Critical Incident Reporting System.

The documented records for the residents showed multiple incidents where resident #003 was physically aggressive towards resident #002.

Per the home's policy related to mandatory reporting procedures, documentation shall be entered on the interdisciplinary progress notes and an incident reported was to be completed. There were multiple incidents of verbal and physical altercations towards resident #002 by resident #003 resulting in harm or risk of harm. There were no incident reports completed.

The Assistant Director of Care (ADOC) stated that the home's prevention of abuse and neglect policy included mandatory reporting requirements and confirmed that abuse which resulted in harm, or a risk of harm, should be immediately reported to the Director. The ADOC stated that if an incident report was not completed, then the management team may not have investigated or reported to the Director.

Sources: Interview with the ADOC and DOC; resident #002's and #003's plan of care; review of the Critical Incident Reporting System; the home's resident assault/abuse policy [689]

This order must be complied with by April 30, 2023

COMPLIANCE ORDER CO #003 - Behaviours and Altercations

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 60 (a)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Non-compliance with: O. Reg. 246/22, s. 60 (a)

The inspector is ordering the licensee to comply with a Compliance Order [O. Reg, s.60 (a)]:

Specifically, the licensee must:

A) Retrain registered nursing staff, personal support workers, agency nursing staff and

compassionate care givers, on the home's responsive behaviours policy, including procedures for responding to residents with responsive behaviours and behaviour management.
B) Maintain records of the training provided including, but not limited to, dates, times, attendees, trainer, and materials taught.
C) Develop and implement a process to ensure that resident #003's plan of care related to behavioural interventions, strategies and triggers is reviewed at least monthly. The review must be completed by a collaborative team, including the home's behavioural support members, the nurse practitioner or physician, one registered nurse, one personal support worker and one compassionate care giver.
D) Maintain a record of the reviews including, but not limited to, the names of staff members involved, the date(s) of the review(s), effectiveness of implemented interventions, interventions removed and/or added to the plan of care and reason for change, behavioural or medical assessments completed and reviewed (if applicable).
E) Communicate any changes made to resident #003's plan of care related to behavioural strategies and interventions to the direct care staff at the beginning of each shift. Maintain a record of the communication, including the date and staff who were informed, until complied by an inspector.
F) Develop and implement a process for shift report review by management staff to ensure appropriate clinical support and follow-up actions are taken, as applicable.

Grounds
The licensee has failed to ensure that procedures and interventions were implemented to assist resident #002 who was at risk of harm or harmed as a result of resident #003's behaviours, and to minimize the risk of altercations and harmful interactions between the residents.

Rationale and Summary
As per the residents' plan of care, resident #003 exhibited behaviours. The care plan documented that the resident expressed verbal/physical aggression with documented interventions.

There were multiple incidents of physical harm towards resident #002 by resident #003 documented in progress notes. Documented interventions by registered staff included separating and informing the residents that their behaviours were not acceptable or appropriate. There was documentation which showed re-occurring physical altercations within the same day post- separation.

A Registered Nurse (RN) stated that there had been numerous physical altercations between

resident #002 and #003. When asked, the RN stated that when an altercation occurred, the two residents were separated, and it was explained to them why they were being separated and why their behaviours were inappropriate. The inspector asked if the explanation of behaviours would be an effective intervention, the RN said no. Resident #002 and #003's plans of care indicated a cognitive impairment. The RN stated that after a while, there were so many incidents that no one knew what to do.

A doctors visit note documented that resident #003 was exhibiting worsening behaviours and had become violent at times. The note stated that staff were not sure what to do.

The Assistant Director of Care (ADOC) and inspector reviewed the physical altercations between resident #002 and #003 as documented in the progress notes. When asked what interventions or strategies were implemented or discussed during this timeframe for the residents to prevent harm, the ADOC stated that the home utilized the same interventions, and no changes were made in the plans of care related to responsive behaviour strategies for resident #003. The Director of Care (DOC) stated that they would not know if the interventions were effective or not if the incidents were not reported to the management and were not made aware of the resident altercations until a specific date.

Ineffective behavioural management for resident #003 led to an increased risk of reoccurring incidents of physical harm towards resident #002.

Sources: Plan of care for resident #002 and #003; Interview with a RN, ADOC and DOC. [689]

This order must be complied with by April 30, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.