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

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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
May 23, 2019	2019_794749_0002	018137-18, 003521-19, 007970-19	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Owen Hill Care Community
130 Owen Street BARRIE ON L4M 3H7

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

AMY PAGE (749), JENNIFER NICHOLLS (691)

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 29 to May 3, 2019, and May 6, 2019.

The following intakes were inspected upon during this Critical Incident System Inspection:
-Two intakes regarding an injury to a resident for which they were taken to hospital; and,
-One intake regarding potential staff to resident abuse.

A complaint inspection # 2019_794749_0003 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and Residents.

The Inspector(s) also conducted a daily walk through of resident care areas, observed the provision of care towards residents, reviewed relevant health care records, and internal investigation documents.

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.
- **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. (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 resident #002 and resident #009's plan of care in relation to a specified assessment was provided as specified in the

plan of care.

A Critical Incident System (CIS) report was submitted to the Director on a specified day in 2019, for an incident which resulted in a resident being transferred to hospital with a possible injury.

The home's policy for a specified assessment, last revised January 2015, was reviewed by Inspector #749, which indicated on page one the Director of Care or designate will complete a specified assessment as per the schedule outlined or as ordered by the Physician.

The specified assessment record was reviewed by Inspector #749. At the top of the record, a schedule indicated when the specified assessment was to be completed and documented at specific intervals up to a specified time frame, or until directed by a physician that the assessment was no longer required.

Inspector #749 reviewed resident #002's specified assessment for the day that the incident occurred. The first documented assessment was completed at the time of incident. The following assessments where not completed at the specific time intervals as stated in the schedule.

Inspector #749 reviewed resident #002's physician orders and did not identify any orders in relation to the specified assessment for the incident.

In an interview with RPN #100, they stated the incorrect frequency of the specified assessment. Together, Inspector #749 and RPN #100 reviewed the specified assessment record for resident #002, specific to documented assessment frequency. RPN #100 stated "those are the times I did it, so those are the times I wrote down". Inspector #749 verified with RPN #100 that the specified assessment should have been completed and documented as outlined in the schedule at the top of the assessment page and not at the intervals that were documented.

In an interview with the DOC #107, they stated the frequency of the specified assessment and documentation should be completed at specific time intervals as outlined on the schedule located at the top of the specified assessment form.

Together, Inspector #749 and DOC #107 reviewed the specified assessment record for resident #002, specific to documented assessment frequency. DOC #107 verified for

Inspector #749 that the specified assessment was not completed and documented at specific timed intervals as stated at the top of the form.

2. Inspector #749 reviewed the specified assessment record for resident #009, for a specified date in 2018, for an incident that occurred. The first two documented assessments were completed at the specified intervals. The remainder of the assessments where not completed at the specific time intervals as outlined in the schedule. At the bottom of the specified assessment form where the RN/RPN completing the assessment were to sign their initials, there were no initials or signatures for a portion of the documented assessments. There were no further records found in resident #009's chart related to the specified assessment for this incident.

Inspector #749 reviewed resident #009's physician orders and did not identify any orders in relation to the specified assessment for this incident.

Together, Inspector #749 and RPN #103 reviewed the specified assessment record for resident #009, specific to documented assessment frequency. Inspector #749 verified with RPN #103 the specified assessment was to be completed and documented at specific timed intervals as outlined at the top of the record and not at the intervals that were documented.

Together, Inspector #749 and RPN #100 reviewed the specified assessment record for resident #009, specific to documented assessment frequency. Inspector #749 verified with RPN #100 assessments were completed not at the specified time intervals.

Inspector #749 verified with DOC #107 that the documented specified assessment for resident #009, for the incident on a specified date 2018, started at the time of the incident. When asked if the specified assessment was to be assessed and documented as specified in the schedule at the top of the specified assessment form, DOC #107 replied "yes".

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 the resident as specified in the plan is, 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 there were care plan strategies and interventions in place to meet the needs of each individual resident.

A CIS report was submitted to the Director, on a specified day in 2019, for an incident of alleged staff to resident abuse. The CIS report identified that PSW #113 was providing care to resident #007, and resident #007 became physically aggressive, which resulted in an injury to the PSW.

A review of the progress notes, care plan, and the CIS report identified that a specified focus in the care plan did not have specified interventions.

Inspector #691 reviewed the home's policy titled "Responsive Behaviors –Management", # VII-F.10.20, last revised November 2018, which stated that the management of

residents experiencing responsive behaviors will be met using an interprofessional approach to screening, assessment, reassessment, and identification of behavioral triggers that may result in responsive behaviors, whether cognitive, physical, emotional, social, environmental or other, and to determine the occurrence, frequency and the duration of responsive behavior concerns."

Inspector #691 reviewed the home's policy titled "Plan of Care and Care Plan Definitions VII-C-10.70-SSLI (e), last revised April 2018, which stated that the care plan must identify risks the resident may pose to others, including behavioural triggers and safety measures to mitigate those risks.

During an interview with PSW #109, they indicated that the care plan for resident #007 identified the specified responsive behaviour focus, but did not identify strategies to respond to that focus.

During an interview with RPN #100, they indicated that the care plan for resident #007 identified a specified focus and they assumed that the interventions for another specified focus gave appropriate direction to staff.

During an interview with RN #106, they indicated that the care plan for resident #007 identified a specified focus, but did not have any interventions to respond to this focus.

During an interview with the DOC #107, Inspector #691 reviewed the care plan for resident #007, and the DOC confirmed that there were no interventions for the staff in relation to the specified focus for resident #007. The DOC confirmed that the expectation for the care plan was to identify specific foci and interventions to assist staff in providing care to the residents.

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 for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible; and 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 is, to be implemented voluntarily.

Issued on this 23rd day of May, 2019

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

Original report signed by the inspector.