Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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
Feb 10, 2020	2020_751649_0002	015098-19, 017203-19, 020772-19, 020773-19, 020849-19, 021717-19, 023867-19, 001309-20, 001479-20	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

Fieldstone Commons Care Community
1000 Ellesmere Road SCARBOROUGH ON M1P 5G2

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

JULIEANN HING (649), IANA MOLOGUINA (763)

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): January 8, 9, 10, 13, 14, 16, 17, 20, 30, 31, and off-site January 18 and 19, 2020.

Tollowing logs were inspected during this inspection.
Logs #015098-19/Critical Incident System (CIS) #2906-000021-19, #020772-1/CIS #2906-000029-19, #020849-19/CIS #2906-000031-19, #023867-19/CIS #2906-000038-19, #020773-19/CIS #2906-000028-19 related to prevention of abuse and neglect.
Log #017203-19/CIS #2906-000024-19 related to plan of care.
Logs #021717-19/CIS #2906-000034-19 and #001479-20/CIS #2906-000006-20 related to falls prevention and management.
Log #001309-20/CIS #2906-000004-20 related to transferring and positioning technique.

During the course of the inspection, the inspector(s) spoke with the director of care (DOC), assistant directors of care (ADOCs), registered nurses (RNs), registered dietitian (RD), physiotherapist (PT), registered practical nurses (RPNs), personal support workers (PSWs), private sitter (PS), residents and family members.

Note: A Voluntary Plan of Correction (VPC) related to O. Reg. 79/10 s. 48 (1) and to LTCHA, 2007, c.8, s.6 (9), identified in Complaint Inspection Report #2020_751649_0001 will be issued in this Inspection Report which was conducted concurrently with that inspection.

During the course of the inspection the inspectors reviewed residents' health records, staffing schedules, investigation notes, conducted observations related to the home's care processes, and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Medication
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

8 WN(s)
8 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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for residents #015 and #013 was provided to the residents as specified in the plan.

A critical incident system (CIS) report detailing an incident where resident #015 fell was submitted, resulting in transfer to hospital and diagnosis of an injury.

Inspector observed resident #015's room on an identified date and noted there was no fall mat present in or around the vicinity of the room. Inspector spoke to RN #133 who confirmed resident #015 required a fall mat by their bed to be used as part of their falls prevention interventions but did not have access to one in their room. RN #133 noted they were unsure why a floor mat was not available for resident #015 and that they would contact maintenance to get a floor mat for the resident.

Inspector spoke to PSW #134 who provided morning care to resident #015 three days prior to the inspector's observation. PSW #134 indicated there was no floor mat in resident #015's room when they got resident #015 up that morning.

Inspector spoke to PSW #132 who provided morning care to resident #015 on the date of the observation. PSW #132 indicated there was no floor mat in resident #015's room when they got resident #015 up that morning.

Inspector spoke to RN #112 the charge nurse for the unit on that shift. RN #112 confirmed that resident #015 required a floor mat as part of their plan of care and

confirmed that there was no floor mat available for use for resident #015 on that shift. RN #112 was unsure why resident #015 did not have a floor mat for use in their room. RN #112 indicated the floor mat was a current plan of care intervention for resident #015 and was unsure whether the floor mat was available as a fall prevention intervention for resident #015 since it was added to the plan of care. RN #112 indicated it was staff expectation to ensure that the care set out in the plan of care for residents is provided as specified in the plan, such as a floor mat, and to have the mat readily available so that it can be used as part of the indicated intervention.

ADOC #105 confirmed it was the home's expectation that if there were specific interventions in a resident's plan of care, these were to be provided to the resident as specified in the plan right away. ADOC #105 confirmed the floor mat was part of resident #015's plan of care and was required to be implemented as part of their falls prevention strategies.

The licensee has failed to ensure that the care set out in the plan of care for resident #015 was provided to the resident as specified in the plan. [s. 6. (7)]

2. A CIS report detailing an incident of an allegation of abuse by resident #013 towards resident #012 was submitted. The CIS report indicated that resident #013 was assigned one-to-one monitoring during a specified period due to a history of responsive behaviours however no one-to-one staff was working at the time of the incident. Resident #013 was left unattended in their room and when the PSW returned 10 minutes later, found resident #012 in resident #013's room talking. Resident #013 was touching resident #012.

Record review indicated resident #013 had a history of inappropriate responsive expressions, including towards other residents. Resident #013's written plan of care also indicated they were to receive one-to-one monitoring and that resident #013's assigned PSW were to report to the charge nurse when they started and finished a shift and when going on break.

Resident #013's records were reviewed and indicated several incidents where resident #013 did not have access to one-to-one monitoring despite requiring this intervention.

During an interview, PSW #135 confirmed that they were working at the time of the incident, as resident #013's primary caregiver. PSW #135 indicated they brought resident #013 to their room to provide care. PSW #135 left resident #013 in their washroom,

closing the washroom door behind them, and went to help another staff member with another resident. On their return, PSW #135 noted resident #012 was in resident #013's room and resident #013 was touching resident #012. PSW #135 told the nurse and the nurse separated both residents. PSW #135 then went on to attend to another resident's needs, leaving resident #013 in the washroom alone. PSW #135 indicated there was no one-to-one staff available to work at the time of the incident, and that they were required to care for other residents concurrently with resident #013. PSW #135 indicated that, when one-to-one staff were not available on their shift, they would try their best to watch resident #013 closely. PSW #135 indicated they needed one-to-one staff to watch resident #013 all the time as they would be unable to provide one-to-one monitoring while also providing care to other assigned residents.

During an interview, RN #133 indicated the home did not use a staffing agency to fill one-to-one shifts, and instead relied on internal staff to fill one-to-one shifts when available. RN #133 indicated there have been incidents where residents required one-to-one monitoring, but staff were unavailable to work those shifts. In these situations, the home directed the staff to ensure ongoing monitoring of residents as able.

ADOC #105 confirmed it was the home's expectation that if there were specific interventions in a resident's plan of care, these were to be provided to the resident as specified in the plan. ADOC #105 confirmed one-to-one monitoring was an example of such an intervention and that, when one-to-one was used as an intervention, it was expected that one-to-one staff monitoring be available. ADOC #105 indicated that one-to-one staff monitoring meant ongoing supervision of the resident by staff, including times when staff needed to step away from the resident to help another resident. ADOC #105 confirmed resident #013 required one-to-one monitoring at the time of the reported incident and understood that as no one-to-one staff were available for that shift, the plan of care was not implemented as directed.

The licensee has failed to ensure that the care set out in the plan of care for resident #015 was provided to the resident as specified in the plan. [s. 6. (7)]

3. The licensee has failed to ensure that the provision of the care set out in the plan of care were documented for residents #003, #001, and #006.

(a) A CIS report was submitted to the Ministry of Long-Term Care (MLTC) related to resident #003's falls and injury.

A review of resident #003's care plan indicated that they were at risk for falls and staff were to assist them with an identified intervention as a fall prevention intervention.

In an interview with PSW #129, they told the inspector that they were completing the identified intervention for resident #003 several times on their shift. The inspector inquired if they were documenting the identified intervention for the resident and they explained that this intervention was not set up in point of care (POC). They further explained that they have the option of making more than one entry in POC to indicate when they had completed the identified intervention for the resident but have not been utilizing this practice.

(b) A complaint was reported to the MLTC expressing concern about the frequency of resident #001's falls.

A review of resident #001's care plan indicated that they were at risk for falls and required an identified intervention. The care plan further indicated that the resident was at increased risk for falls when they required the identified intervention.

In an interview with PSW #104, they told the inspector that they were completing the identified intervention for resident #001 several times on their shift. The inspector inquired if they were documenting this intervention for the resident and they responded that they were supposed to document in POC each time they completed the intervention for the resident but have not been doing this.

In an interview with DOC #109, they acknowledged that resident #003 and #001's identified intervention had not been documented.

(c) As a result of non-compliance identified for resident #001, the sample was expanded to include resident #006.

A review of resident #006's written care plan indicated that they had an area of altered skin integrity and required staff to turn and reposition them every two hours.

A review of the resident's turning and repositioning documentation in POC for identified periods indicated it was blank.

In an interview with PSW #120, who was working with the resident during the above mentioned dates indicated that they had turned and repositioned the resident but had not

documented.

In an interview with DOC #109, they told the inspector that the staff are expected to document each time they turned and repositioned resident #001. [s. 6. (9)]

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 and the provision of the care set out in the plan of care are documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with for residents #003 and #001.

In accordance with O. Reg. 79/10, s. 48 (1) 1. the licensee was required to have a falls prevention and management program to reduce the incidence of falls and the risk of injury and in reference to O. Reg. 79/10, s. 30. (1) 1. there must be a written description of the program that includes policies and procedures and provides for methods to reduce risk and monitor outcomes.

Specifically, staff did not comply with the licensee's Falls Prevention and Management policy (policy # VII-G-30.10, current revision date of April 2019) that directed the nurse to complete a head injury assessment as required.

A complaint was reported to the MLTC expressing concern about the frequency of resident #001's falls.

A review of the home's policy #VII-G-30.10 titled Falls Prevention and Management with a current revision date of April 2019 directs the nurse when a fall occurs to:
-Initiate a head injury routine if a head injury is suspected, or if the resident's fall is un-witnessed and he/she is on anticoagulant therapy.
-Monitor head injury as per the schedule on the post-fall form for signs of neurological changes i.e. facial droop, behavioural changes, weakness on one side etc.

A review of resident #001's clinical record indicated they sustained several falls. As a result of the falls head injury routine (HIR) was initiated after each fall.

According to the HIR initiated after the resident's first, second, and third falls indicated it was not completed at the scheduled times because the resident was sleeping.

In separate interviews with RN #100 and RN #102, they both acknowledged that the HIR should have been completed when the resident fell on the above mentioned dates at the scheduled times.

In an interview with the DOC #109, they acknowledged that the HIR should have been completed for resident #001 at the scheduled times, therefore the home's policy had not been followed. [s. 8. (1) (a),s. 8. (1) (b)]

2. A CIS report was submitted to the MLTC related to resident #003's falls and injury.

A review of resident #003's HIR monitoring initiated after the resident's fall indicated it had not been completed at scheduled times because the resident was sleeping.

In an interview with DOC #109, they acknowledged that the HIR should have been completed at the scheduled times and explained because the resident was sleeping should not be an excuse for not completing the HIR. The DOC explained if staff had not taken the resident's vitals they would not know if something was wrong with them. [s. 8.

(1) (b)]

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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy is complied with, to be implemented voluntarily.

WN #3: 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 resident #014 was protected from physical abuse.

In reference to O. Reg. 79/10, s. 2. (1) (a), “physical abuse” means the use of physical force by anyone other than a resident that causes physical injury or pain.

A CIS report was submitted detailing an incident of an alleged staff abuse towards resident #014. Family member of resident #014 reported that PSW #117 was verbally abusive to them and the resident, and physically abusive towards the resident. The family member provided a photo of the resident's injury.

Record review indicated resident #014 had responsive behaviours and required one staff to assist them with most ADL, and two staff if having responsive behaviours.

Record review indicated that while PSW #117 was providing care to resident #014 they began having a responsive behaviour and sustained an injury.

During an interview, the family member stated they heard resident #014 scream loudly and went to check on them, where they noted that resident #014 had an injury. The family member noted resident #014 was not agitated when they saw resident #014, but resident #014 appeared upset. The family member noted that resident #014 was pointing at PSW #117 angrily, indicating they were upset with them. The family member left and went back to resident #014's room to get other supplies, returned, and heard PSW #117 using swear words towards resident #014. PSW #117 explained to the family member that their uniform was torn as a result of their interaction with resident #014 but they insisted that PSW #117 should have been more patient with resident #014. The family member then went to the charge nurse to report resident #014's injuries and the profanities used against them.

The family member showed inspector a photo of resident #014's injury during the time of the incident.

During an interview, PSW #117 confirmed they tried to give resident #014 an identified care. PSW #117 noted they asked an identified family member to help them with the care because resident #014 had a history of responsive behaviour, but they refused to help. PSW #117 then brought resident #014 to an identified area and indicated resident #014 was not displaying responsive behaviours at that time. PSW #117 then tried to take off resident #014's clothing however resident #014 became resistive and started having an identified responsive behaviour. PSW #117 indicated resident #014 then grabbed them on the open zipper pocket of their uniform, causing it to rip. Resident #014 wouldn't let go of the uniform, so PSW #117 touched resident #014 to get them to let go of their uniform. At this point, PSW #117 noticed an injury on resident #014 but wasn't sure how it had occurred.

During an interview, RPN #118, charge nurse noted that resident #014 had responsive behaviour and mood could fluctuate. They sometimes exhibited responsive behaviours during care, to both unfamiliar and regular staff. RPN #118 confirmed that PSW #117 tried to give resident #014 care on the day of the incident. RPN #118 was administering medications on the other end of the hall during the incident when they heard a loud scream coming from resident #014. RPN #118 noted resident #014 tended to scream loudly when they were having an identified responsive behaviour. RPN #118 went to resident #014 and noted an injury and that they were upset. RPN #118 recognized resident #014 can get upset during care and told PSW #117 that if resident #014 was being resistive, to leave them. The family member then came by after and offered to help

PSW #117. PSW #117 said okay, and RPN #118 left the two with resident #014, going back to the other end of the hallway and continuing with medication administration. The family member then came to RPN #118, asking to report PSW #117 for abusing resident #014. RPN #118 directed the family member to go the nurse manager to report the abuse and provide treatment to resident #014's injury. RPN #118 confirmed the injury was not present prior to PSW #117 attempting to provide resident #014 with care.

During an interview, DOC #109 confirmed resident #014 was agitated during the care and noted that the home's investigation of the incident indicated this was not a new behaviour for resident #014. The home spoke with PSW #117 after the incident and revisited resident #014's responsive behaviour with PSW #117, re-educating them about re-approaching resident #014 or having someone else present for support when resident #014 showed signs of responsive behaviours. DOC #109 noted no other staff member in the vicinity heard PSW #117 use profanities towards resident #014. DOC #109 also confirmed resident #014's injury was sustained during care by PSW #117.

The licensee has failed to ensure that resident #014 was protected from physical abuse. [s. 19. (1)]

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 residents are not abused by anyone, to be implemented voluntarily.

WN #4: 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. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure a report to the Director with the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

A CIS report was submitted to the MLTC, related to an allegation of staff to resident physical abuse. Further review of the CIS report indicated it had not been updated with the outcome of the home’s investigation.

In an interview with the DOC #109, they told the inspector that the home had completed their investigation of the incident and acknowledged that the CIS report had not been updated by the home with the results of their investigation. [s. 23. (2)]

2. A CIS report was reported to the MLTC, alleging staff to resident abuse.

A review of the above CIS report did not indicate the outcome of the home’s investigation related to resident #005's allegation of staff to resident abuse.

In an interview with the DOC #109, they acknowledged that they should have amended the CIS report after the home had completed their investigation. [s. 23. (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 to ensure a report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b), to be implemented voluntarily.

WN #5: 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 a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls for residents #003 and #001.

A CIS report was submitted to the MLTC related to resident #003's falls.

A review of the home's post-fall incident report indicated that resident #003 sustained two falls several hours apart. Further record review indicated that only one post-fall assessment was completed after the resident fell twice on the same shift, several hours apart.

In an interview with DOC #109, they acknowledged that only one post-fall assessment was completed after resident #003 sustained two falls and their expectation were for staff to complete a post-fall assessment after each fall. [s. 49. (2)]

2. A complaint was reported to the MLTC expressing concern about the frequency of resident #001's falls.

A review of resident #001's clinical records indicated two fall entries were made in risk management on an identified date each five minutes apart. Further review indicated that the two entries made were related to only one fall. No post-fall assessment was completed after the resident fell.

In separate interviews with RN #100 and #102, they both acknowledged that no post-fall assessment had been completed after resident #001's fall on the above mentioned date.

In an interview with DOC #109, they acknowledged that a post-fall assessment had not been completed after resident #001 fell. They further explained that a post-fall assessment was initiated but then removed and that staff might have gotten confused and accidentally cleared it. [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 to 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #005’s pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A CIS report was reported to the MLTC alleging staff to resident abuse. According to the CIS report resident #005 started to complain of pain to an identified area, and reported to the home the following day that they had sustained an injury because staff had been rough with them.

Resident #005 was not interviewable due to cognitive decline.

A review of resident #005’s x-ray report of an identified area indicated an identified medical diagnosis. Further review of the resident's progress notes indicated that they had reported pain on several dates and pain medication was administered. Progress notes documentation indicated that the pain medication had not been effective on the above mentioned days. No pain assessment was completed using a clinically appropriate assessment instrument after there was documentation that the pain medication had not been effective.

In separate interviews with RN #112 and DOC #119, they both acknowledged that there was documentation that resident #005’s pain medication had not been effective on the above mentioned days, and no pain assessment using a clinically appropriate pain assessment instrument had been completed. [s. 52. (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 to ensure that when a resident’s pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #7: 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, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A CIS report was submitted detailing an incident of an alleged staff abuse towards resident #014. The family member for resident #014 reported that PSW #117 was verbally and physically abusive to resident #014. The family member indicated PSW #117 provided care while resident #014 was resistive.

Record review indicated PSW #117 took resident #014 to an area to provide care, however resident #014 had an identified responsive behaviour and was heard screaming loudly and found to have sustained an injury.

Resident #014's written plan of care indicated that they had responsive behaviours during care and to manage such behaviours interventions had been implemented. The written plan of care indicated resident #014 required one staff to assist them with care. It was noted that two persons were required if responsive behaviours occurred during care. The written plan of care also indicated resident #014 required communication support as resident #014 spoke another language and staff were to ask for help from resident #014's family member who spoke the same language.

Progress note records for resident #014 indicated ADOC #124, lead for the BSO program at the time, reviewed the resident on an identified date and indicated resident

#014 had no responsive behaviours that was significantly hindering care.

Progress notes were reviewed and indicated several incidences of responsive behaviours as well as loud screaming.

The Responsive Behaviour Management policy # VII-F-10.10 (dated October 2019) indicated that, for residents exhibiting responsive behaviours, the nurse was to conduct and document an assessment of the resident experiencing responsive behaviours that were to include several assessment factors, for instance:

-Completing behavioural assessments based on resident need, including but not limited to: Behavioural Assessment Tools (BAT), Depression Scale, Mini-mental, Cohen-Mansfield Aggression Inventory, and PIECES.

-Initiating observation tools, such as BSO-DOS monitoring, as required.

The policy also indicated that the nurse was to complete an electronic Responsive Behaviour Referral to the internal Behavioural Support Lead/Designate when there was a new, worsening or changing responsive behaviour.

Record review did not indicate that any behavioural assessments or referrals to BSO were submitted. Physical chart review indicated no BSO-DOS monitoring or other behavioural assessments were completed for resident #014 since their admission.

During an interview, PSW #117 indicated that resident #014 had responsive behaviors and that their behaviours have worsened since admission. During these episodes of responsive behaviours, PSW #136 would re-approach the resident with another staff member after some time and re-attempt care. PSW #136 noted resident #014 sometimes showed behaviours when they were in a bad mood and during care. PSW #136 indicated asking another staff member who spoke resident #014’s language helped calm them down, as well as having two staff assist with care.

During an interview, PSW #137 indicated resident #014 demonstrated responsive behaviours during care some days. PSW #137 indicated on days when resident #014 exhibited such behaviours, they would re-approach the resident with a second staff member who helped them with any care provision for resident #014. PSW #137 sometimes used the family member as the second person to help calm the resident, but if unavailable, they asked the charge nurse’s assistance or a staff member who spoke

resident #014’s language.

RPN #118 indicated resident #014 demonstrated responsive behaviors sometimes to all staff and confirmed that resident #014 often refused care. RPN #118 indicated staff also tried to keep the resident distracted during care with other activities to help decrease responsive behaviours. RPN #118 also noted staff who spoke the same language as resident #014, if available, helped deescalate their behaviours by speaking to them during or before care. RPN #118 noted that not all of these interventions to manage resident #014’s responsive behaviours were included in their written plan of care. RPN #118 indicated when resident #014 demonstrated responsive behavior during care with PSW #117 no changes were made to their written plan of care after the incident since this was a typical behaviour for resident #014. RPN #118 indicated BSO-DOS monitoring would only be started if the resident experienced new behaviours, and that BSO or the physician would be referred if these behaviours were ongoing at the end of the observation period.

ADOC #124 indicated resident #014 was not part of the BSO program at the time of the interview. ADOC #124 indicated resident did have responsive behaviours in the past and they were aware of some of resident #014’s triggers. ADOC #124 were not sure if there were other triggers or if resident #014’s behaviours were being monitored by staff since they were not part of the BSO program.

ADOC #124 noted resident #014 was not part of the BSO program because they were not referred by nursing staff for consideration. ADOC #124 indicated resident #014 has been at the home for a while and that they assumed staff knew resident #014’s triggers and were managing them. ADOC #124 expected staff to refer residents for the BSO program for an unmanaged behaviour. Staff were also to complete assessments such as BSO-DOS monitoring when behaviours were ongoing .

Inspector reviewed the incident with ADOC #124, when resident #014 had demonstrated responsive behaviour resulting in them being injured. ADOC #124 indicated they were unaware of the details of this incident and were not clear whether the resident required BSO involvement at this point. ADOC #124 indicated that they thought this was a one-time incident for resident #014 and that they were not aware that resident #014 had a history of responsive behaviours during care. ADOC #124 indicated that because the incident they expected the staff to refer resident #014 to the BSO program after the incident.

ADOC #124 confirmed that the written plan of care also did not include other interventions to manage resident #014's behaviours during care. ADOC #124 was not sure what behavioural assessments were completed by staff for resident #014. ADOC #124 was unaware that resident #014 displayed responsive behaviours since their last involvement with the resident.

The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented. [s. 53. (4) (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 to ensure that, for each resident demonstrating responsive behaviours, 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, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The license has failed to ensure that all areas where drugs are stored was kept locked at all times, when not in use.

On Monday January 13, 2020, at approximately 1255 hours on an identified home area the inspector observed the medication cart outside of the unit dining room unlocked. No residents were observed within the area and the inspector pointed it out to RN #108.

On Tuesday January 14, 2020, at approximately 0910 hours the inspector observed the medication cart unlocked on the same identified home area. The medication cart was parked outside of the unit dining room in the hallway and a resident in a mobility device was observed a few feet away from the unlocked medication cart. At the time of the observation, the inspector was able to pull open medication drawers observing various residents' medications.

In separate interviews with RN #108 and DOC #109, they both acknowledged that the medication cart should have been locked when they stepped away. [s. 130. 1.]

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 all areas where drugs are stored shall be kept locked at all times, when not in use, to be implemented voluntarily.

Issued on this 12th day of March, 2020

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

Original report signed by the inspector.