Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

# 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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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Sep 24, 2021 | 2021_575214_0012 | 003690-21, 006962-21, 009923-21, 011424-21 | Critical Incident System |

### 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

R. H. Lawson Eventide Home
5050 Jepson Street Niagara Falls ON L2E 1K5

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

CATHY FEDIASH (214)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): August 26, 30, 31, September 1, 2, 3, 7, 8, 9, 10, 13, 14, and 15, 2021.**

**Please note the following:**

**This inspection was conducted simultaneously with Complaint inspection #2021_575214_0011 and Follow Up inspection #2021_575214_0010.**

**The following intakes were completed during this Critical Incident System (CIS) inspection:**

**-log #003690-21- related to falls prevention and management.**
**-log #006962-21- related to falls prevention and management.**
**-log #009923-21- related to personal support services.**
**-log #011424-21- related to prevention of abuse and neglect and responsive behaviours.**

**During the course of the inspection, the inspector(s) spoke with the interim Executive Director (interim ED), interim Director of Care (interim DOC), Director of Environmental Services, maintenance staff, COVID-19 screener, housekeeping staff, front office staff, Resident Assessment Instrument (RAI) Co-ordinator, registered staff, Personal Support Workers (PSW`s), and residents.**

**During the course of this inspection, the inspector reviewed CIS submissions, relevant policy and procedures, temperature logs, temperature records for the area the home was located, resident clinical records, home`s notes and specified electronic documentation.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Infection Prevention and Control**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**
**Safe and Secure Home**

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

- **9 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| **NON-COMPLIANCE / NON - RESPECT DES EXIGENCES** | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 failed to ensure that an activity of daily living (ADL) for a resident, had been provided as specified in their plan.

A CIS report indicated that on an identified date, a resident was provided care that resulted in minimal harm.

Documentation indicated while assisting the resident with an ADL, staff had left them unattended.

The resident's care plan indicated the resident did not require the type of care provided by the staff; however, the resident may call if a certain aspect of this care was required. Interview with PSW staff confirmed the resident had not called for this required care.

Interview with the interim ED confirmed that care had not been provided to the resident, as specified in their plan of care.

Sources: CIS report, resident care plan, the home's notes and letters, and interview's with PSW and interim ED. [s. 6. (7)]

***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 identified ADL needs for the resident are provided as specified in their plan, to be implemented voluntarily.***

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**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 failed to ensure that where the Act and 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.

In accordance with S. O. 2007, s. 8 (1), and in reference to O. Reg. 79/10, s. 49(1), the licensee was required to have written policies developed for the falls prevention and management program which must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

Specifically, registered staff had not complied with the licensee's policy titled, "Falls Prevention and Management Program", which indicated the following:

Under Falls Prevention- Registered Nursing Staff:
-A Fall risk assessment is completed within 24 hours of admission, and quarterly, significant change in health status, falls resulting in serious injury.

Under The fall's prevention team meets at minimum, quarterly and as needed (prn) to:
-Discuss falls that have occurred and determine the possible causes.

A CIS report and other documentation, indicated that on an identified date, a resident had an unwitnessed fall resulting in injury.

Documentation indicated that a specified assessment had been completed, approximately one month following their fall with injury and had not been completed for the following quarterly time period.

In an interview, the interim DOC indicated the fall team had not met this year. No meeting minutes were available in relation to this resident's fall. The interim DOC confirmed that the specified assessments had not been conducted and the licensee`s Falls Prevention and Management Program, had not been complied with.

Sources: CIS report, resident progress notes, and assessments, the licensee's Falls Prevention and Management Program (# N-52, effective October 15, 2018), and an interview with the interim DOC. [s. 8. (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 the licensee`s Falls Prevention and Management Program policies are complied with, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements**

**Specifically failed to comply with the following:**

**s. 20. (1.3) The heat related illness prevention and management plan for the home shall be implemented by the licensee every year during the period from May 15 to September 15 and it shall also be implemented,**
**(a) any day on which the outside temperature forecasted by Environment and Climate Change Canada for the area in which the home is located is 26 degrees Celsius or above at any point during the day; and O. Reg. 79/10, s. 20 (1.3).**
**(b) anytime the temperature in an area in the home measured by the licensee in accordance with subsections 21 (2) and (3) reaches 26 degrees Celsius or above, for the remainder of the day and the following day. O. Reg. 79/10, s. 20 (1.3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure the heat related illness prevention and management plan for the home was implemented during the period from May 15 to September 15 and any day which the outside temperature for the area the home was located was 26 degrees Celsius (°C) or above at any point during the day and anytime the measured temperature in an area in the home reached 26 °C or above, for the remainder of the day and the following day.

A review of the home's air temperature log sheets for a specified period of ten days, identified three bedroom air temperatures had each been recorded at 26 °C, or greater for two consecutive days.

A review of the outside temperatures for the same ten day period, for the city in which the home was located, identified nine out of the ten days had been recorded with an actual outside air temperature that was greater than 26 °C.

During an interview with the Director of Environmental Services, they confirmed the home had not developed and implemented their heat related illness prevention and management plan as per the legislative requirements.

During an interview with the Interim ED, they indicated the home was following their Hot Weather Guidelines policy which had not been developed in accordance to the heat related illness and prevention plan requirements that were effective on May 15, 2021.

Sources:  temperature logs, outside air temperature readings for the area the home was located in, and interviews with the Director of Environmental Services, the interim ED and other staff. [s. 20. (1.3)]

***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 heat related illness prevention and management plan for the home is implemented during the period from May 15 to September 15 and any day which the outside temperature for the area the home is located is 26 degrees Celsius (°C) or above at any point during the day and anytime the measured temperature in an area in the home reaches 26 °C or above, for the remainder of the day and the following day, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance**

**Specifically failed to comply with the following:**

**s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure their written policy to promote zero tolerance of abuse and neglect of a resident, was complied with.

A CIS report indicated that on an identified date, a resident was provided care that resulted in minimal harm. The CIS was first reported to the Director, four days following the incident.

The licensee's policy for Resident Abuse (#GA-34, effective April 29, 2019), indicated the following:

-The home has a zero tolerance policy that takes all appropriate actions to address the prevention, reporting and elimination of abuse at our Home.
-The home promotes the reporting of abuse and protecting those who report abuse.
-Staff who witness abuse or suspect the abuse of a resident or who receive complaints of abuse should report the incident immediately to their direct supervisor or to the Director of Care, Executive Director or to the MOHLTC.
-In any case of abuse or suspected abuse, the employer or any other person witnessing or having knowledge of an incident shall, verbally, report the incident immediately to their department or immediate supervisor, or during the evening and night hours to the most senior supervisor available.
-If the incident is reported to a supervisor, or Charge Nurse, he/she will immediately report to the Director of Resident Care and Administrator.

The home`s notes and an interview with the ED, indicated that a registered staff member, who responded to this incident, sent electronic communication to the interim ED on the date of the incident to inform them and indicated the Charge Nurse provided direction to monitor the resident. The interim ED indicated that this communication had been sent to them during their non-working hours and they had not been informed verbally, as per the policy. The interim ED indicated they informed the Director of this incident, as soon as they had become aware.

Sources: critical incident system, the licensee's Resident Abuse policy (#GA-34, effective April 29, 2019), specified electronic correspondence, and an interview with the interim ED. [s. 20. (1)]

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature**

**Specifically failed to comply with the following:**

**s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the home's air temperatures were measured and documented in writing, at a minimum, in two resident bedrooms, in different parts of the home and one resident common area, three times daily, at intervals specified in the regulations.

A review of the home's air temperature log sheets for a specified period of ten days, indicated on two days, no temperatures had been measured and documented for all required intervals, as identified by the regulations.

During an interview with the Director of Environmental Services, they indicated specific staff obtained and documented temperatures in the required locations for the day and afternoon intervals and other staff completed the evening intervals. They confirmed they had been unaware of the missing air temperatures for the dates and times identified.

Sources: temperature logs, and an interview with the Director of Environmental Services and other staff. [s. 21. (3)]

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**WN #6: 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 failed to report to the Director, the results of their investigation involving an altercation between two resident's.

A CIS report indicated on an identified date, an incident of physical abuse had occurred between two resident's, resulting in harm to one of the resident's.

During an interview with the interim ED, they indicated as a result of the home’s investigation, the incident was determined to have been an altercation between the two residents.

The interim ED confirmed the CIS had not been amended and reported to the Director, to include the results of their investigation.

Sources: CIS report, home's notes, and an interview with the interim ED. [s. 23. (2)]

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**WN #7: 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 failed to ensure a clinically appropriate post-fall assessment was conducted for a resident, when they sustained a fall with injury.

A CIS report and review of documentation indicated that on an identified date, a resident had an unwitnessed fall resulting in injury.

A review of assessments indicated the home used a specified post fall assessment. Review of the resident`s clinical records indicated this post fall assessment had not been conducted for this incident.

A review of another tool used by the home, indicated the resident`s fall had been documented in this section. The documentation indicated the assessor had identified factors that may have contributed to the fall, however, this tool had not provided the assessor the ability to document the impact of the identified factors, including any interventions to implement in order to prevent or minimize reoccurrences. This tool also contained a statement that indicated information in this section was privileged and confidential, not part of the medical record, and do not copy.

During an interview with the interim ED, they confirmed a clinically appropriate post fall assessment had not been completed for the resident when they fell and sustained an injury.

Sources: CIS report, resident assessments, and other documentation, and an interview with the interim ED. [s. 49. (2)]

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

**s. 53. (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,**
**(a) integrated into the care that is provided to all residents; O. Reg. 79/10, s. 53 (2).**
**(b) based on the assessed needs of residents with responsive behaviours; and O. Reg. 79/10, s. 53 (2).**
**(c) co-ordinated and implemented on an interdisciplinary basis. O. Reg. 79/10, s. 53 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that written approaches to care, including screening protocols, assessment and reassessments and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other, were integrated into the care provided to two residents.

A CIS report indicated on an identified date, an unwitnessed incident of physical abuse had occurred between two resident's, resulting in harm to one of the resident's. The home had video footage of this incident.

Review of the video footage, the home’s notes and an interview with the interim ED, indicated that as a result of the altercation, one of the resident's sustained an injury.

Documentation prior to this incident, indicated staff had observed one of the resident's to have been in the other resident's room, going through their drawers, verbalizing an item had been taken. The staff member redirected the resident out of the other resident's room.

The licensees policy for responsive behaviours (#N-98, effective April 1, 2021), indicated when a resident demonstrates a responsive behaviour, staff shall:

-Identify potential triggers and or contributing factors.
-Determine pattern of episodes/behaviour, daily patterns or prior routines using a specified system.
-The use of evident-based practices tools, and listed eight specified tools.

A review of both resident's clinical records, including paper and electronic records,

indicated the use of evidence- based practice tools had not been conducted for these residents, following this altercation, as required by the policy.

During an interview with a registered staff and the interim ED, it was confirmed that both resident's had not been involved in any prior altercations.

The interim ED confirmed the home’s written approaches to care for responsive behaviours had not been integrated into the care provided to both resident's, following this altercation.

When written approaches to care are not implemented, such as assessments and reassessments, identification of contributing factors and triggers that may contribute to responsive behaviours, may not be identified to assist in preventing or minimizing further altercations between and amongst residents.

Sources: CIS report, progress notes, assessments, and the paper chart for both resident's, the licensees Responsive Behaviours policy (#N-98, effective April 1, 2021), and interview’s with a RPN, interim ED and other staff. [s. 53. (2) (a)]

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations**
**Every licensee of a long-term care home shall ensure that,**
**(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident’s behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and**
**(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that procedures and interventions were developed and implemented until weeks following an altercation between two resident's.

A CIS report indicated on an identified date, an unwitnessed incident of physical abuse had occurred between two resident's, resulting in harm to one of the resident's. The home had video footage of this incident.

Review of the video footage, the home’s notes and an interview with the interim ED, indicated that as a result of the altercation, one of the resident's sustained an injury.

Review of both resident's plans of care, including their care plan indicated procedures and interventions to minimize the risk of altercations between and amongst residents, had not been implemented until approximately five weeks following the altercation.

During an interview with the RAI Co-ordinator and the interim ED, they indicated that procedures and interventions were to have been implemented right after this altercation, to minimize the risk of further occurrences.

When implementation of procedures and interventions are delayed, there is a potential for further altercations to occur between and amongst residents.

Sources: CIS report, plans of care including care plans, for both resident's, and interview’s with the RAI Co-ordinator, and interim ED. [s. 55. (a)]

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**Issued on this 28th day of September, 2021**

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

**Original report signed by the inspector.**