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
Apr 11, 2019	2019_640601_0009	005448-18, 015822-18, 005493-19	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 6) GP Inc. as general partner of CVH (No. 6) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Regency Long Term Care Home
66 Dorset Street East PORT HOPE ON L1A 1E3

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

KARYN WOOD (601)

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): March 27, 28 and 29, 2019.

Log #005493-19, log #005448-18, and log #015822-18, related to a fall.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Health Care Aide (HCA), Behavioural Support Ontario (BSO), and residents.

The inspectors also reviewed residents' health care records, and observed the delivery of resident care and services, including staff-resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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 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 the behavioural triggers for resident #001 who was demonstrating responsive behaviours were identified, and that strategies were developed and implemented to respond to these behaviours and that action was taken to respond to the needs of resident #001, who was demonstrating responsive behaviours, including assessments, reassessments, interventions and that the resident's responses to the interventions were documented.

Related to log #005493-19:

On a specified date, a Critical Incident Report (CIR) was submitted to the Director. The CIR indicated that on a specified date, resident #001 was displaying identified responsive behaviours. PSW #101 provided an identified intervention three times with no effect and left the resident in an identified resident care area. As PSW #101 was walking away from the resident, RN #102 was alerted by the resident's identified falls prevention device and witnessed the resident's fall, at an identified time. The resident was transferred to a specified health care facility and an injury was identified. The resident returned from the specified health care facility on a specified date.

Record review of the Behaviour Support Ontario (BSO) team documentation for a specified date by Inspector #601, identified that resident #001's had one identified responsive behaviours. The outcome of the meeting indicated that more detailed documentation was required to determine what interventions could be put into place. It was also indicated that further assessments were required using specific tools and could be initiated, if needed.

Record review of the BSO team documentation for a specified date by Inspector #601, identified that resident #001's several responsive behaviour had been identified. The resident's responsive behaviours also identified specific triggers that were upsetting the resident. No interventions to minimize responsive behaviours were initiated.

Record review of resident #001's care plan related to mood and responsive behaviours identified that the resident had two identified responsive behaviours. There were documented interventions for resident #001's responsive behaviours in place at the time of the injury. The documented interventions did not include all of resident #001's responsive behaviours.

Record review of resident #001's progress notes and point of care documentation, by Inspector #601 for a specified period of time related to responsive behaviours indicated that the resident had displayed several incidents of identified responsive behaviours and two specific triggers. Resident #001 also had a number of documented behavioural altercations with co-residents and one of the specific triggers was occurring at the time of the altercations with co-residents.

Separate interviews on two specified dates, PSW #101, HCA #111, PSW #113, PSW #116, BSO/PSW #117, RN #102 and RN #115 indicated to Inspector #601, that resident #001 had displayed several incidents of identified responsive behaviours and three specific triggers.

During separate interviews with PSW #111, HCA #111, PSW #113, PSW #116, BSO/PSW #117, RN #102 and RN #115 and review of resident #001's progress notes by Inspector #601, identified that since a specified date, several identified interventions specific to the resident's responsive behaviours had been utilized by staff to manage resident #001's responsive behaviours.

Record review of resident #001's Medication Administration Records (MAR's) related to responsive behaviours was completed by Inspector #601. Resident #001 was prescribed an identified medication to manage responsive behaviours, as needed for up to three times daily. During this time, resident #001 had received the as needed medication for responsive behaviours on a number of identified dates, over an identified period of time. The resident's medication had been documented as effective on some of the occasions.

During an interview on a specified date, the RPN/BSO #121 indicated to Inspector #601

that resident #001's as needed medication for responsive behaviours had not been utilized on a regular basis. RPN/BSO #121 also indicated that the Physician had been informed of the resident's responsive behaviours and had requested that the as needed identified medication be administered for the resident's responsive behaviours.

During an interview on a specified date, the DOC indicated to Inspector #601 that the BSO team was tracking resident #001's behaviours monthly and that the resident's behaviours had increased. The DOC also indicated that they were not aware of any new interventions being put into place to manage the resident's increased behaviours. According to the DOC, staff had been managing the resident's responsive behaviours and that the written plan of care in place at the time of the resident's injury did not include all of the interventions in place. The DOC further indicated that further assessments were not initiated following the BSO meeting.

The licensee did not ensure that the behavioural triggers for resident #001 who was demonstrating responsive behaviours were identified, and that strategies were developed and implemented to respond to these behaviours and that action was taken to respond to the needs of resident #001, who was demonstrating responsive behaviours, including assessments, reassessments, interventions and that the resident's responses to the interventions were documented. [s. 53. (4) (c)]

Issued on this 18th day of April, 2019

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

Original report signed by the inspector.