Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 29, 2019	2019_532590_0026	018726-19	Complaint

Licensee/Titulaire de permis

Richmond Terrace Limited
284 Central Avenue LONDON ON N6B 2C8

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

Richmond Terrace
89 Rankin Avenue AMHERSTBURG ON N9V 1E7

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

ALICIA MARLATT (590)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 4 and 7, 2019.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, a Manager of Clinical Services, a Registered Nurse that was the Long Term Care Homes Behaviour Supports Ontario Team Lead for Essex County, three Registered Practical Nurses and one complainant.

During the course of the inspection, the inspector(s) observed resident and staff interactions, infection prevention and control practices, the posting of required information, a specific resident home area, one resident room and the general maintenance and cleanliness of the home.

During the course of the inspection, the inspector(s) reviewed one resident's clinical record, one Critical Incident System report, one Infoline report, email correspondence, meeting minutes and Request for Resident Record Forms.

The following Inspection Protocols were used during this inspection:
Reporting and Complaints
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 had failed to ensure that the actions taken to meet the needs of the resident with responsive behaviours included documentation of the resident's responses to the interventions.

A complaint was received by the Ministry of Long -Term Care (MOLTC) from an identified complainant regarding resident #001. The complainant shared that they were concerned about the staff medicating the resident for behaviour management with a specific medication prior to attempting any other non-medicinal interventions.

This inspector reviewed resident #001's clinical record for a three month time frame in 2019 for this inspection.

Review of resident #001's progress notes showed that the resident had responsive behaviours that affected other people. Triggers for the behaviours were identified and several interventions were implemented by the staff to assist in managing the behaviours. The interventions in the resident's care plan were observed to mostly be non-pharmacological in nature.

Review of resident #001's electronic Medication Administration Record (eMAR) for a three month time period in 2019, showed that the resident was scheduled a specific medication twice a day for behaviour management. There was an as needed order for a dose range of 1 to 2mg of the same specific medication that could be given twice a day if it was needed for acute behavioural changes.

The eMAR's showed that the as needed dose of the medication was given 11 times in one specified month, 11 times in a second specified month and eight times in a third specified month in 2019. The progress notes written on the days that the as needed medication was given were reviewed. The notes described resident #001's behaviours in depth, along with the safety risks the staff were attempting to manage. There was also documentation present to describe the effectiveness of the as needed medication that was given. Lacking, in each note, was documentation about any interventions attempted prior to medicating the resident, or the effectiveness of any intervention attempted prior to medicating the resident.

In an interview with Registered Practical Nurse (RPN) #106, they shared that they had cared for resident #001 and administered the as needed medication during this time frame in the three identified months in 2019. They shared that the resident frequently displayed behaviours that affected others. The RPN shared that during times of agitation the resident appeared to be in physical distress. The RPN shared that themselves, along with all the other registered staff, always attempt any non-pharmacological interventions prior to using medications. The RPN shared that before medicating the resident for behaviours, the staff need to ensure that all the possible reasons for the behaviour have been addressed. Examples they provided included ensuring that basic care needs were met such as hunger, thirst, pain, positioning and identified continence care. They shared that there were other identified interventions specific to resident #001 that were also implemented. The RPN shared that when utilizing identified non-pharmacological interventions, they were not always effective with the resident. When asked what documentation was required when the staff utilized an as needed medication, the RPN shared that they were required to document the behaviours that were being displayed, the interventions attempted and their outcomes, the reason for giving the medication and the effectiveness of the medication given, and this was to be documented in the progress notes.

In an interview with RPN #104 they shared that they had also cared for resident #001 during the three month time frame in 2019. The RPN said that they have had to utilize the as needed medication for behaviour management on their shift. The RPN said that the resident displayed behaviours on an almost daily basis. When asked what the staff were to do when a resident displayed behaviours, the RPN said that they would implement non-pharmacological interventions first. The RPN said that medications for behaviour management were used as a last resort, and that other care needs should be met before medicating the resident. The staff were to provide care to the resident by utilizing all the interventions identified. When asked about the documentation

requirements for behaviours and administering an as needed medication for behaviour management the RPN shared that they were required to document the behaviours exhibited, interventions tried and the outcomes of the interventions in the progress notes.

In an interview with Executive Director #100 and Director of Care #101, they said that when the staff give an as needed medication for behaviour management they were expected to document the behaviours the resident was displaying, any interventions that had been attempted and their outcomes, the reason for giving the medication and the effectiveness of the medication.

The licensee had failed to ensure that the actions taken to meet the needs of resident #001 experiencing responsive behaviours included documentation of the resident's responses to the interventions. [s. 53. (4) (c)]

Issued on this 30th day of October, 2019

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

Original report signed by the inspector.