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 10, 2019	2019_575214_0010	008186-17, 014000-17, 006235-18	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Niagara
1815 Sir Isaac Brock Way THOROLD ON L2V 4T7

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

Upper Canada Lodge
272 Wellington Street P.O. Box 1390 NIAGARA-ON-THE-LAKE ON L0S 1J0

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): March 25, 26, 28, April 2, 2019.

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Resident Care (DRC); Registered staff; Personal Support Workers (PSW's) and residents.

During the course of the inspection, the inspector observed staff to resident interactions and the provision of care; reviewed Critical Incident System (CIS) submission; resident clinical records; relevant policies and procedures; the home's internal investigation notes; program evaluation and staff training records.

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

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 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. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions.

1. A review of CIS # M587-000004-17, log #008186-17, indicated that on an identified date and time, resident #001 was observed to have demonstrated an identified responsive behaviour towards resident #002 and #003.

A review of a progress note for resident #001, dated the following day, indicated that an identified intervention had been implemented for a specified period of time.

A review of a progress note for resident #001 and dated nine days later, indicated that resident #001 had the same identified intervention in place for a specified period of time. Resident #001 was observed to have approached resident #003 and demonstrated an identified responsive behaviour. Resident #001 was observed to have also demonstrated an identified responsive behaviour toward resident #004. The specified intervention intervened at this time and resident #001 had no further responsive behaviours.

During an interview with the DRC they confirmed that even though the specified intervention had been implemented and in place at the time of the incidents on an identified date, steps taken by the specified intervention were expected to have been implemented in a manner so as to minimize the risk of potentially harmful interactions between and amongst residents.

2. A review of CIS # M587-000007-18, log #006235-18, indicated that on an identified date and time, resident #006 and #007 had been observed together in an identified location. Both residents began to demonstrate an identified behaviour. Resident #007 demonstrated an identified action toward resident #006, who responded by demonstrating an identified responsive behaviour toward resident #007, which resulted in an identified outcome to resident #007.

Staff assessed resident #007 with no noted concern, at this time. Later on the same day, resident #007 verbalized an identified symptom and demonstrated an identified change

in their health status. Resident #007 received an identified treatment in a specified location for an identified diagnoses.

A review of resident #006's progress notes for an identified period of time, following the above incident indicated the following:

a) Progress note titled, "Responsive Behaviour Progress Note" and dated with an identified date and time, indicated that resident #006 had demonstrated identified responsive behaviours towards staff and others. The progress note indicated that interventions attempted had not been successful; however, had not identified what interventions had been tried that were unsuccessful.

Progress note titled, "Incident/Risk Management Progress Note", dated the same day and approximately 45 minutes later, indicated that resident #002 had attempted to converse with resident #006. Resident #006 demonstrated identified responsive behaviours toward resident #002. The progress note indicated that resident #006 was prone to an identified diagnoses and a specified intervention would be implemented.

b) Progress note titled, "Incident/Risk Management Progress Note", with an identified date and time, indicated that resident #006 was reported to have had a responsive behaviour toward another co-resident. This progress note template included an area for staff to document additional notes and/or comments. Documentation for this area indicated a previous implemented intervention.

A progress note titled, "Incident Progress Note", for the same incident, indicated that resident #006 demonstrated responsive behaviours toward another co-resident. The progress note indicated an identified intervention put into place at the time and interventions to be implemented when resident #006 demonstrated an identified behaviour.

c) Progress note titled, "Physician Contact/Orders", dated two days later, indicated that the physician had been notified of an identified testing outcome and specified treatment interventions were received.

d) Progress note titled, "Incident/Risk Management Progress Note" and dated five days later, indicated at a specified time that resident #006 had demonstrated an identified responsive behaviour towards resident #002, which resulted in resident #002 to demonstrate an identified responsive behaviour toward resident #006. Additional notes

and comments for this progress note had reiterated the actions between both residents and had not indicated any interventions to minimize the risk of altercations and potentially harmful interactions between and among residents.

Another progress note for this same incident, titled, "Incident Progress Note", dated with the same date, indicated the same information as the initial progress note; however, included an identified diagnoses for both residents. This progress note template included an area for staff to document interventions to prevent re-occurrence. Documentation for this area indicated that staff were instructed to try and keep the two residents apart.

e) Progress note titled, Incident/Risk Management Progress Note" and dated six days later, indicated that resident #006 was approached by resident #002 who attempted to converse with resident #006. The progress note indicated that resident #006 had not wanted to converse. Resident #006 demonstrated an identified responsive behaviour toward resident #002. The progress note indicated that both residents then demonstrated an identified responsive behaviour toward each other. Staff immediately implemented an identified intervention. This progress note template included an area for staff to document additional notes and/or comments. Documentation for this area indicated an identified reason for the responsive behaviour.

No further documentation was observed for this incident that included any interventions that were implemented to minimize the risk of altercations and potentially harmful interactions between and amongst residents.

f) Progress note titled, "Incident/Risk Management Progress Note" and dated three days later, indicated that resident #002's identified mobility device had come in contact with resident #006's identified mobility device. Resident #006 demonstrated an identified responsive behaviour toward resident #002. Resident #002 then demonstrated an identified responsive behaviour toward resident #006. This progress note template included an area for staff to document additional notes and/or comments. Documentation for this area indicated that staff were aware of the relationship between both residents and work to keep them apart and separate them quickly if there are any signs of aggression.

g) Progress note titled, "Responsive Behaviour Progress Note" and dated 16 days later, indicated that resident #006 was observed to be demonstrating an identified responsive behaviour towards staff and other residents. While resident #006 was demonstrating this identified responsive behaviour, an identified visitor had come in and resident #006 had

no longer demonstrated the identified responsive behaviour. The progress note indicated that staff were advised to not allow other residents at near proximity to resident #006.

An interview with the DRC confirmed that over an identified period in time, resident #006 had been involved in six incidents of potentially harmful interactions between and amongst co-residents. The DRC confirmed that while no injuries had occurred to any of the residents involved, steps taken to minimize the risk of altercations and potentially harmful interactions between residents such as notifying an identified health personnel a

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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions, 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 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 plan, policy, protocol, procedure, strategy or system was in compliance with and was

implemented in accordance with applicable requirements under the Act and in accordance with s. 8(1)(a)(b) which requires every licensee of a long-term care home to ensure that there is an organized program of nursing services for the home to meet the assessed needs of the residents; and an organized program of personal support services for the home to meet the assessed needs of the residents.

A review of the licensee's policy titled, ""Responsive Behaviours Program"(RKM00-015 and dated with a reviewed and revised date of June 2017), indicated the following under responsibilities:

• The Administrator /DRC/ADRC may authorize 1:1 to support a resident who is at an acute risk of injury to self or others.

• Registered staff in consultation with the attending physician and the DRC will ensure that the Substitute Decision Maker (SDM) is kept informed of behavioural changes and will document in the progress notes.

• Registered staff will complete: Responsive behaviour progress notes in Point Click Care (PCC) indicating what transpired, actions taken and triggers (s) for behaviour(s).

• The Physician or Nurse Practitioner in collaboration with the home's Responsive Behaviours Team and Registered staff, may consider medications to manage responsive behaviours after other interventions have been ineffective, or in the event that a resident is in imminent danger to self or others.

A review of CIS # M587-000007-18, log #006235-18, indicated that on an identified date and time, resident #006 and #007 had been observed together in an identified location. Both residents began to demonstrate an identified behaviour. Resident #007 demonstrated an identified action toward resident #006, who responded by demonstrating an identified responsive behaviour toward resident #007, which resulted in an identified outcome to resident #007.

Staff assessed resident #007 with no noted concern, at this time. Later on the same day, resident #007 verbalized an identified symptom and demonstrated an identified change in their health status. Resident #007 received an identified treatment in a specified location for an identified diagnoses.

A review of resident #006's progress notes for a prior identified period of time, indicated

that the resident had not demonstrated any responsive behaviours.

A review of resident #006's progress notes for an identified period of time, following the above incident indicated the following:

a) Progress note titled, "Responsive Behaviour Progress Note" and dated with an identified date and time, indicated that resident #006 had demonstrated identified responsive behaviours towards staff and others. The progress note indicated that interventions attempted had not been successful; however, had not identified what interventions had been tried that were unsuccessful.

Progress note titled, "Incident/Risk Management Progress Note", dated the same day and approximately 45 minutes later, indicated that resident #002 had attempted to converse with resident #006. Resident #006 demonstrated identified responsive behaviours toward resident #002. The progress note indicated that resident #006 was prone to an identified diagnoses and a specified intervention would be implemented.

b) Progress note titled, "Incident/Risk Management Progress Note", with an identified date and time, indicated that resident #006 was reported to have had a responsive behaviour toward another co-resident. This progress note template included an area for staff to document additional notes and/or comments. Documentation for this area indicated a previous implemented intervention.

A progress note titled, "Incident Progress Note", for the same incident, indicated that resident #006 demonstrated responsive behaviours toward another co-resident. The progress note indicated an identified intervention put into place at the time and interventions to be implemented when resident #006 demonstrated an identified behaviour.

c) Progress note titled, "Physician Contact/Orders", dated two days later, indicated that the physician had been notified of an identified testing outcome and specified treatment interventions were received.

d) Progress note titled, "Incident/Risk Management Progress Note" and dated five days later, indicated at a specified time that resident #006 had demonstrated an identified responsive behaviour towards resident #002, which resulted in resident #002 to demonstrate an identified responsive behaviour toward resident #006. Additional notes and comments for this progress note had reiterated the actions between both residents

and had not indicated any interventions to minimize the risk of altercations and potentially harmful interactions between and among residents.

Another progress note for this same incident, titled, "Incident Progress Note", dated with the same date, indicated the same information as the initial progress note; however, included an identified diagnoses for both residents. This progress note template included an area for staff to document interventions to prevent re-occurrence. Documentation for this area indicated that staff were instructed to try and keep the two residents apart.

e) Progress note titled, Incident/Risk Management Progress Note" and dated six days later, indicated that resident #006 was approached by resident #002 who attempted to converse with resident #006. The progress note indicated that resident #006 had not wanted to converse. Resident #006 demonstrated an identified responsive behaviour toward resident #002. The progress note indicated that both residents then demonstrated an identified responsive behaviour toward each other. Staff immediately implemented an identified intervention. This progress note template included an area for staff to document additional notes and/or comments. Documentation for this area indicated an identified reason for the responsive behaviour.

No further documentation was observed for this incident that included any interventions that were implemented to minimize the risk of altercations and potentially harmful interactions between and amongst residents

f) Progress note titled, "Incident/Risk Management Progress Note" and dated three days later, indicated that resident #002's identified mobility device had come in contact with resident #006's identified mobility device. Resident #006 demonstrated an identified responsive behaviour toward resident #002. Resident #002 then demonstrated an identified responsive behaviour toward resident #006. This progress note template included an area for staff to document additional notes and/or comments. Documentation for this area indicated that staff were aware of the relationship between both residents and work to keep them apart and separate them quickly if there are any signs of aggression.

g) Progress note titled, "Responsive Behaviour Progress Note" and dated 16 days later, indicated that resident #006 was observed to be demonstrating an identified responsive behaviour towards staff and other residents. While resident #006 was demonstrating this identified responsive behaviour, an identified visitor had come in and resident #006 had no longer demonstrated the identified responsive behaviour. The progress note

indicated that staff were advised to not allow other residents at near proximity to resident #006.

An interview with the DRC confirmed that over an identified period in time, resident #006 had been involved in six incidents of potentially harmful interactions between and amongst co-residents. The DRC confirmed that while no injuries had occurred to any of the residents involved, steps taken to minimize the risk of altercations and potentially harmful interactions between residents such as notifying an identified health personnel and incorporating an identified intervention, had not been implemented as per the licensee's policy.

The DRC confirmed that not all incidents identified above were documented using the "Responsive behaviour progress note" as identified in the licensee's policy. The DRC indicated that this note type was specific to behaviours that a resident was demonstrating and prompted the author to identify triggers, behaviours, interventions and the outcome of interventions that had been put into place. [s. 8. (1) (b)]

WN #3: 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 that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy was complied with.

A review of CIS # M587-000004-17, log #008186-17, submitted as an identified abuse, indicated that on a specified date and time, resident #001 was observed to have demonstrated an identified responsive behaviour toward resident #002 and resident #003.

Review of a progress note for resident #001 and dated the same date, indicated that staff implemented an identified intervention for all residents.

A review of the licensee's policy titled, "Abuse and Neglect- Zero Tolerance" (RR00-001 and dated with a reviewed and revised date of July 30, 2014) indicated the following:

Under Procedure - Reporting and Investigation of Abuse and Neglect:

• Employee(s) who are reporting or witness abuse or a neglect situation such as abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, are to report it to the Registered Nurse (RN) in charge or a manager if available immediately.

• A report of an alleged or witnessed incident of abuse or neglect must be reported to the Director of Resident Care, Administrator, or designate immediately.

An interview with the DRC confirmed that this policy was the policy that was in place at the time of the CIS. The DRC reviewed the home's investigative notes at the time of this CIS and indicated that the previous DRC spoke with staff #108, who was identified on the CIS as being present and/or discovered the incident. The DRC indicated that staff #108 indicated that they had left a note for the day RN, scheduled the following day and had not reported the critical incident to the RN or manager on duty at the time of the critical incident.

The DRC confirmed that the licensee's policy to promote zero tolerance of abuse and neglect of resident's had not been complied with. [s. 20. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A review of CIS # M587-000004-17, log #008186-17, submitted as an identified abuse, indicated that on a specified date and time, resident #001 was observed to have demonstrated an identified responsive behaviour toward resident #002 and resident #003.

Review of a progress note for resident #001 dated the same day, indicated that staff implemented an identified intervention for all resident's.

Resident #001 was observed by staff to again demonstrate an identified responsive behaviour toward resident #002. Staff members responded. Resident #001 was then observed to approach resident #003 where they verbalized an identified request. Resident #003 did not respond. Resident #001 then began to demonstrate an identified responsive behaviour toward resident #003.

A review of a progress note for resident #001 dated the next day, indicated that an identified intervention had been implemented for a specified period of time.

A review of a progress note for resident #001 and dated nine days later, indicated that resident #001 had the same identified intervention in place for a specified period of time. Resident #001 was observed to have approached resident #003 and demonstrated an identified responsive behaviour. Resident #001 was observed to have also demonstrated an identified responsive behaviour toward resident #004. The specified

intervention intervened at this time and resident #001 had no further responsive behaviours.

A review of resident #003 and #004's clinical records indicated that no documentation regarding the above incidents had been documented in either of the resident's clinical records, including the actions of any assessments or the residents response to interventions put into place.

An interview with the DRC confirmed that the incidents on an identified date and any actions taken with respect to residents #003 and #004, including any assessments or the resident response to interventions, had not been documented in their clinical records. [s. 30. (2)]

Issued on this 26th day of April, 2019

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

Original report signed by the inspector.