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 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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 15, 2017	2017_623626_0007	007482-17, 008014-17, 008098-17, 009484-17	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF KAWARTHA LAKES
26 Francis Streeet LINDSAY ON K9V 5R8

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

VICTORIA MANOR HOME FOR THE AGED
220 ANGELINE STREET SOUTH LINDSAY ON K9V 4R2

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

DENISE BROWN (626)

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): May 26, 29, 30, 31 and June 1, 2, 22 and 23, 2017

The following Critical Incident logs were inspected during the course of the inspection:

Intake Log #008014 -17: Related to alleged resident to resident abuse
Intake Log #009484 -17: Related to alleged staff to resident abuse
Intake Log #007482 -17: Related to alleged resident to resident abuse
Intake Log #008098 -17: Related to alleged resident to resident abuse
Intake Log #011538 -17: Related to alleged resident to resident abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Service Manager (RSM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

During the inspection, the Inspector, toured the residents' home areas, observed resident to resident interaction and staff to resident provision of care. The Inspector reviewed residents' health records, internal related investigations, applicable policies and critical incidents.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
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	Legendé 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 there was a written plan of care for each resident that sets out, the planned care for resident #007, related to responsive behaviours.

Related to Intake Log #008014-17 regarding resident #007:

The Director was informed on a specified date, regarding an alleged incident of resident to resident abuse resulting in injury.

Registered Practical Nurse #103, witnessed part of the incident between resident #007 and resident #006 which occurred in an identified area. Resident #007 had prior history of a specified responsive behaviour. A review of resident #007's written care plan that was in place at the time of the incident, did not identify resident #007's specified responsive behaviour or indicate interventions.

In separate interviews by Inspector #626 on a specified date with RPN #103 and PSW #102, both indicated that resident #007 would display this specified responsive behaviour and often required redirection. In another interview on the same specified date, RN #105 indicated that resident #005's responsive behaviours included this specified behaviour.

In an interview with Inspector #626 on a specified date, RPN #103 indicated that resident #006 had no previous responsive behaviours directed towards other residents.

During an interview with Inspector #626 on a specified date, the DOC indicated that resident #007 was a recent admission and there might not have been sufficient time to

have known the resident and develop a plan of care.

The licensee failed to ensure that there were interventions in the written plan of care to address resident #007's specified responsive behaviour. On a specified date, while resident #006 was engaging in this specified behaviour, there was an incident of abuse by resident #006 to resident #007, resulting in injury to resident #007. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan related to responsive behaviours.

Related to Intake Log #011538-17 regarding resident #005:

The Director was informed on a specified date, regarding an alleged incident of resident to resident abuse.

According to the current written care plan, resident #005's was to receive heightened staff supervision after the incident involving resident #008. The written care plan in place at the time of the incident, noted that resident #005's interventions also included increased frequent documented observation as monitoring.

On a specified date, the licensee was unable to provide heightened staff supervision during a specified time period. The resident was to receive increase frequent documented observation as monitoring. It was indicated that on the same date, resident #005 displayed responsive behaviours which were directed towards resident #009 and resident #010. A review of resident #005's health records for a specific period of time, indicated that there was no documentation that resident #005 was monitored frequently.

In an interview with inspector #626 on a specified date, RPN #107 indicated that staff were aware, that there was no staff coverage available for the heightened staff supervision, until a specified time that day and staff were to monitor resident #005 frequently.

In separate interviews with Inspector #626 on a specified date, PSW #101, PSW #115 and RPN 114, all indicated not being aware that there was no staff coverage for the heightened supervision on the specified date, and that resident #005 was to be frequently monitored.

In an interview with Inspector #626 on a specified date, the ADOC indicated that the licensee was unable to provide the heightened supervision to resident #005 during a specified period and date, and staff were to monitor resident #005 frequently during that period.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident #005 by not ensuring that the resident was supervised and monitored as specified in the plan. [s. 6. (7)]

Issued on this 15th day of August, 2017

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

Original report signed by the inspector.