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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Amended Public Copy/Copie modifiée 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
Dec 05, 2019	2019_730593_0033 (A1)	019702-19	Complaint

Licensee/Titulaire de permis

Almonte General Hospital
75 Spring Street ALMONTE ON K0A 1A0

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

Fairview Manor
75 Spring Street ALMONTE ON K0A 1A0

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

Amended by GILLIAN CHAMBERLIN (593) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Wording changes to the grounds under r. 53.

Issued on this 5 th day of December, 2019 (A1)

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

Original report signed by the inspector.

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*

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

Amended by GILLIAN CHAMBERLIN (593) - (A1)

Amended 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 28, 30 - 31, November 4 - 5, 2019.

Complaint log #019702-19 was inspected related to allegations around lack of interventions to manage a resident with aggressive responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nursing staff, Personal Support Workers (PSWs) including the behavioural support PSW and residents.

The Inspector observed the provision of care and services to residents, staff to resident interactions, resident to resident interactions, residents' environment, and reviewed resident health care records, training records and investigation records.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of the original inspection, Non-Compliances were issued.
- **3 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 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for resident #001 that sets out, the planned care for the resident.

An anonymous complaint was received through the Action Line, regarding the responsive behaviours of resident #001. It was alleged in the complaint that an altercation occurred between resident #001 and PSW #100 that resulted in injuries sustained by PSW #100.

Inspector #593 reviewed the progress notes which showed an increase in agitation and aggression since admission to the home resulting in an admission to hospital as a result of these behaviours:

Day 9, 2019, 1113 hours- while PSW's #100 and #113 were assisting resident #001, the resident became physically aggressive, resident #001 had pinned PSW #113 against the wall. PSW's were unable to calm the situation and they left the room when the resident became aggressive.

Day 9, 2019, 1115 hours- RN #101 informed the homes physician of the residents increase in aggression and agitation. The home's physician stated to send the resident to the emergency department.

Day 9, 2019, 1455 hours- resident #001 taken to emergency.

Day 20, 2019, 1555 hours- resident #001 returned from hospital. Began to wander at 2030 hours became increasingly agitated with staff. Administered a PRN (as needed medication) at 2110 hours with two staff holding the residents arms, walked immediately away from staff after the PRN was administered and continued to pace for half an hour. Sat in a chair across from the nursing station and fell asleep.

During an interview with Inspector #593, October 31, 2019, PSW #104 indicated that they were working the night shift when the incident occurred four days after return from hospital. PSW #104 added that at shift report, it was communicated to the night shift team to leave the resident be if staff were not comfortable with their behavior and night rounds were always supposed to be done in pairs.

During an interview with Inspector #593, November 4, 2019, RPN #109 indicated that when resident #001 returned from hospital, there was a new intervention for the resident and explained that the DOC and ADOC were adamant that if staff approached the resident to complete care and they were not willing to follow, staff had to back off and leave the resident. The reason for this was to not pressure the resident to do what staff needed to do. RPN #109 said that they felt like this was

hard for the PSWs as they are very task oriented and RPN #109 mentioned to the ADOC that perhaps a memo should be sent to the PSWs about this direction. However it was decided that this would be communicated verbally at shift report until it could be updated in the plan of care. This information was passed shift to shift at shift report.

During an interview with Inspector #593, November 6, 2019, BSO PSW #111 indicated that a BSO intervention sheet had not been completed for resident #001. They added that this was in the process and one of the interventions that was to be included was to leave the resident if they became agitated and re-approach however this was not documented in the residents plan of care.

During an interview with Inspector #593, November 4, 2019, the ADOC indicated that one of the triggers for resident #001's responsive behaviours was care. They added that the resident was content for the most part but they did not sleep well at night and was often up at night pacing and then would fall asleep during the day, otherwise the resident was content to pace back and forth. It was when staff tried to do care, the resident would react but not always with aggression. Since return from hospital, there were new interventions which included two person care and leaving the resident, if they became agitated or resistive. The care plan had not yet been updated with the new interventions when the incident happened, however, they were verbally communicated to staff at shift report.

Inspector #593 reviewed resident #001's health care record and found that there were no documented interventions for resident #001 related to the interventions implemented upon return from hospital.

Resident #001 returned to the home from a hospital admission and new interventions to manage the resident's responsive behaviours were communicated verbally however were not included in the resident's written plan of care. As such, the licensee failed to ensure that the written plan of care for resident #001, set out the planned care for the resident. [s. 6. (1) (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 ensuring that there was a written plan of care for each resident that sets out, (a) the planned care for the resident, to be implemented voluntarily.

WN #2: 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 for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours for resident #001.

An anonymous complaint was received through the Action Line regarding the responsive behaviours of resident #001. It was alleged in the complaint that an altercation occurred between resident #001 and PSW #100 that resulted in injuries sustained by PSW #100.

Inspector #593 reviewed the progress notes which showed an increase in agitation and aggression since admission to the home:

Day 9, 2019, 1113 hours- while PSW's #100 and #113 were assisting resident

#001, the resident became physically aggressive. Resident #001 had pinned PSW #113 against the wall. PSW's were unable to calm the situation and they left the room when the resident became aggressive.

Day 9, 2019, 1115 hours- RN #101 informed the homes physician of the residents increase in aggression and agitation. The home's physician stated to send the resident to the emergency department.

Day 9, 2019, 1455 hours- resident #001 taken to emergency via wheelchair accompanied by police, the DOC and RN #101.

Day 20, 2019, 1555 hours- resident #001 returned from hospital. Began to wander at 2030 hours became increasingly agitated with staff. Administered PRN (as needed medication) at 2110 hours with two staff holding the residents arms, walked immediately away from staff after PRN administered and continued to pace for half an hour. Sat in a chair across from the nursing station and fell asleep.

Day 21, 2019, 1142 hours- resident #001 remained agitated, pacing hallway. Pants soaked with urine, refusing to let staff change them. PRN given, resident has slowed down and agitation seems to have decreased however continues to refuse staff to complete care.

Day 22, 2019, 1000 hours- resident #001 was pacing quickly with clenched fists, difficult to redirect. PRN administered at 1010 hours. BSO PSW was able to redirect resident at approximately 1030 hours. Resident continued to pace hallway with no expressions of anger.

Day 23, 2019, 1845 hours- resident #001 refused HS medications, began pacing in the hallways very quickly. PRN was administered in juice. Resident still pacing hallway, second PRN given.

Day 24, 2019, 0218 hours- resident #001 found awake in bathroom. Resident was wet and refusing to be changed, resident was pacing the hallways.

Day 24, 2019, approx. 0230 hours- PRN administered in juice.

Day 24, 2019- After PRN was administered, PSW #100 was trying to direct the resident into the bathroom to change their clothes when the resident became

upset, pushed the PSW into a wall and stabbed the PSW with a pen. Code white called, ER physician ordered PRN medications which were administered. Resident #001 was taken to the ER via wheelchair.

A review of the home's investigation records, found the following witness statements from the incident:

PSW #100- (summary)

At around 0220 hours, I went to unit A to get soaker pads. Resident #001 was up and pacing the hallways, I noticed they were wet and I asked the resident if they wanted to get into dry clothes, I reached my hand out and the resident pushed it away. I asked RN #105 if they should medicate the resident now rather than waiting for their aggression to escalate. RN #105 agreed. I asked PSW #104 to go to unit B as I was going to stay on unit A with RN #105. RN #105 joined resident #001 and I near the TV room, the RN offered juice with the medication in it, the resident hit their arm away. I asked the RN if they wanted me to try, they said yes. I offered the juice to resident #001 and they pushed my hand away and told me to "(explicit)". I followed the resident into the dining room, I asked if they were hungry, they said "(explicit)". The resident kicked the unit door and started walking back towards the TV room, I watched the resident turn the corner and continue down the hallway. They stopped outside of room A/B and kicked the door, I told the resident that it was not their room and tried to redirect the resident to their room, they told me to "go mind your (explicit) business". The resident continued down the hall and was at room C/D, they tore down the yellow band across the doorway. I shut the room door and replaced the yellow band across the doorway. I saw the resident was entering room E, I called out their name and took their hand. I told the resident that I would show them back to their room where they could change out of their wet clothes. The resident grabbed me by my right wrist and said "what's your (explicit) problem". I said "let go right now", the resident said "that's what you want isn't it". I turned my body so that my back was against their chest and pulled my body away from them. This made the resident let go of my wrist. The resident was then back at room C/D, they had removed the yellow band and were entering the room. I pulled at the back of their shirt, this made the resident turn around and focus on me. The resident kept repeating "what is your (explicit) problem". I unclipped my phone from my back pocket as I was walking backwards in direction of the TV room. The resident did not follow me for long, they turned away from me and started to enter room C/D again. I pulled the bottom of their shirt, the resident turned around and hit the phone out of my hand

(the witness statement continues to detail the physical altercation but it does not relate to the non-compliance).

PSW #104- (summary)

I was in the spa room on unit A at 0145 hours, PSW #100 came in to tell me they were taking bed pads to the other unit. Once I left the spa room, I heard talking and I saw PSW #100 talking to resident #001 and suggesting that the resident go to bed. I noticed that the resident was a little agitated, I suggested to PSW #100 "I think you should just leave them alone". PSW #100 suggested I go over to unit B as PSW #100 did not want the nurse to be alone with resident #001. At 0230 hours, I heard an alarm, I stood at the fire doors separating the two units but I could not hear anything. I called the charge nurse RN #105 who told me that everything was fine. Five minutes later I heard the main fire alarm, I went back to unit A and I saw PSW #100 on the floor with RN #105. Resident #001 was pacing back and forth, this was their usual pacing, the resident was not acting aggressively.

During an interview with Inspector #593, October 31, 2019, PSW #104 indicated that they were working the night shift when the incident occurred. PSW #104 said that they were assigned to unit A where resident #001 lived and PSW #100 was assigned to unit B, but the two PSWs assigned to these units, work in pairs. PSW #104 said that when they first saw PSW #100 interact with resident #001, the resident was starting to become agitated and so they suggested to PSW #100 to leave the resident alone, as the resident was just pacing which was typical behavior for the resident and the resident was not trying to enter other resident rooms at this time. PSW #104 added that at shift report, it was communicated to the night shift team to leave the resident be if staff were not comfortable with the residents behavior and night rounds were always supposed to be done in pairs. PSW #104 indicated that after the incident, the resident was pacing, they were not agitated or aggressive or trying to enter other residents rooms, this pacing was typical for the resident.

During an interview with Inspector #593, November 4, 2019, RPN #109 indicated that when resident #001 returned from hospital, there was a new intervention for the resident and explained that the DOC and ADOC were adamant that if we approached the resident to do care and the resident was not willing to follow, we had to back off and leave the resident. The reason for this was to not pressure the resident to do what staff needed to do. RPN #109 indicated that they felt like this

was hard for the PSWs as they are very task oriented and mentioned to the ADOC that perhaps a memo should be sent to the PSWs about this, however it was decided that this would be communicated verbally at shift report until it could be updated in the plan of care. This information was passed shift to shift at shift report.

During an interview with Inspector #593, October 31, 2019, RN #105 indicated that they were the charge RN on the night shift when the incident occurred and their base was in unit A. PSW #104 was the PSW assigned to unit A, however PSW #100 sent PSW #104 to unit B and told RN #105 that resident #001 was starting to pace and asked whether RN #105 should give the resident some medications. RN #105 reported that they administered a PRN in juice and the resident took a good swallow of the juice, with the RN confident that resident #001 received most of the medication. RN #105 added that If the resident was still agitated after 20 minutes, they could administer a second PRN but the 20 minutes was not up and the resident was still pacing. There was no aggression unless someone approached them. The resident was wet and PSW #100 wanted to change them, I told the PSW, no, leave the resident alone, as this was the direction for this resident. Pacing was typical for this resident which sometimes included wandering into other residents rooms, however resident #001 was not aggressive toward other residents and if they saw an open door they would wander in, but if it was dark, they would turn around and leave again. RN #105 indicated that they did not see any aggression from the resident until the code white team arrived from the hospital after the incident and they restrained the resident to administer a medication via injection.

During an interview with Inspector #593, November 4, 2019, the ADOC indicated that one of the triggers for resident #001's responsive behaviours was care, but they were content for the most part. The resident did not sleep well at night as the resident was often up at night pacing and then they would fall asleep during the day, otherwise they were content to pace back and forth. It was mostly when staff tried to do care, the resident would react but not always with aggression. Since return from hospital, the antipsychotic medications had been increased and this had really slowed the resident down. The ADOC indicated that resident #001 was never aggressive to other residents and if they did enter another residents room, it was usually to use the bathroom and then they would leave. There were also new interventions since returning from the hospital, which included two person care as well as leaving the resident, if they became agitated or resistive. The care plan had not been updated with the new interventions when the incident happened

however, they were verbally communicated to staff at shift report.

Staff at the home were aware of resident #001's aggressive behaviours during care including an incident occurring day 9, 2019 that was witnessed by PSW #100 . It was reported to leave resident #001 alone if they were becoming agitated and on day 24, 2019, both PSW #104 and RN #105 indicated that PSW #100's approach was agitating resident #001 and both staff members told the PSW to leave the resident alone. PSW #100 continued to approach resident #001 from behind which including touching the resident by pulling their shirt with the resident becoming more agitated until an altercation occurred between the resident and PSW #100. [s. 53. (4) (b)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or intervals provided for in the regulations.

As per regulation 219. (1) the interventions for the purpose of subsection 76 (4) of the Act are annual intervals.

Under subsection (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

Under subsection (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section.

An anonymous complaint was received through the Action Line regarding the responsive behaviours of resident #001. It was alleged in the complaint that an altercation occurred between resident #001 and PSW #100 that resulted in injuries sustained by PSW #100.

The training records for PSW #100 were reviewed and it was found that PSW #100 did not review the long-term care home's policy to promote zero tolerance of abuse and neglect of residents in 2018.

Inspector #593 reviewed the 2018 training records for all staff in the home regarding reviewing the home's policy to promote zero tolerance of abuse and neglect of residents. It was found that out of 104 staff members who were required to review the policy in 2018, 35 staff members did not review the home's policy to promote zero tolerance of abuse and neglect of residents in 2018.

The licensee has failed to ensure that all staff of the long-term care home received re-training in 2018 on the home's policy to promote zero tolerance of abuse and neglect of residents. [s. 76. (4)]

Issued on this 5 th day of December, 2019 (A1)

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

Original report signed by the inspector.