Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: December 11, 2023	
Inspection Number: 2023-1149-0007	
Inspection Type: Critical Incident	
Licensee: Blackadar Continuing Care Centre Inc.	
Long Term Care Home and City: Blackadar Continuing Care Centre, Dundas	
Lead Inspector Julie Lampman (522)	**Inspector Digital Signature** Julie Lampman Digitally signed by Julie Lampman Date: 2023.12.18 15:03:23 -05'00'
Additional Inspector(s) Ina Reynolds (524) Pauline Waldon (741071)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 4, 5, and 6, 2023.

The following intake(s) were inspected:
• Intake: #00084026/Critical Incident System (CIS) report #2641-000012-23 related to improper/incompetent treatment of a resident;
• Intake: #00087060/CIS #2641-000016-23 related to improper/incompetent treatment of a resident;
• Intake: #00091955/CIS #2641-000028-23 related to resident to resident abuse;
• Intake: #00093333/CIS #2641-000029-23 related to resident to resident abuse;
• Intake: #00096613/CIS #2641-000034-23 related to falls prevention and management.

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The following intake(s) were completed in this inspection:
• Intake: #00020092/CIS #2641-000003-23, Intake: #00022297/CIS #2641-000011-23, Intake: #00093723/CIS #2641-000031-23 and Intake: #00097796/CIS #2641-000037-23 related to falls prevention and management.

The following **Inspection Protocols** were used during this inspection:

Falls Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
Integration of assessments, care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident collaborated with each other, in the development and implementation of the resident's falls management plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

Rationale and Summary
A resident was at risk for falls and a specific falls intervention was in place to prevent falls.

On two occasions, Inspector #522 observed that the falls intervention for the resident was not in place.

Personal Support Worker (PSW) #105, PSW #109 and Registered Practical Nurse (RPN) #110 all stated that the resident was at risk for falls. PSW #105 and PSW #109 acknowledged that the resident would remove the falls intervention when it was in place. PSW #105 stated the resident should have a different falls intervention in place, and they did not know why the other falls intervention had not been trialled for the resident.

The Falls Lead stated they were not aware that the resident was removing the falls intervention when it was in place. The Falls Lead stated if staff had let them know then they would have put a different falls intervention in place for the resident.

There was risk to the resident as staff did not collaborate with each other regarding the use of falls interventions for the resident.

Sources: A Critical Incident System (CIS) report, the resident's clinical records, and interviews with PSW #105, PSW #109, RPN #110 and the Falls Lead. [522]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

Duty of licensee to comply with plan

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.

The licensee has failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in the plan.

Rational and Summary

A Critical Incident System (CIS) report documented that a resident had sustained an injury, resulting in the resident requiring medical assistance and a significant change in their health status.

The plan of care for the resident gave staff specific directions for staff when transporting the resident in their assistive device.

Physiotherapist #103 said that due to the resident's condition strategies had been put in place which staff were to follow when transporting the resident.

The Director of Care (DOC) acknowledged that staff failed to follow the resident's care plan when transporting the resident. Staff not following the care plan resulted in harm as the resident was injured from the incident.

Sources: A CIS report, a resident's clinical records, and interviews with the DOC and

Physiotherapist #103. [524]

WRITTEN NOTIFICATION: Duty to Protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to protect a resident from physical abuse by another resident.

Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

Rationale and Summary:
A Critical Incident System (CIS) report was submitted for an incident where a resident was abused by another resident. As a result, the resident sustained injuries.

The resident reported that although they maintained distance from the other resident and they did not bother one another, the resident was fearful of the other resident.

As a result of not being protected from abuse, the resident sustained an injury and expressed fear of the other resident.

Sources: A CIS report, residents' progress notes, care plans and interviews with a resident and the DOC. [741071]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning techniques when they assisted a resident.

Rational and Summary

A Critical Incident System (CIS) report documented that while being transferred by a personal support worker a resident had sustained injuries.

The Director of Care (DOC) acknowledged that staff had failed to do a safety risk assessment at point of care to prevent an injury and had not used safe positioning techniques when assisting the resident.

As a result of the improper transfer and positioning there was harm to the resident, as they sustained injuries and sought medical treatment.

Sources: Two CIS reports, a resident's clinical records, and interviews with the DOC and other staff. [524]

WRITTEN NOTIFICATION: Required Programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to comply with the home's falls prevention and management policy related to head injuries, included in the required falls prevention and management program in the home, for a resident.

Rationale and Summary

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that written policies and protocols were developed for the falls prevention and management program and ensure they were complied with.

Specifically, staff did not comply with the licensee's "Falls Prevention and Management Program" policy #RC-15-01-01, last reviewed March 2023, related to clinical monitoring of neurovital signs.

The home's "Falls Prevention and Management Program" policy stated if a resident hits their head or is suspected of hitting their head (e.g. unwitnessed fall), staff were to complete a Clinical Monitoring Record, which included neurovital signs.

A resident had an unwitnessed fall which resulted in an injury. An initial Clinical

Monitoring Record was not completed when the resident fell and required neurovital signs. There were no initial neurovital signs documented in the resident's clinical record.

The Falls Lead stated that neurological checks should be completed as part of the post fall assessment for unwitnessed falls.

The Director of Care (DOC) stated an initial neurological check should have been completed for the resident.

Sources: A Critical Incident System (CIS) report, the resident's clinical records, the home's Falls Prevention and Management Program" policy #RC-15-01-01, last reviewed March 2023, and interviews with the Falls Lead, the DOC and other staff. [522]

WRITTEN NOTIFICATION: Required Programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee has failed to comply with the home's pain management policy related to comprehensive pain assessments included in the required pain management program in the home, for a resident.

Rationale and Summary

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that written policies and protocols were developed for the pain management program and ensure they were complied with.

Specifically, staff did not comply with the licensee's "Pain Identification and Management" policy RC-19-01-01, last reviewed March 2023, related to comprehensive pain assessments.

The home's "Pain Identification and Management" policy stated all residents would have a comprehensive pain assessment completed with any new pain or new diagnosis of a painful disease.

A resident had an unwitnessed fall which resulted in the resident sustaining an injury. At the time of the fall, the resident stated that they had pain. The resident sought medical treatment and had an order for pain medication, as needed.

After the incident, the resident complained of pain on several occasions and also received pain medication.

There was no comprehensive pain assessment completed for the resident when they sustained an injury and were experiencing pain.

The Director of Care (DOC) acknowledged that a pain assessment had not been completed for the resident. The DOC stated the home had a lot of agency staff which may have contributed to the assessment being missed.

Completing a comprehensive pain assessment for the resident after they sustained

an injury would have helped in developing a pain management plan of care for the resident.

Sources: A Critical Incident System (CIS) report, the resident's clinical records, the home's "Pain Identification and Management" policy RC-19-01-01, last reviewed March 2023, and interviews with the DOC and other staff. [522]