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
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Original Public Report

Report Issue Date: March 22, 2024	
Inspection Number: 2024-1127-0001	
Inspection Type: Critical Incident	
Licensee: DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC II Long Term Care GP Inc. and Arch Venture Holdings Inc.	
Long Term Care Home and City: Niagara Long Term Care Residence, Niagara On The Lake	
Lead Inspector Jonathan Conti (740882)	**Inspector Digital Signature** Jonathan Conti Digitally signed by Jonathan Conti Date: 2024.04.08 10:16:39 -04'00'
Additional Inspector(s) Katie Roy (000839) was present for shadowing of this inspection.	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 28-29, 2024, and March 4-8, 2024.
The inspection occurred offsite on the following date: March 1, 2024.

The following intakes were inspected in this Critical Incident (CI) inspection:

- Intake #00087790 - [CI 2618-000008-23]- Prevention of abuse and neglect.
- Intake: #00105526 - [CI 2618-000001-24] – Falls prevention and management.

The following intakes were completed in this CI inspection: Intake #00022221/ CI# 2618-000003-23, Intake #00092019/CI#2618-000013-23, and Intake #00104848/ CI#2618-000020-23 were related to falls prevention and management.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

Plan of care

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 the plan of care for a resident was provided as specified in the plan related to activities of daily living for locomotion in their wheelchair.

Rationale and Summary

A resident was assessed as a risk for falls and required monitoring by staff at the nursing station. During observation of the resident by the nursing station on

identified dates in February and March 2024, it was noted that the resident's assistive device did not have the required adjustments made by the staff as specified in their plan of care.

The Director of Care (DOC) acknowledged that the resident was at risk for falls, and they may have been at an increased risk of injury due to their plan of care not being followed.

Sources: Resident observations; interviews with staff and the DOC; care plan, progress notes, and fall assessments for resident. [740882]

WRITTEN NOTIFICATION: Duty to protect

NC #002 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 failed to ensure that resident #002 was protected from physical abuse by resident #003.

As per O. Reg. 246/22, s. 2(1), "physical abuse" from resident to resident is defined as the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitements d'ordre physique").

Rationale and Summary
On a date in May 2023, there was an altercation between resident #003 and resident #002 that resulted in physical injury to resident #002.

Resident #002 complained of pain during the assessment completed by Registered Practical Nurse (RPN) #109 post-incident.

On further assessment on a date in May 2023, resident #002 had developed injuries requiring identified assessments and monitoring. Resident #002 continued to have pain to the identified areas and had required the use of pain medication as needed.

The Assistant Director of Care (ADOC) acknowledged that resident #002 had emotional distress as well as physical injuries related to physical force used by resident #003. The ADOC confirmed that further intervention and behavioural monitoring was initiated following the incident for resident #003 to prevent further abuse to other residents.

Failure to protect resident #002 from physical abuse by resident #003 caused physical injury and presented a risk to resident #002's safety.

Sources: Resident #002 and resident #003 clinical records including progress notes, care plans, assessments, electronic administration record (eMAR); CI Report #2618-000008-23; the home's policy "Abuse and Neglect Policy" (reviewed date April 28, 2023); interviews with ADOC and staff. [740882]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure immediate reporting to the Director of the alleged abuse of a resident that resulted in physical injury, emotional distress, and risk of harm.

Rationale and Summary
A Critical Incident (CI) report was submitted in relation to an incident of physical abuse the following day on which it occurred.

The ADOC confirmed they were first made aware of the incident through phone calls with registered staff immediately after the incident occurred. The ADOC acknowledged that the incident was then not immediately reported to the Director through the after-hours line when they were first made aware of the incident.

Sources: Interviews with ADOC and staff; Critical Incident Report 2618-000008-23; resident progress notes; internal investigation notes. [740882]

WRITTEN NOTIFICATION: Responsive behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(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.

The licensee has failed to ensure that a resident's monitoring of their behaviours using the Dementia Observational System (DOS) assessment tool and summary of the assessment was fully documented.

Rationale and Summary
On a specified date, DOS charting was ordered for a resident following concerns from staff that they demonstrated responsive behaviours that put the resident at risk for injury to self. The resident was assessed as a risk for falls based on observed responsive behaviour history. The progress notes for the resident indicated that DOS charting was initiated on a specified date.

The home's program for responsive behaviours included the DOS assessment tool, which was to be used by staff to document the monitoring and observations of behaviours for a period, and that the results would be described and analyzed in a summary assessment.

The DOC acknowledged that there was no record of the DOS assessment tool in the residents chart, nor was there a documented summary of the DOS charting for that period. The DOC acknowledged that the summary of the DOS charting was required to identify and address any responsive behaviours that the resident may have had.

The homes failure to fully complete the DOS assessment tool and summarize the behavioural monitoring may have resulted in an incomplete assessment of the resident's responsive behaviours and any ineffective plan of care interventions.

Sources: A resident's clinical record; the home's program titled "Responsive Behaviour Philosophy" (revised December 21, 2023); interviews with RN and DOC. [740882]

WRITTEN NOTIFICATION: Medication management system

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

Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

Medication management system

s. 123 (3) The written policies and protocols must be,

(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee has failed to comply with ensuring registered staff used best practice standards to initial the electronic Medication Administration Record (eMAR) and document for medications that could not be given.

Specifically, staff did not implement their policy regarding medication documentation.

Rationale and Summary

On a specified date, a resident was ordered to receive a one-time use of a specified medication. Staff confirmed that the medication could not be provided to the resident due to refusals and multiple attempts by staff. The progress notes for the resident specified that the medication was refused, and attempts would be made later. The paper copy of the Narcotic and Controlled Substances Administration Record indicated that the dose ordered for the resident was wasted and discarded on a specified date.

The resident's eMAR did not contain documentation of the electronic signature of the staff responsible for administration of the medication on the specified date, and the refusal reason code was not checked off.

The ADOC acknowledged that the staff did not document in eMAR as per policy.

The ADOC and registered staff confirmed the expectation for appropriate documentation was to sign the eMAR for the refusal of the specified medication.

As a result, general medication administration practices were not followed when eMAR documentation of the one-time use medication refusal was not completed.

Sources: Interviews with ADOC, registered staff; resident clinical record including eMAR; Policies and Procedures: Manual for MediSystem Serviced Homes. [740882]