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

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Original Public Report

Report Issue Date: October 20, 2023	
Inspection Number: 2023-1543-0004	
Inspection Type: Critical Incident	
Licensee: Corporation of the County of Elgin	
Long Term Care Home and City: Elgin Manor, St Thomas	
Lead Inspector Julie Lampman (522)	**Inspector Digital Signature** Julie Lampman Digitally signed by Julie Lampman Date: 2023.10.23 12:43:51 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 12, 13, 16, 18, 2023
The inspection occurred offsite on the following date(s): October 17, 2023

The following intake(s) were inspected:

- Intake: #00093949/Critical Incident System (CIS) report #M518-000016-23 related to resident to resident abuse.
- Intake: #00094010/CIS #M518-000018-23 related to a significant change in health status.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Resident Care and Support Services
Responsive Behaviours

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 (9) 1.

The licensee has failed to ensure that a resident's behaviours and interventions implemented were documented as per the physician's orders.

Rationale and Summary
There were three separate incidents where a resident displayed responsive behaviours towards other residents.

The resident's physician ordered that registered staff were to monitor the resident every shift for specific behaviours. The order indicated if the resident displayed behaviours that staff were to complete a progress note of what the resident was doing and what interventions were implemented.

Documentation in the resident's electronic Treatment Administration Record (eTAR) over a three month period, noted the resident displayed behaviours on 46 occasions. On nine (19.5%) occasions there were no corresponding progress notes of what behaviour the resident displayed and the interventions implemented. On one occasion staff did not indicate in the eTAR if the resident displayed any behaviours that shift.

The Manager of Resident Care (MRC) stated registered staff had a pattern of indicating that the resident was displaying behaviours in the eTAR but not documenting a progress note as ordered. The MRC stated that they might need to clarify the order with the registered staff.

Staff were not consistently documenting the resident's behaviours and the interventions implemented. Consistent documentation would help identify possible causes and contributing factors of the behaviours the resident expressed and identify effective interventions in deescalating the resident's behaviours.

Sources:
Review of a Critical Incident System Report, the resident's clinical records and interviews with the MRC and other staff. [522]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (3) (a)

The licensee has failed to ensure that screening protocols for responsive behaviours were implemented in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Rationale and Summary
A resident had displayed responsive behaviours towards another resident. A Behavioural Supports Ontario-Dementia Observation System (BSO-DOS) Worksheet was initiated after the incident.

A BSO-DOS Worksheet was also initiated on three other occasions related to the resident's behaviors.

On each BSO-DOS Worksheet Step #1 and #3 were not completed including:
• The dates the BSO-DOS observation period was to begin and end;
• Analysis and Planning;
• Patterns that emerged and what the BSO-DOS data revealed;
• Possible causes and contributing factors of the behaviours expressed during the observation period;
• Next Steps based on the learnings from the BSO-DOS,

The BSO Registered Practical Nurse (RPN) stated the BSO team did not complete Step #3 of the BSO-DOS Worksheet. The BSO RPN stated it was brought up by the Provincial BSO Lead that Step #3 of the BSO-DOS should be completed for analysis and planning.

The Manager of Resident Care stated all staff had training on how to complete the BSO-DOS Worksheet and they would need to reinforce with registered staff that they needed to finish the BSO-DOS document.

The BSO-DOS tool was not being utilized per best practices, to identify the level of risk associated with the resident's behaviours, and to identify behavioural triggers, patterns, contributing factors, environmental factors, the type and frequency of behaviour.

Sources:
Review of a CIS report, the resident's clinical records, the home's "Responsive Behaviour" policy with a revision date of March 2022, the BSO-DOS User Guide dated May 2019, and interviews with the BSO RPN and the MRC. [522]