Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 22, 2020	2020_543561_0003	017555-19, 022574-19, 023290-19, 023496-19, 023598-19, 000170-20, 000395-20, 002143-20	Critical Incident System

Licensee/Titulaire de permis

Grace Villa Limited
284 Central Avenue LONDON ON N6B 2C8

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

Grace Villa Nursing Home
45 Lockton Crescent HAMILTON ON L8V 4V5

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

DARIA TRZOS (561), YULIYA FEDOTOVA (632)

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): February 13, 14, 18, 19, 20, 21, 24, 25, 26, 27, 28, 2020.

The following Critical Incident System (CIS) inspections were conducted during this inspection:

log #023290-19 - CI 2741-000026-19 - related to a fall with injury,
log #023496-19 - CI 2741-000027-19 - related to a fall with injury,
log #002143-20 - CI 2741-000003-20 - related to a fall with injury,
log #000395-20 - CI 2741-000002-20 - related to a fall with injury,
log #017555-19 - CI 2741-000017-19 - related to a fall with injury,
log #022574-19 - CI 2741-000020-19 - related to altercation between residents that caused an injury,
log #023598-19 - CI 2741-000028-19 - related to alleged visitor to resident abuse.

A Follow Up Inspection (FUI) with a log #000170-20, was completed with this inspection.

A complaint inspection with an inspection number 2020_543561_0004 was conducted concurrently with this inspection.

PLEASE NOTE: A Written Notification related to LTCHA, 2007, s. 6(7), identified in a concurrent inspection #2020_543561_0004 (Log # 003426-20) was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Associate Executive Director (AED), Director of Clinical Services (DOCS), Associate Director of Clinical Services (ADOCS), Director of Culinary Services, Registered Dietitian, Social Worker, Physiotherapist, Wound, Care Nurse, Pharmacist, Cook, Behavioural Supports Ontario (BSO) Clinical Coach, BSO Personal Support Worker (PSW), Dietary Aides (DA), Registered staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), PSWs, residents and family members.

During the course of the inspection, the inspectors: toured the home, observed the provision of care, observed meal services, reviewed investigation notes, reviewed clinical records, reviewed relevant policies and procedures, reviewed evaluations of programs and training records.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 8. (1)	CO #001	2019_689586_0026	632

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).

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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for the resident that set out clear directions to staff and others that provided direct care to the resident.

A Critical Incident (CI) report was submitted to the Director, and indicated that resident #003 sustained a fall on an identified date in 2019, resulting in injury.

The written plan of care in effect during the incident, indicated that resident #003 was assessed to be at risk for falls and had an intervention implemented for falls if appropriate.

PSW #119 was interviewed and stated that they did not recall resident having the identified intervention in place. RN #120 stated in an interview, that the resident had the identified intervention prior to the fall, and it was discontinued after the fall.

Interview with PT identified that they provided the identified intervention for this resident prior to the fall, and staff were expected to apply it at all times. When PT reviewed the written plan of care, they acknowledged that the written plan of care did not provide clear directions to staff related to the application of the intervention when it stated to apply it if appropriate.

The licensee failed to ensure that there was a written plan of care for resident #003 that set out clear directions to staff and others who provided direct care to resident #003 related to the application of falls intervention. [s. 6. (1) (c)]

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

A) A CI report was submitted to the Director related to an incident in 2019, when resident #007 exhibited responsive behaviours towards co-resident #006.

Clinical records review indicated that resident #007 exhibited responsive behaviours towards co-residents in the home since their admission to the home.

Review of the Psychogeriatric Resource Consultant (PRC) recommendations directed the home to complete an identified assessment along with other recommendations.

BSO Clinical Coach #113 was interviewed and indicated that the assessment recommended was not completed. It was completed on the day of the interview with Inspector #632.

The home failed to ensure that the identified assessment set out in the plan of care for resident #007 was completed as specified in their plan. (632)

B) The plan of care for resident #001 identified that the resident was using an identified device; however, on an identified date this device was changed to another ambulation device which was provided by the home.

A progress note identified that the resident was assessed by PT and recommended that the resident required a different device suitable for their needs and found one through an identified program at no cost. The PT stated that this device would be the best suitable one for this resident to reduce falls and injury. PT also stated that it has not been picked up for the resident as yet.

The DOCS and ADOCS were both interviewed and stated that the device was available for this resident; however, was not picked up yet.

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

C) During the course of this inspection, resident #013's substitute decision maker (SDM) was interviewed and stated that they were not informed of an altered skin integrity that the resident sustained in 2020. The SDM was concerned of how the resident sustained this. Inspectors #561 and #632 observed the altered skin integrity during the interview and it was still visible.

The review of the written plan of care for resident #013, identified that the resident had a potential risk of impaired skin integrity and indicated that the PSW staff were to report any altered skin integrity to registered staff and registered staff were to notify the resident’s SDM.

The progress notes were reviewed and identified that on an identified date in 2020, registered staff documented that the SDM reported to them that they observed an area of altered skin integrity and wondered why they were not notified of that. The registered staff then assessed the resident and identified that this skin issue was not new. The plan of care did not include when the identified altered skin integrity was first observed by staff or to indicate that the SDM was notified of it when it first appeared.

In an interview, RPN #136 they described the process in the home for skin and wound which was not followed in this case. The RPN also stated that the resident was prone to altered skin integrity and had lots of areas which sometimes were difficult to keep up with.

The ED and DOCS acknowledged that the written plan of care stated that PSW staff were required to report any altered skin integrity to registered staff and to notify the SDM.

Please note: Non-compliance (C) was identified during a complaint inspection 2020_543561_0004, completed concurrently with this inspection. [s. 6. (7)]

3. The licensee failed to ensure that the provision of care set out in the plan of care was documented.

A) The plan of care for resident #001, identified that the resident required to have identified interventions for falls.

Interview with PSW #112 indicated that application of those interventions were being documented in Point Click Care (PCC) under the task section which would show on Point of Care (POC).

RN #102 stated that the PSWs were expected to document the provision of care, such as application of interventions for falls in POC. The registered staff were the ones to add this under the task section in PCC, if a resident required those interventions.

POC was reviewed for resident #001 and the provision of care related to application of identified interventions for falls were not set up under the task and therefore, were not being documented by PSW staff.

In an interview with the ADOCS and the DOCS, they stated that it was an expectation to document the application of interventions for falls for this resident and acknowledged that it was not being done.

B) The plan of care for resident #003, indicated that the resident was at risk for falls and required to have interventions for falls.The POC was reviewed and the application of the falls interventions were not being documented.

PSW #119 was interviewed and confirmed the application of identified interventions for falls.
RN #102 stated that PSW staff were expected to document the provision of care, including interventions for falls in POC. The registered staff were the ones to add this under the task section in PCC, if a resident required those interventions.

The DOCS and ADOCS stated that it was an expectation to document the application of the falls interventions and acknowledged it was not being done.

The licensee failed to ensure that the provision of care for resident #001 and resident #003 related to the falls interventions was being documented. [s. 6. (9) 2.]

4. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A) Review of resident #011's current plan of care identified the resident wore glasses and for staff to ensure that they were clean and available. Review of move-in documentation in progress notes indicated that resident #011 had a pair of glasses for reading. Review of an identified assessment indicated "glasses for reading" for the resident.

Minimum Data Set (MDS) documentation indicated no glasses for the resident in Vision Appliances section. During the inspection, resident #011 indicated that they did not have their glasses. RPN #105 stated that the resident no longer had glasses and the DOCS indicated that the resident did not wear their glasses and it was not revised on their care plan.

Review of the home's policy titled "Care Plan Policy", section C.3 (effective date April 2016), indicated that the resident's care plan should be revised from information obtained from the resident, the resident's family, health records, MDS assessment, and all disciplines involved in the resident's care.

The home did not ensure that resident #011's plan of care was reviewed and revised at the time when the resident's care needs changed in relation to wearing glasses. (632)

B) Review of resident #006's current plan of care identified the resident wore glasses at all times. Review of admission documentation in a progress note also indicated that resident #006 wore their glasses.
MDS documentation indicated no glasses were used by the resident. During the inspection, RN #102 indicated that the resident lost their glasses.

Review of the home's policy titled "Care Plan Policy", section C.3 (effective date April 2016), indicated that the resident's care plan should be revised from information obtained

from the resident, the resident's family, health record, MDS assessment, and all disciplines involved in the resident's care.

The home did not ensure that resident #006's plan of care was reviewed and revised at the time when the resident's care needs changed in relation to wearing glasses. (632)

C) A CI report was submitted to the Director indicating that resident #002 sustained a fall on an identified date in 2020, with the initial assessment showing no injury. On a different date in 2020, resident #002 had a change in condition and was sent to the hospital for further assessment. The CI indicated that resident #002 sustained an injury due to the identified fall.

The clinical record review identified that resident #002 was ambulatory with an identified device prior to the fall in 2020. After the fall with injury, the resident was assessed and required the use a different device for ambulation.

Interview with PSW #112 who provided direct care to the resident identified that since the fall that resulted in injury, the resident had interventions implemented for falls. These interventions have been in place since the identified fall. Inspector #561 observed the resident and the interventions were in place; however, they were not included in the written plan of care.

The ADOCS was interviewed and stated that it was the registered staff expectation to revise the care plans when new interventions were being implemented.

The licensee failed to ensure that the written plan of care was revised with the new interventions for falls when resident #002's care needs changed.

D) A CI report was submitted to the Director indicating that resident #001 had a fall on an identified date in 2020, was sent to the hospital and sustained an injury.

Clinical records were reviewed and indicated that resident #001 sustained multiple falls in 2019 and 2020 with a number of injuries as a result.

Interviews with registered staff #102, #104 and PSW #107 in the home that provided direct care to the resident stated that over the past several months the resident sustained multiple falls with injuries.

Review of the home's policy titled "Care Plan Policy", section C.3 (effective date April 2016), indicated that the resident's care plan should be revised from information obtained from the resident, the resident's family, health record, MDS assessment, and all disciplines involved in the resident's care.

The written plan of care was reviewed and did not include the identified injuries sustained.

The ADOCS stated that the plan of care should have been revised to include the injuries sustained after the identified falls.

E) Clinical record review for resident #001 indicated that the resident was assessed for a specific activity in 2019. On an identified date in 2019, the resident had a change in condition and was no longer able to participate in the identified activity.

Interviews with registered staff #102 stated that since the resident had a change in condition they were no longer able to participate in the identified condition.

The current written plan of care was not revised to reflect the change in condition.

The DOCS acknowledged that the written plan of care was not revised when the resident's condition changed and they were no longer able to participate in the identified activity.

F) Clinical record review for resident #001 indicated that the resident was diagnosed with a health condition in 2020, which was treated with a medication. The resident's condition did not resolve and more treatment was ordered. On an identified date in 2020, the resident was hospitalized and a third treatment was ordered for the same health condition in the hospital as the condition has not resolved.

The written plan of care was reviewed and indicated that resident #001 had history of the identified health condition; however, it was not revised to include interventions and treatment for the identified health condition.

The home's policy titled "Care Plan Policy", section: C.3, (effective April 2016), stated that the home was expected to develop a system of care plan review/revision to include whenever there is a change in the resident's condition. The resident's care plan shall be revised from information obtained from the resident, the resident's family, health records,

MDS assessment, and all disciplines involved in the resident's care.

Registered staff #102 was interviewed and stated that the care plan was to be revised with any changes to the health condition.

The ADOCS was interviewed and stated that registered staff were expected to revise the written plan of care with the necessary interventions. The ADOCS acknowledged that the written plan of care was not revised when resident #001 was diagnosed with the identified health condition in 2020.

The licensee failed to ensure that the written plan of care was revised when resident #001's health condition changes and interventions were no longer necessary. [s. 6. (10) (b)]

5. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan was not effective.

Clinical records for resident #001 were reviewed and indicated that the resident had multiple falls in 2019 and 2020. The resident had an intervention implemented on an identified date in 2020.
A progress note on an identified date indicated that this intervention was changed and no longer necessary.

In an interview, PT stated that they trialed the identified intervention for several days; however, this was changed as the intervention was not effective.

Resident #001's room was observed by Inspector #561 and the intervention was no longer in place.

The plan of care was reviewed and identified that it was not revised when the intervention was ineffective and no longer necessary. The current written plan of care still included this intervention.

The home's "Care Plan Policy", Section C.3 (effective April 2016), indicated that the home was expected to develop a system of care plan review/revision to include the care no longer necessary or not effective.

The DOCS acknowledged that the care plan was not revised when the care set out in the plan had not been effective. [s. 6. (10) (c)]

6. The licensee failed to ensure that if the resident was being reassessed and the plan of care was being revised because care set out in the plan had not been effective, that different approaches were considered in the revision of the plan of care.

A CI report was submitted to the Director related to resident #001 having a fall on an identified date in 2020, and as a result was sent to the hospital due to an injury.

Clinical record review identified that resident #001 had multiple falls with and without injuries in the past several months.

Interviews with staff identified that resident #001’s falls were associated with the resident’s identified behaviour. RN #116 stated that prior to the injuries, the resident was able to ambulate on their own with the assistance of a device. They were able to go outside for a specified activity. When the resident's condition had changed and they were no longer able to participate in the identified activity the resident had an increase in falls. The RN stated that most falls occurred due to an identified behaviour.

A) Clinical record review identified that the resident was referred to BSO on an identified date in 2019, due to an identified behaviour. BSO notes were reviewed and identified they were gathering information. No interventions were recommended or implemented except for one identified intervention. The resident was also placed on dementia observation system (DOS) monitoring/assessment several times during the assessment period. Clinical records identified that the DOS monitoring sheets were not analyzed once they were completed.

The ADOCS stated that the purpose for DOS monitoring/assessment was to identify triggers, look at patterns of behaviours and based on that recommend interventions. The ADOCS acknowledged that behaviours were not reassessed when the DOS was not analyzed

B) Clinical record review indicated that resident #001 was diagnosed with a health condition in 2019 and a treatment was ordered. Other tests were also performed. The lab results came back and indicated that resident's health condition has not resolved. Clinical records indicated that the physician had ordered to repeat the same treatment again.

On an identified date in 2020, the resident was sent to the hospital due to an injury after a fall and was also diagnosed with the same health condition that has not previously resolved. The resident returned to the home with another order of the same treatment. The resident had another fall was sent to the hospital with injury for further assessment and was also diagnosed with the identified health condition that has not previously resolved. This time was ordered a different treatment.

RPN #111 and RN #102 were interviewed and described the process in the home for testing and treatment of the identified health condition.
RN #102 also stated that it was up to the physician to decide on the course of treatment.

In an interview with the ADOCS and the DOCS they acknowledged that the treatment for the resident’s health condition was not effective; however, the resident continued to receive the same intervention for days.

C) The home called the Nurse Practitioner (NP) to come and assess resident #001 during this inspection, completed a thorough assessment of the resident and documented detailed description of the diagnosis and state of the resident's health conditions and specified activity the resident was involved with and currently not able to perform.

As per the progress notes, NP recommended interventions to treat resident's changes in health condition.

The licensee failed to ensure that when the resident was being reassessed the plan of care was not effective and different approaches were not considered in the revision of the plan of care related to falls, behaviours, an activity and treatment for the unresolved health condition. [s. 6. (11) (b)]

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 to ensure that there is a written plan of care for the resident that sets out clear directions to staff and others that provide direct care to the resident; to ensure that the care set out in the plan of care is provided to the resident as specified in the plan; to ensure that the provision of care set out in the plan of care is documented; to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or when care set out in the plan is no longer necessary; to ensure that if the resident is being reassessed and the plan of care is being revised because care set out in the plan is not effective, that different approaches are considered in the revision of the plan of care, 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. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

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 failed to ensure that a written record was kept relating to each evaluation under clause (b) that included the summary of the changes made and the date that the changes were implemented.

Review of "Quality Management Audit Report Behaviour/Responsive Behaviour Management Audit and Evaluation" (completed on November 14, 2019) contained "Yes", "No" and "Not Applicable (N/A)" format used for the Program evaluation and no written record of the dates, when those changes were implemented was included.

During the inspection, the ED acknowledged that the Annual Evaluation of the Responsive Behaviour Management Program did not contain a written record of the dates, when those changes were implemented.

The home failed to ensure that the Responsive Behaviour Management Program Annual Evaluation did not contain the dates that the changes were implemented in a summary of the changes made. [s. 53. (3) (c)]

2. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible.

A) A CI report was submitted to the Director related to the incident that occurred on an identified date in 2019, when resident #007 exhibited a responsive behaviour towards co-resident #006.

According to progress notes and interview with resident #009, identified that resident did witness the incident. RPN #105 indicated that resident #006 was assessed and there was a minor skin alteration caused as a result of this incident.

Clinical record review indicated that resident #007, exhibited responsive behaviours towards co-residents in the home since their admission.

Review of the Psychogeriatric Resource Consultant (PRC) recommendations indicated to complete an identified assessment, considering non-pharmacological approaches for the behaviour management and other interventions to be implemented for a specific time in a day.

Review of the resident’s plan of care did not include implementation of the PRC’s recommendations.

During the inspection, the ADOCS indicated that the registered staff in the home would review the PRC’s recommendations with the team and would update the care plan and try if the recommendation was effective. The BSO would also receive a copy of the recommendations and would talk with the team about what was working and what was not.

Review the BSO visit notes the recommendations and strategies were not included to manage resident #007’s identified behaviour, which was acknowledged by the ADOCS.

The home failed to ensure that, for resident #007, demonstrating responsive behaviours,

the PRC's strategies were implemented to respond to these behaviours, where possible.

B) Clinical record review indicated that resident #011 exhibited responsive behaviours in the home.

Progress notes review indicated resident #011 refused their medications. Review of the electronic Medications Administration Report (eMAR) documentation for an identified period of time in 2020, indicated the increase in medications refusal by the resident.

During the inspection RPN #117 confirmed that resident #011 refused their medications.

Strategies developed by the PRC included recommendation to ensure that required medications were given using a specified approach. Written plan of care for resident #011 indicated interventions for staff to evaluate effectiveness and side effects of medications and to monitor the resident's mood state and/or behavior. No strategies were included to ensure that required medications were given to resident #011 using the identified approach, which was acknowledged by the ADOCS.

Review of the BSO visit notes and review of the BSO Team Weekly Planning Tool did not include the recommendations and strategies to manage medication refusal behaviour.

The home failed to ensure that, for resident #011, demonstrating responsive behaviours related to the medications refusal, strategies were implemented to respond to these behaviours, where possible". [s. 53. (4) (b)]

3. The licensee failed to ensure that actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Clinical record review identified that resident #001 was placed on DOS monitoring for a number of days in 2019 and in 2020. DOS monitoring sheets were reviewed and identified that on several days and time frames the staff were not documenting the resident's behaviours using DOS.

RN #102 indicated that DOS charting was to be completed every half hour as indicated on the DOS monitoring sheet. The RN confirmed that resident #001 was being observed; however, it was evident that the staff forgot to document their observation on the DOS

DOS monitoring sheet identified on the back of the form, that the purpose of completing the form was to identify the behaviour and frequency of it, interpret the results. DOS would then assist front line staff in identifying potential triggers for the behaviours. This was also acknowledged by the BSO clinical coach.

The ADOCS was interviewed and indicated that DOS charting was an important tool to identify triggers for behaviours, look at the pattern of behaviours which would then assist in developing appropriate interventions. They acknowledged that staff were not always documenting this for resident #001.

The licensee failed to ensure that the assessment of resident #001's behaviour using a DOS tool was being documented. [s. 53. (4) (c)]

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 to ensure that, for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible; and to ensure that a written record is kept relating to each evaluation under clause (b) that includes the summary of the changes made and the date that the changes were implemented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to comply with s. 24. (1) 2 in that a person, who had reasonable grounds to suspect abuse of a resident failed to report the alleged abuse immediately to the Director in accordance with s. 24. (1) 2 of the LTCHA.
Pursuant to s. 152. (2) the licensee was vicariously liable for staff members failing to comply with subsection 24. (1).

A CI report was submitted to the Director on an identified date in 2019, alleging resident #007 abused resident #006.

Investigation notes and clinical records were reviewed and indicated that on an identified date in 2019, resident #007 exhibited a responsive behaviour towards co-resident #006 with details of the incident.

During the inspection, RPN #105 indicated that the incident of alleged abuse of resident #006 by resident #007 was reported by resident #009 to a PSW, who, in turn, reported it to them. RPN #105 indicted that resident #006 was assessed and there was a minor skin alteration as a result. During the inspection, resident #009, indicated that they witnessed the incident.

During the inspection, the ED indicated that they were informed of the incident on an identified date in 2019, by RN #138 and acknowledged that they did not report this incident immediately to the Director.

Review of the home’s “Abuse – Prevention, Elimination and Reporting Policy” (effective date September 2019), which stated that the Ministry of Health was to be notified immediately upon the home became aware of an alleged or witnessed incident of abuse or neglect that resulted in potential injury or pain to the resident or that caused distress to the resident and that could potentially be detrimental to the resident's health or well-being.

The home failed to ensure that a person a person, who had reasonable grounds to suspect abuse of resident #006, failed to report the alleged abuse immediately to the Director in accordance with s. 24. (1) 2 of the LTCHA, pursuant to s. 152. (2) the licensee was vicariously liable for staff members failing to comply with subsection 24. (1). [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure to keep a written record relating to each evaluation under paragraph 3 that included a summary of the changes made and the date that those changes were implemented.

Review of “Quality Management Audit Report Annual Evaluation – Skin Care and Wound Management Program” (completed on November 14, 2019) contained “Yes”, “No” and “N/A” format used for the Program evaluation and no summary of the changes made and the date that those changes were implemented were identified.

During the inspection, the ED acknowledged that the Skin Care and Wound Management Program Annual Evaluation did not contain a summary of the changes made and the date that those changes were implemented.

The home failed to ensure that the Skin Care and Wound Management Program Annual Evaluation did not contain a summary of the changes made and the date that those changes were implemented. [s. 30. (1) 4.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee’s policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation:
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and (e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the
changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

The licensee failed to ensure that a written record of everything provided for in clause (e) that a written record of everything provided for in clause (b) and the date of the evaluation, the date that the changes and improvements were implemented was promptly prepared.

Review of "Quality Management Audit Report Annual Evaluation – Resident Abuse and Neglect Policy" (completed on November 4, 2019) contained "Yes", "No" and "N/A" format used for the Program evaluation. During the inspection it was identified that the Annual Evaluation did not contain a written record of the Resident Abuse and Neglect Program's changes and improvements were required to prevent further occurrences and the date that the changes and improvements were implemented.

During the inspection, the ED acknowledged that the Annual Evaluation did not contain a written record of the Resident Abuse and Neglect Program's changes and improvements were required to prevent further occurrences and the date that the changes and improvements were implemented.

The home failed to ensure that a written record of Resident Abuse and Neglect Program changes and improvements were required to prevent further occurrences and the date that the changes and improvements were implemented. [s. 99. (e)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was maintained for each resident of the home.

A review of CI report submitted to the Director on an identified date in 2019 indicated that resident #007 exhibited responsive behaviour towards co-resident #006.
Review of progress notes for resident #007 identified that DOS charting was initiated on an identified date in 2019. During the inspection, the resident's plan of care was reviewed and the documentation was not available in the resident's chart.

During an interview with RPN #117, they acknowledged that after an extensive search of the resident's chart, they were unable to find the DOS charting initiated for this resident.

The home failed to ensure that DOS charting was maintained for resident #007 in the home. [s. 231. (a)]

Issued on this 27th day of May, 2020

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

Original report signed by the inspector.