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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901
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Original Public Report

Report Issue Date: March 9, 2023
Inspection Number: 2023-1003-0002
Inspection Type: Complaint Critical Incident System
Licensee: King Nursing Home Limited
Long Term Care Home and City: King Nursing Home, Bolton

Lead Inspector	**Inspector Digital Signature**
Helene Desabrais (615)	Helene Desabrais Digitally signed by Helene Desabrais Date: 2023.03.10 11:35:12 -05'00'

Additional Inspector(s) Craig Michie (000690)

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 28, March 1, 2, 6, 7, 2023.

The following intake(s) were inspected:

- Intake #00016563, complaint related to plan of care;
- Intake #00017812/Critical Incident related to prevention of abuse and neglect.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Residents' Rights and Choices
Falls Prevention and Management

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

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

Rationale and Summary:

"Physical abuse" is defined as the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitements d'ordre physique"). O. Reg. 256/22. S. 2 (2) (c).

A resident was to be continuously monitored by a staff member after demonstrating increased responsive behaviours related to physical aggression and concerns about the safety of other residents and staff. Days later the staff member observed the resident standing with an object in their hand beside a co-resident who had been injured.

The home's policy regarding continuously monitoring of a resident directed the staff to not leave the resident alone unless the care plan had changed. There was no documentation to indicate the care plan had change.

The Interim ADOC stated that just before the incident occurred the staff member was not monitoring the resident as required.

The Interim ADOC, the Registered Practical Nurse (RPN)-Behavioural Support Ontario (BSO) Lead and a Personal Support Worker (PSW) stated that the resident had responsive behaviours, was unpredictable and should have been closely monitored as directed.

The staff's failure to provide continuous close monitoring of a resident resulted in a resident being abused that caused injuries.

Sources: Residents clinical records, home's CI and interviews with a PSW, the RPN-BSO Lead, the Interim ADOC and the DOC.
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WRITTEN NOTIFICATION: Care Plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that there was a written plan of care that sets out clear directions to staff and others who provided direct care to a resident.

Rationale and Summary:
When a resident was admitted to the home, the resident's Substitute Decision Maker (SDM) requested the home to implement a specific intervention. This request was documented in the resident's profile tab in Point Click Care (PCC). Later, it came to the attention of the SDM that the requested intervention had not been implemented which caused harm to the resident

A Personal Support Worker (PSW) stated that staff relied on residents' care plan and kardex when providing care and would not look into a resident's PCC's profile tab to get that information. The resident's care plan did not include the SDM's request prior to the incident.

The Administrator of the home stated that staff were unaware of the SDM's wishes as it was not documented in the resident's care plan.

Sources: Resident's clinical records, email correspondences and interviews with resident's SDM, a PSW, the Activation Manager and the Administrator.

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