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

London District
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London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: March 26, 2024	
Inspection Number: 2024-1222-0001	
Inspection Type: Critical Incident	
Licensee: Kingsway Nursing Homes Limited	
Long Term Care Home and City: Kingsway Lodge Nursing Home, St Marys	
Lead Inspector Debbie Warpula (577)	**Inspector Digital Signature** Debbie L Warpula Digitally signed by Debbie L Warpula Date: 2024.04.10 09:53:37 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 6, 7, 8, 12, and 13, 2024
The inspection occurred offsite on the following date(s): March 11, 2024

The following intake(s) were inspected:

- Intake: #00109868 - 2726-000003-24 - related to a resident fall with injury;
- Intake: #00102117 - 2726-000018-23 - related to resident to resident abuse;
- Intake: #00103279 - 2726-000021-23 - related to resident to resident abuse;
- Intake: #00109192 - 2726-000001-24 - related to resident to resident abuse;

- Intake: #00109250 - 2726-000002-24 - related to resident to resident abuse; and
- Intake: #00109965 - 2726-000004-24 - related to resident to resident abuse

- Intake: #00096945 - 2726-000015-23 - related to a resident fall with injury, was completed during this inspection.

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

Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 119 (2) 1.

Requirements relating to restraining by a physical device
s. 119 (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 35 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

The licensee has failed to ensure that a resident who was restrained by a particular device, the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

Rationale and Summary:
A review of the home's policy "Physical Restraint – 09-01-01-B" indicated that staff were required to obtain a physician's order for the use of a restraint.

During an observation, Inspector #577 noted a resident seated in a specific mobility aid with a particular device.

Upon record review of physician orders, Inspector #577 noted that there was not an order for a particular device.

During an interview with a Personal Support Worker (PSW), they advised that they attached the device that morning as the resident required it for safety.

A Registered Nurse (RN) reviewed the physician orders and confirmed that there was not an order for the particular device, and they obtained an order.

The resident was at risk by having a particular device applied without the proper assessment and physician's order.

Sources: review of a CIS report, review of a resident's health records, the home's policy "Physical Restraint", observations of a resident, interviews with a PSW, an RN and the DOC.

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Date Remedy Implemented: March 11, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 119 (7) 4.
Requirements relating to restraining by a physical device
s. 119 (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 35 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
4. Consent.

The licensee has failed to ensure that every use of a physical device to restrain a resident under section 35 of the Act, consent was documented.

Rationale and Summary:
A review of the home's policy "Physical Restraint – 09-01-01-B" indicated that staff were required to obtain consent from the resident or Substitute-Decision Maker (SDM) to apply a particular device.

During an observation of a resident, Inspector #577 noted a resident seated in a specific mobility aid with a particular device.

Upon review of a resident's records, Inspector #577 noted that there was not consent for the particular device.

During an interview with a PSW, they advised that they attached the device that morning as the resident required it for safety.

An RN reviewed the resident's records and confirmed that there was not consent for the particular device, and they obtained consent from the residents SDM.

A PSW put the resident at risk by applying a particular device without the proper assessment and consent.

Sources: review of a CIS report, review of a resident's health records, the home's policy "Physical Restraint", observations of the resident, interviews with a PSW, an RN and the DOC.
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Date Remedy Implemented: March 11, 2024

WRITTEN NOTIFICATION: Responsive Behaviors

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (a)
Responsive behaviors
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviors,
(a) the behavioral triggers for the resident are identified, where possible;

The licensee has failed to ensure that behavioral triggers were identified for two residents who demonstrated specific behaviors.

Rationale and Summary:
A resident was identified in four Critical Incident System (CIS) reports over a four month time period, for specific behaviors from them toward other residents.

Another resident was identified in one CIS report for specific behaviors toward a resident.

Review of the homes policy "Responsive Behaviors - 09-01-52" indicated that prevention included identifying triggers for responsive behaviors and altercations. Prevention strategies included screening protocols, assessment tools (PIECES template), Cornell Scale for depression, Cohan-Mansfield Agitation Intervention (CMAI) and/or Delirium Observation Screening (DOS).

A) A review of a resident's progress notes over a specific time-period, indicated that the resident had an identified number of incidents towards other residents.

A review of the resident's current care plan had not identified any behavioral triggers.

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During an interview with a PSW, they advised that the resident had particular triggers.

In an interview with a Behavioral Supports Ontario (BSO) RN and a previous BSO Registered Practical Nurse (RPN), together reviewed the resident's care plan and

they confirmed that triggers were not identified in the care plan. The BSO RPN stated that the resident had particular triggers.

All residents on a specific unit were at risk as the resident had specific behaviors, specifically towards three specific residents; there was an identified number of incidents over a specific time period, and triggers for their behaviors were not identified.

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B) A review of another resident's progress notes over a specific time period, indicated that the resident had an identified number of incidents towards other residents.

A review of the resident's care plan had not identified any behavioral triggers.

During an interview with a PSW, they indicated that the resident had incidents with residents and had a tendency towards three specific residents.

In an interview with an RN they indicated that a specific resident was a trigger for the resident. During an interview with a BSO PSW, they advised that the resident had a tendency toward four specific residents. They stated that the resident had specialized care since a specific time.

During an interview with the Director of Care (DOC) they stated that triggers were not identified in the residents' care plan.

All residents on a specific unit were at risk as there was an identified number of incidents involving the resident and triggers for their behaviors were not identified.

Sources: review of five CIS reports, review of two resident's health records, the home's policy "Responsive Behaviors", observations of the two residents, interviews with a PSW, a BSO RN, previous BSO RPN, BSO PSW, an RN and the DOC.

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WRITTEN NOTIFICATION: Responsive Behaviors

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 for two residents, who demonstrated responsive behaviors, 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.

Rationale and Summary:
Review of the homes policy "Responsive Behaviors - 09-01-52" indicated that screening tools and assessment tools to be utilized included PIECES three question template, Cornell Scale for depression, Cohen-Mansfield Agitation Intervention (CMAI) and/or Delirium Observation Screen (DOS). A behavior assessment

conference was to be completed within 24 hours (hrs) and monthly until the behaviors resolved; and request evaluation from seniors mental health team physician.

A) A review of a resident's progress notes over a specific time period, indicated that the resident had an identified number of incidents towards other residents.

During a review of a particular assessment, Inspector #577 found 12 missing assessments.

During a review of the resident's progress notes and assessments, Inspector #577 noted that a referral to BSO and screening/assessment tools were not completed.

During an interview with the DOC, they stated they thought the resident had been referred to BSO. They advised that specific assessment tools were not completed and the behavior assessment was not completed after each incident.

All residents on a specific unit were at risk as there was an identified number of incidents involving the resident, assessment tools were not completed until the BSO referral on a specific date, and should have been completed at an earlier identified date; and their required behavior assessment was not completed after each incident.

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B) A review of another resident's progress notes over a specific time period, indicated an identified number of incidents toward other residents.

During a review of a particular assessment, Inspector #577 found nine missing assessments.

During an interview with the DOC, they advised that the behavior assessment was not completed after each incident.

All residents on a specific unit were at risk as there was an identified number of incidents involving the resident; and their behavioral assessments were not completed after each incident.

Sources: review of five CIS reports, review of two resident's health records, the home's policy "Responsive Behaviors", observations of two residents, interviews with BSO PSW and the DOC.

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COMPLIANCE ORDER CO #001 Duty to protect

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

A) Ensure that two specific residents do not abuse any other residents in the home

B) Revise the home's policy on Responsive Behaviors/BSO policy to include the following:
-the procedure for how to process a referral to BSO and Seniors Mental Health (SMH)
-outline who is responsible for sending referrals
-outline who is responsible for completing screening protocols and assessment tools, including when the tools must be implemented
-outline who is responsible to document triggers and interventions in the resident's care plan
-outline the specific responsibilities of BSO staff

C) Re-train registered nursing staff and direct care staff on the home's revised policies related to responsive behaviors. Maintain a written record of the training, what the training entailed, who completed the training, and when the training was completed

D) Conduct a knowledge test for the re-trained staff on the home's revised policies related to responsive behaviors. Maintain a written record of the knowledge test results, include what the test entailed, who completed the test and when the test was completed. Please include any remedial actions taken for staff who require this.

E) Ensure that the two residents with responsive behaviors, have documented triggers in their care plan

F) Ensure that the behavior assessment conference for the two residents is completed after every resident to resident altercation, as per the home's policy.

Grounds
Non-compliance with: FLTCA, 2021 s.24 (1)

The licensee has failed to protect residents from physical abuse by two residents.

Rationale and Summary:
According to the O. Reg, 246/22, physical abuse was defined as the use of physical force by a resident that causes physical injury to another resident.

Review of the home's policy "Resident Abuse – ADM-5027" indicated that In the event of resident-to-resident abuse, registered staff were to implement new interventions to prevent further abuse and a behavioral assessment conference was to be completed and a meeting was to be held within 72 hours of the incident.

A) A resident was identified in four Critical Incident System (CIS) reports over a four month time period, for specific behaviors from them toward other residents.

A review of the resident's progress notes over a specific time-period, indicated that the resident had an identified number of incidents toward other residents. On two identified dates, a resident suffered specific injuries.

During an interview with an RN, they indicated that the resident has had incidents with other residents. They advised that on an identified date, BSO requested specific assessments and the initiation of a specific type of assessment record. They stated that a referral was supposed to be sent to BSO at an earlier specified date, and the resident was not referred until two months later.

In an interview with a BSO PSW, they advised that they received a referral for the resident on an identified date, a specific type of assessment record was initiated and the assessment tools were completed following the referral.

During an interview with the DOC, they advised that specialized care was initiated on an identified date, and thought the resident was referred to BSO at an earlier date.

Reported that staff were not following the Responsive Behaviors policy when the assessment tools were not completed and the behavior assessment was not completed after each incident.

All residents on a specific unit were at risk as the resident had specific behaviors, specifically towards three specific residents; there was an identified number of incidents over a specific time period, triggers for their behaviors were not identified, assessment tools and a referral to BSO was not initiated until a later date. A behavior assessment was not completed after every incident.

Non-compliance #003 was issued related to triggers not being identified for the resident. Non-compliance #004 was issued related to assessments not being completed for the resident related to behaviors. Please see these non-compliances for further details.

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B) Another resident was identified in a CIS report for specific behaviors from them toward a resident.

A review of the resident's progress notes over a specific time-period, indicated an identified number of incidents toward other residents.

During an interview with a PSW, they indicated that the resident had incidents with residents and had a tendency towards three specific residents.

During an interview with the DOC they indicated that the resident had initiated incidents with different residents and approached residents that they disliked. Reported that staff were not following the Responsive Behaviors policy when the

behavior assessment was not completed after each incident and triggers were not identified in the residents' care plan.

All residents on a specific unit were at risk as there was an identified number of incidents involving the resident over a specific time period; they had a tendency toward six residents; triggers for their behaviors were not identified, and a behavior assessment was not completed after every incident.

Non-compliance #003 was issued related to triggers not being identified for the resident. Non-compliance #004 was issued related to assessments not being completed for the resident related to behavior. Please see these non-compliances for further details.

Sources: review of five CIS reports, review of two resident's health records, the home's policy "Responsive Behaviors", observations of two residents, interviews with a PSW, BSO RN, previous BSO RPN, BSO PSW, an RN and the DOC.

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This order must be complied with by May 7, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.