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
Jan 3, 2020	2019_810654_0009	013980-19, 015125-19, 018066-19	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 365 Bloor Street East, 15th Floor TORONTO ON M4W 3L4

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

Kipling Acres
2233 Kipling Avenue ETOBICOKE ON M9W 4L3

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

SIMAR KAUR (654)

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): November 21, 22, 27, 28, 29, December 02, 03, 04, 05, 06, and 09, 2019.

The following intakes were completed during this Critical Incident System Inspection:

Log # 015125-19, CIS #545-000037-19;
Log # 018066-19, CIS #545-000051-19; and
Log # 013980-19, CIS #545-000033-19 were related to alleged abuse.

A complaint inspection 2019_810654_0008 (log #019520-19) was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Registered Staff RN/ RPN; Personal Support Worker (PSW); Social Worker; Behaviour Support Ontario (BSO) Lead; Nurse Manager; and residents.

During the course of the inspection, the inspector made observations related to the home's care processes; staff to resident, and resident to resident interactions; conducted record reviews and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #002's right to be protected from abuse was fully respected and promoted.

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC), related to alleged abuse of resident #002.

Review of the CIS report indicated that on an identified date, housekeeping staff #101 witnessed that resident #002's identified family member abused them. The staff reported the incident to RPN #102. Resident #002 was using a portable identified exercise equipment in an identified resident home area with the family member's assistance. The family member slapped the resident on an identified area of their body as the resident did not follow their instructions during the exercise. The police were notified of the incident.

Record review of resident #002's Resident Assessment Instrument-Minimum Data Set (RAI- MDS) assessment indicated severe cognitive impairment.

Review of the resident's incident report indicated that resident #002 was abused by the above identified family member when they refused to comply with their instructions while using the identified exercise equipment. The incident was witnessed by housekeeping staff #101.

Review of the resident's skin assessment completed after the incident indicated slight redness on the above identified area of their body.

Interview with housekeeping staff #101 indicated that on the above identified date, during an identified shift they witnessed that resident #002 was using the exercise equipment and the above identified family member was assisting them. The resident's identified family member slapped the resident when they stopped using the equipment. The staff further indicated that the resident did not react when they were slapped.

Interview with RPN #102 indicated that they were informed by housekeeping staff #101 of the above-mentioned incident. They assessed the resident and noted that the resident had slight redness on the identified body area but did not express any pain or discomfort. The RPN further indicated that the resident and their identified family member had a history of slapping each other before admission to the long term care home.

Interview with the home's Director of Nursing (DON) indicated that upon the home's investigation, the resident's above identified family member denied hitting the resident on

the identified body area. The DON further indicated that the home reviewed the policy on Zero Tolerance of Abuse and Neglect with the resident's family member on an identified date.

Interview with RPN #102, housekeeping staff #101 and the DON indicated that resident #002's right to be protected from abuse was not fully respected during the above mentioned incident.

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 residents right to be protected from abuse was fully respected and promoted, 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 license has failed to ensure that the written record was kept relating to Behaviour Management program evaluation that includes a summary of the changes made, and the date that those changes were implemented.

Record review of the home's behaviour management program annual evaluation for January- December 2018 completed in an identified month in 2019, provided by the home's DON did not indicate a summary of the changes made and the date that those changes were implemented.

Interview with the home's DON indicated that the home has revised its template for the annual evaluation form this year. They indicated that the annual evaluation mentioned above did not include the summary of the changes made and the date that those

changes were implemented, and it should have included those.

2. The licensee has failed to ensure that for residents #003 and #006 demonstrating responsive behaviours, actions were taken to respond to the need of the resident, including assessments, reassessments, and interventions and that the resident's response to interventions were documented.

Two CIS reports were submitted to the MLTC related to alleged abuse of resident #004 from resident #003.

(A) Review of resident #003's RAI-MDS assessment indicated that the resident had a long-term memory problem, but their short-term memory was fine. The resident's CPS score indicated moderate cognitive impairment.

Review of resident #003's plan of care indicated that the resident exhibited identified inappropriate behaviour towards a particular co-resident #004.

Record review of resident #003's progress notes and incident reports indicated two incidents on two identified dates and shifts when resident #003 exhibited the above identified behaviour toward resident #004.

Further review of the progress notes and separate interviews with PSW #110, RPN #109, and RN #116 indicated the identified inappropriate behaviour towards PSWs. They also indicated multiple incidents where resident #003 had attempted to enter resident #004's room or was found in their room and were redirected by the staff.

Review of the home's policy #RC-0306-00, titled "Altercation and Potential Harmful Interactions Between and among residents", indicated after any incident of alleged suspected and/or observed altercations and potential harmful interactions between and among residents: Conduct an identified behavioural assessment.

Review of the resident's clinical record and interview with the home's BSO lead #106 indicated that resident #003 did not have the identified assessment after the above-mentioned first incident with resident #004. The resident received the assessment two months after the first identified incident.

Interview with the home's DON indicated that the home used an identified assessment tool as a part of the responsive behaviour management program. BSO lead and any

trained registered staff were responsible to conduct the above identified assessment. They indicated that resident #003 did not have this assessment and they should have completed the assessment after the first above identified incident.

Review of the home's policy #RC-0517-07, with an identified title, indicated as follows:

-Complete an identified monitoring tool as a component of the assessment for new or escalating behaviours to gain a better insight and understanding of the time, pattern and antecedents leading to behavioural response.
-Review the identified monitoring tool's data with the care team and document the result of the data analysis in the progress note.

Record review of the resident's clinical records and interview with BSO lead #106 indicated that resident #003 was on the identified monitoring for the inappropriate behaviour on six identified periods in 2019.

The BSO lead #106 further reviewed resident #003's progress notes and indicated that there was no documentation review, and analysis completed and documented by the staff for the identified monitoring tool for the above identified period and thereafter.

(B) The resident sample was expanded to resident #006 related to responsive behaviour management due to a non-compliance identified related to resident #003.

Review of resident #006's RAI-MDS assessment indicated that they had moderate to severe cognitive impairment. Under their behavioural symptoms, it indicated that they exhibited multiple identified responsive behavioural symptoms.

Review of the resident's revised plan of care indicated that the resident exhibited the above identified multiple responsive behavioural symptoms related to their cognitive impairment. Interventions directed staff to remove the resident from the common area when they exhibit the responsive behavioural symptoms or may cause harm to themselves and others. It also indicated to initiate an identified behaviour monitoring tool.

Review of the resident's clinical record indicated that the above identified monitoring was completed for an identified period in 2019, to monitor their responsive behaviours.

Interview with PSW #104 and RPN #105 indicated that resident #006 exhibited the above identified multiple responsive behavioual symptoms towards staff during personal

care. PSW #104 further indicated that resident #006 could exhibit the responsive behavioural symptoms towards co-residents. They observed resident #006 exhibiting the responsive behaviour toward another unidentified resident on an identified date.

Interview with Nurse Manager #107 indicated that resident #006 was on the identified behaviour monitoring tool during the above identified period, for their escalating responsive behaviours. They further reviewed the resident's clinical record and indicated that there was no review, and analysis completed and documented after the monitoring tool was completed by the staff for the above identified period.

Interview with RPN #109 and RN #108 indicated that as per the home's expectations and process the identified behaviour monitoring was initiated for a resident with any new or escalating behaviour by the registered staff. They indicated that the BSO lead was responsible to review and analyze the data and document. They both further indicated that they were not aware if it was registered staffs' responsibility.

Interview with BSO lead #106 indicated that the behaviour monitoring tool was an assessment tool used by the home and the registered staff were responsible to review the documentation and analyze the results after it was completed. They further indicated that there was no set process the home had at this time to review and analyze the data of behaviour monitoring tool.

Interview with the DON indicated that according to the home's policy registered staff were required to review the above identified behaviour monitoring tool with the care team; which involved BSO lead, PSWs, and the physician. They further acknowledged that the process of data review, analysis and documentation was not completed for residents #003, and #006 for the above identified periods.

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 the written record is kept relating to Behaviour Management program evaluation that includes a summary of the changes made, and date that those changes are implemented; and for each resident demonstrating responsive behaviours, the actions are taken to respond to the needs of the resident including assessment, reassessments, interventions, and the resident's response to the interventions are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #003 and #004 by identifying and implementing interventions.

Two CIS reports were submitted to the MLTC related to alleged identified abuse of resident #004 from resident #003.

Review of resident #003's RAI-MDS assessment indicated that the resident had a long-term memory problem, but their short-term memory was fine. The resident's CPS score indicated moderate cognitive impairment.

Review of resident #004's RAI-MDS assessment indicated that the resident had short term and long-term memory problems. Their CPS score indicated moderate cognitive impairment.

Review of resident #003's plan of care indicated that the resident exhibited identified inappropriate behaviours towards a particular co-resident resident #004.

Record review of resident #003's progress notes and incident reports indicated two incidents on two identified dates and identified shifts when resident #003 exhibited above identified behaviour toward resident #004. Review of resident #003's progress notes further indicated that the resident was started on an identified responsive behaviour monitoring intervention, due to the inappropriate behaviours towards co-residents.

Review of the plan of care indicated that resident #003 was on the above identified responsive behaviour monitoring intervention during the above identified two incidents.

In separate interviews RPN #109 and RN #116 indicated that they both had responded to the first above identified incident. They further indicated that resident #003 did not have an assigned PSW to provide the identified monitoring intervention, when the incident had occurred.

Interview with PSW #115 indicated that the resident #003 did not have an assigned PSW to provide the identified monitoring intervention when the second above identified incident had occurred.

Interview with Nurse Manager #107 indicated that resident #003 was scheduled to receive the identified responsive behaviour monitoring intervention when the above mentioned incidents had occurred towards resident #004. The home was unable to fill the above identified shifts to assign a PSW to provide the monitoring intervention. Therefore, the resident did not receive the identified responsive behaviour monitoring intervention on the identified dates.

Interview with the home's DON indicated that for a resident who required to have the identified responsive behaviour management intervention, the home should schedule an assigned PSW for it. The DON acknowledged that the home did not implement the above identified intervention to prevent the above mentioned incidents between resident #003 and #004 as they were unable to fill the identified shifts on the above identified dates.

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 steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions between and among residents, including identifying and implementing interventions, to be implemented voluntarily.

WN #4: 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of care set out in the plan of care for resident #003 was documented.

Two CIS reports were submitted to the MLTC related to alleged abuse of resident #004 from resident #003.

Review of resident #003's clinical records indicated that the resident was being monitored for their identified responsive behaviour by using an identified behaviour monitoring tool in an identified month in 2019.

Review of the behaviour monitoring tool record did not indicate documentation on eight identified shifts in the above identified month in 2019.

Interview with the home's BSO lead #106 indicated that the resident was being monitored for the identified responsive behaviour on the above identified dates. However, the behaviour monitoring was not documented on the above mentioned behaviour monitoring tool.

Interview with the home's DON indicated that registered staff and PSWs both were responsible to document on the monitoring tool. The registered staff were responsible to ensure that the documentation on the tool was completed and documented at the end of each shift. They further indicated that the monitoring for resident #003 on the above identified dates was not documented as expected by the home. [s. 6. (9) 1.]

Issued on this 24th day of January, 2020

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

Original report signed by the inspector.