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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Amended Public Copy/Copie modifiée du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 26, 2021	2021_678590_0014 (A1)	016882-20, 025730-20, 001766-21, 007917-21	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

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

Weston Terrace Care Community
2005 Lawrence Avenue West Toronto ON M9N 3V4

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

Amended by ALICIA MARLATT (590) - (A1)

Amended 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): May 31, June 1 - 4 and 7 - 9, 2021.

The following intakes were completed in this Critical Incident System inspection (CIS):

Log #016882-20/CIS #2874-000021-20 and Log #001766-21/CIS #2874-000002-21 were related to prevention of abuse and neglect;

Log #025730-20/CIS #2874-000027-20 was related to a fracture of unknown origin; and

Log #007917-21/CIS #2874-000011-21 was related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Director of Care, an Associate Director of Care, a Physician, the Behavioural Supports Ontario Lead, four Registered Nurses, five Registered Practical Nurses and seven Personal Support Workers.

During the course of the inspection, the inspector(s) observed infection prevention and control practices, the provision of resident care and staff and resident interactions and reviewed Critical Incident System reports, residents' clinical records, internal investigation notes and policies and written procedures relevant to inspection topics.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.

- **4 WN(s)**
- **2 VPC(s)**
- **2 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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that a Personal Support Worker used safe techniques when transferring resident #002 using a mechanical lift.

During the morning on an identified day, resident #002 was observed by staff to have extensive bruising on an extremity which had become edematous, and they had been expressing non-verbal signs of pain. The resident was transferred to the hospital where a fracture was confirmed. During the home's investigation of the fracture, it was discovered that a Personal Support Worker (PSW) had improperly transferred the resident the day before. They had used a type of mechanical lift that the resident had not been assessed for. The appropriate mechanical lift to use, had been identified in the resident's plan of care at the time of the transfer; as well as visually communicated to the staff by a transfer logo posted on the residents' wall.

The PSW did not use techniques as per the Safe Resident Handling and Zero Lift & Protocol policies, as they should have known the resident's transfer status prior to performing any transfers. The staff member had been trained on how to complete safe lifts and transfers and had access to resources to identify the residents transfer status prior to performing the transfer.

Sources: The Long Term-Care Home's (LTCH's) investigative notes; LTCH's policy titled Zero Lift & Protocol, current revision in March 2021, with policy #: IV-M-10.10; LTCH's policy titled Safe Resident Handling, current revision in April 2019, with policy #: VII-G-20.301; Resident #002's plan of care; one employee's education record related to safe lifts and transfers; and interviews with Director of Care (DOC) #100 and other staff. [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

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. (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 has failed to ensure that actions taken to meet the needs of resident #004, with responsive behaviours, included assessments, interventions, and documentation of resident #004's responses to the interventions.

Review of the home's "Responsive Behaviours Management" policy noted that the nurse should conduct and document an assessment of a resident who was experiencing responsive behaviours that may include a urinary tract infection (UTI) or pneumonia and initiate observation tools, such as Behavioural Supports Ontario (BSO)-Dementia Observation Scale (DOS) monitoring, as required. Further, the policy directs the nursing staff to also:

- Strategize with other members of the interprofessional team to identify risk level, causes, and triggers.
- Provide treatment and interventions as required e.g. pain assessment.
- Evaluate the effectiveness of a planned intervention on the plan of care

addressing specific responsive behaviours.
- Complete an electronic Responsive Behaviour Referral to the internal Behavioural Support Designate when there is a new or worsening, or change in responsive behaviours.

A) Review of resident #004's electronic progress notes in point click care (PCC) noted no documented behaviours for resident #004 in December 2020.

In January 2021, resident #004 was noted as wandering in the hallway and damaging property in the home. Later that month, resident #004 was noted as wandering at night in the hallway and inside other residents' rooms. Resident #004 was noted to pull anything they could see at the nurses' station including the computer monitor while staff were using it. Resident #004 also pulled the fire alarm.

There was no documentation to support the physician or the BSO lead was contacted regarding the behaviour.

Review of resident #004's hard copy chart noted DOS monitoring was not initiated until 12 days after the last incident, and there were no documented pain assessments in PCC.

Review of resident #004's electronic medication record noted resident #004 had an order dated in December 2020, for medication as needed for agitation and behaviours. The as needed medication had never been administered to resident #004.

In an interview, Registered Practical Nurse (RPN) #112 stated if a resident had an increase in behaviours staff should offer the as needed medication to the resident and notify the doctor of the behaviours.

In an interview, RPN #107 stated DOS charting should be completed and a referral to BSO if a resident has new or worsening behaviours. RPN #107 acknowledged resident #004 did not have a pain assessment completed when they had an increase in behaviours in January 2021.

In interviews, Registered Nurse (RN) #110 acknowledged DOS charting was not initiated for resident #004 immediately after the incidents. RN #110 stated staff should do a pain assessment on a resident with increased behaviours, and a lot

of times staff do complete a pain assessment but do not document the assessment. RN #110 acknowledged resident #004 did not receive the as needed medication but was unsure why.

In an interview, Physician #119 stated they had not been notified of resident #004's behaviours in January, at the time they had occurred.

In an interview, BSO Lead #113 stated they had not received a referral when resident #004 had an increase in behaviours in January 2021.

B) Reviewed St. Michael's Psychogeriatric Resource Consultation (PRC) report for resident #004 and noted resident #004 had the following behaviours:

-Wandering in and out of other resident rooms
-Agitation and unpredicted responses to staff interventions
-Resistance to care-at times difficult to provide care
-Defecating in other resident rooms
-At night walking in the hallways and reaching out to grab computer monitor or phone or papers in care station
-Difficult to redirect
-Safety concern with grabbing co-residents to walk with them
-Attempts to pick up things from the care station.

The consultation noted the following interventions for resident #004:
-Demonstrate what you propose to do and connect with resident when you approach.
-Stay 2-3 feet away when you are communicating with resident.
-Speak slowly using as few words as possible, augmenting words with gestures.
-Model the activity or demonstrate with gestures what you want resident to do.
-Use Stop and Go approach.
-Engage him with his care by giving him a wash cloth to wash his face.
-Cover the computer monitor with a bed sheet at night so resident does not notice the objects or grab or pull them out.
-Give resident as often as possible a long thick towel to hold onto with both hands so their hands are busy, to reduce anxiety about wanting to grab or hold or pick something for security
-Rounding every 15-30 minutes after family has left (8:00 pm until resident goes to bed at 11:30 pm).

Review of resident #004's plan of care noted the interventions had not been documented in resident's care plan. There was no documentation to support which interventions had been trialled and resident #004's response to the interventions.

In an interview, BSO Lead #113 stated they were currently working with resident #004 and had received the PRC report. BSO Lead #113 acknowledged there was no documentation of recommended interventions from the PRC that were trialled for resident #004 and current recommended interventions had not been included in the resident's plan of care.

Sources:
Review of CIS report #2874-000002-21, resident #004's clinical records, the home's "Responsive Behaviours Management" Policy #VII-F-10.10 with a revision date of October 2019, St. Michael's Psychogeriatric Resource Consultation (PRC) report for resident #004 and interviews with PSW #109, RPN #107, RPN #112, RN #106, RN #110. BSO Lead #113, Physician #119 and DOC #100. [s. 53. (4) (c)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004's responsive behaviour plan of care provided clear direction.

During the inspection, resident #004 was observed wandering in the hallway and was further observed to have grabbed the elbow of a co-resident and was walking with them while holding their onto their elbow.

In an interview, Personal Support Worker (PSW) #109 stated resident #004 likes to grab onto other residents. PSW #104 stated when resident #004 did this they would give resident #004 something else to hold or distract resident #004 and give the resident their hand to hold and the resident would let go of the other resident and PSW #109 would then walk with resident #004 for a little while.

PSW #104 stated when they provide care to resident #004 they need to show the resident a couple of times what they would like the resident to do. PSW #104 stated when they take resident #004 to the washroom, they flushed the toilet which gave resident #004 the cue to go to the bathroom.

In an interview, RN #110 stated resident #004 would grab onto other residents and resident #004 was very strong. RN #110 stated they monitored resident #004 and would take the resident for walks. RN #110 stated resident #004 was worse in the evenings.

Review of resident #004's plan of care noted no documented interventions related to grabbing onto other residents when walking, and to take the resident for walks. There was also no intervention for staff to demonstrate to resident #004 what they would like the resident to do when providing care to the resident.

In an interview, BSO Lead #113 acknowledged the above interventions were not in resident #004's plan of care.

Sources: Observations of resident #004, resident #004's clinical records, and interviews with PSW #109, RN #110, RN #106, BSO Lead #113, and DOC #100. [s. 6. (1) (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 resident #004's responsive behaviour plan of care provides clear direction, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #004 had an increase in medication there was monitoring and documentation of resident #004's response and the effectiveness of the medication increase.

The home had received a complaint from resident #004's family related to an increase in medication which resulted in resident #004 becoming more lethargic, incontinent, and unresponsive.

Review of the home's "Responsive Behaviours Management" policy #VII-F-10.10 noted the nurse was to monitor and document a resident's response to new antipsychotic medication using the Behavioural Supports Ontario (BSO) – Dementia Observation Scale (DOS)/Antipsychotic Behavioural Tracking.

On a specified day, Physician #119 had increased resident #004's medication dosage, changed the frequency of administration and noted to monitor for side effects.

There was a progress note entry completed each day for two days after the medication increase and no further entries until four days after that.

A week after the medication was increased, DOS responsive behavior monitoring was initiated regarding wandering.

Eight days after the medication increase, resident #004's family member had requested to hold the resident's medications in the evening as the resident was too sleepy. Resident #004's medication dosage was then decreased at the family's request due to side effects.

In an interview, resident #004's spouse stated there was a significant change in resident #004 when their medication was increased. The spouse stated resident #004 was sleeping all the time, not eating and it was not safe to feed the resident as they would not open their eyes.

In interviews, RPN #110, RPN #111, RPN #107 and RN #110 all stated residents should be monitored for drowsiness, not eating and sleeping through meals with an increase in antipsychotic medication.

RN #110 stated DOS charting was initiated with an increase in antipsychotic medication and acknowledged DOS charting was not initiated on resident #004 until a week after the change, and that there was no other monitoring completed.

RPN #107 stated resident #004 went from very active to calm and it was quite a difference with the increase in medication.

In an interview, Physician #119 stated with an increase in medication staff should have monitored resident #004 for their response to the change in medication and effectiveness.

Sources: Review of CIS report #2874-000002-21, resident #004's clinical records, the home's "Responsive Behaviours Management" Policy #VII-F-10.10 with a revision date of October 2019, and interviews with RPN #107, RPN #111, RN

#110. BSO Lead #113, Physician #119, resident #004’s spouse and the DOC. [s. 134. (a)]

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 when psychotropic medication changes are made to resident #004's medication regimen, there is monitoring and documentation of the response and effectiveness of the medication, to be implemented voluntarily.

Issued on this 26th day of July, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by ALICIA MARLATT (590) - (A1)
Inspection No. / No de l'inspection :	2021_678590_0014 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	016882-20, 025730-20, 001766-21, 007917-21 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 26, 2021(A1)
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, Markham, ON, L3R-0E8
LTC Home / Foyer de SLD :	Weston Terrace Care Community 2005 Lawrence Avenue West, Toronto, ON, M9N-3V4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	John Seebach

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must comply with s. 36 of O.Reg. 79/10.

Specifically, the licensee must:

- Ensure that all staff caring for resident #002 and any other resident, knows how to access the plan of care and where to find a residents' transfer status prior to performing any transfers.

- Ensure that all staff members use safe techniques and the prescribed transferring method as outlined in the plan of care when transferring resident #002 and any other resident.

Grounds / Motifs :

1. The licensee has failed to ensure that a Personal Support Worker used safe techniques when transferring resident #002 using a mechanical lift.

During the morning on an identified day, resident #002 was observed by staff to have extensive bruising on an extremity which had become edematous, and they had been expressing non-verbal signs of pain. The resident was transferred to the hospital where a fracture was confirmed. During the home's investigation of the fracture, it was discovered that a Personal Support Worker (PSW) had improperly transferred the resident the day before. They had used a type of mechanical lift that the resident had not been assessed for. The appropriate mechanical lift to use, had been identified in the resident's plan of care at the time of the transfer; as well as visually communicated to the staff by a transfer logo posted on the residents' wall.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

The PSW did not use techniques as per the Safe Resident Handling and Zero Lift & Protocol policies, as they should have known the resident's transfer status prior to performing any transfers. The staff member had been trained on how to complete safe lifts and transfers and had access to resources to identify the residents transfer status prior to performing the transfer.

Sources: The Long Term-Care Home's (LTCH's) investigative notes; LTCH's policy titled Zero Lift & Protocol, current revision in March 2021, with policy #: IV-M-10.10; LTCH's policy titled Safe Resident Handling, current revision in April 2019, with policy #: VII-G-20.301; Resident #002's plan of care; one employee's education record related to safe lifts and transfers; and interviews with Director of Care (DOC) #100 and other staff.

An order was made by taking the following factors into account:

Severity: The staff member failed to use safe transferring techniques when transferring resident #002. There was actual risk for harm to resident #002 when the PSW was not aware of the resident's transfer status and used a mechanical lifting device that was not prescribed for the resident.

Scope: This non-compliance was an isolated incident. Observations of staff members using mechanical lifts safely were completed.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg. s. 36 and one Written Notification issued to the home. (590)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 06, 2021(A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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;

(b) strategies are developed and implemented to respond to these behaviours, where possible; and

(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).

Order / Ordre :

The licensee must comply with s. 53. (4) of O. Reg. 79/10.

Specifically, the licensee shall:

- Ensure that when resident #004 exhibits responsive behaviours, the resident is appropriately assessed for contributing factors to the behaviours as outlined in the Responsive Behaviours Management policy.

- Ensure that when resident #004 exhibits responsive behaviours, that monitoring is immediately initiated using the home's documentation tools as outlined in the Responsive Behaviours Management policy.

- Ensure that when resident #004 exhibits responsive behaviours, that all interventions identified in the plan of care are utilized as necessary to assist in the behaviour management.

- Ensure that when resident #004 exhibits worsening behaviours that are difficult for the staff to manage, that the Physician is notified for an opportunity to provide other interventions.

- Ensure that all episodes of responsive behaviours and any care provided to resident #004 are documented in the resident's record.

Grounds / Motifs :

1. The licensee has failed to ensure that actions taken to meet the needs of resident #004, with responsive behaviours, included assessments, interventions, and documentation of resident #004's responses to the interventions.

Review of the home's "Responsive Behaviours Management" policy noted that the nurse should conduct and document an assessment of a resident who was experiencing responsive behaviours that may include a urinary tract infection (UTI) or pneumonia and initiate observation tools, such as Behavioural Supports Ontario (BSO)-Dementia Observation Scale (DOS) monitoring, as required. Further, the policy directs the nursing staff to also:

- Strategize with other members of the interprofessional team to identify risk level, causes, and triggers.

- Provide treatment and interventions as required e.g. pain assessment.
- Evaluate the effectiveness of a planned intervention on the plan of care addressing specific responsive behaviours.
- Complete an electronic Responsive Behaviour Referral to the internal Behavioural Support Designate when there is a new or worsening, or change in responsive behaviours.

A) Review of resident #004's electronic progress notes in point click care (PCC) noted no documented behaviours for resident #004 in December 2020.

In January 2021, resident #004 was noted as wandering in the hallway and damaging property in the home. Later that month, resident #004 was noted as wandering at night in the hallway and inside other residents' rooms. Resident #004 was noted to pull anything they could see at the nurses' station including the computer monitor while staff were using it. Resident #004 also pulled the fire alarm.

There was no documentation to support the physician or the BSO lead was contacted regarding the behaviour.

Review of resident #004's hard copy chart noted DOS monitoring was not initiated until 12 days after the last incident, and there were no documented pain assessments in PCC.

Review of resident #004's electronic medication record noted resident #004 had an order dated in December 2020, for medication as needed for agitation and behaviours. The as needed medication had never been administered to resident #004.

In an interview, Registered Practical Nurse (RPN) #112 stated if a resident had an increase in behaviours staff should offer the as needed medication to the resident and notify the doctor of the behaviours.

In an interview, RPN #107 stated DOS charting should be completed and a referral to BSO if a resident has new or worsening behaviours. RPN #107 acknowledged resident #004 did not have a pain assessment completed when they had an increase in behaviours in January 2021.

In interviews, Registered Nurse (RN) #110 acknowledged DOS charting was not initiated for resident #004 immediately after the incidents. RN #110 stated staff should do a pain assessment on a resident with increased behaviours, and a lot of times staff do complete a pain assessment but do not document the assessment. RN #110 acknowledged resident #004 did not receive the as needed medication but was unsure why.

In an interview, Physician #119 stated they had not been notified of resident #004's behaviours in January, at the time they had occurred.

In an interview, BSO Lead #113 stated they had not received a referral when resident #004 had an increase in behaviours in January 2021.

B) Reviewed St. Michael's Psychogeriatric Resource Consultation (PRC) report for resident #004 and noted resident #004 had the following behaviours:

-Wandering in and out of other resident rooms
-Agitation and unpredicted responses to staff interventions
-Resistance to care-at times difficult to provide care
-Defecating in other resident rooms
-At night walking in the hallways and reaching out to grab computer monitor or phone or papers in care station
-Difficult to redirect
-Safety concern with grabbing co-residents to walk with them
-Attempts to pick up things from the care station.

The consultation noted the following interventions for resident #004:
-Demonstrate what you propose to do and connect with resident when you approach.
-Stay 2-3 feet away when you are communicating with resident.
-Speak slowly using as few words as possible, augmenting words with gestures.
-Model the activity or demonstrate with gestures what you want resident to do.
-Use Stop and Go approach.
-Engage him with his care by giving him a wash cloth to wash his face.
-Cover the computer monitor with a bed sheet at night so resident does not notice the objects or grab or pull them out.
-Give resident as often as possible a long thick towel to hold onto with both hands so their hands are busy, to reduce anxiety about wanting to grab or hold or pick

something for security
-Rounding every 15-30 minutes after family has left (8:00 pm until resident goes to bed at 11:30 pm).

Review of resident #004's plan of care noted the interventions had not been documented in resident's care plan. There was no documentation to support which interventions had been trialled and resident #004's response to the interventions.

In an interview, BSO Lead #113 stated they were currently working with resident #004 and had received the PRC report. BSO Lead #113 acknowledged there was no documentation of recommended interventions from the PRC that were trialled for resident #004 and current recommended interventions had not been included in the resident's plan of care.

Sources: Review of CIS report #2874-000002-21, resident #004's clinical records, the home's "Responsive Behaviours Management" Policy #VII-F-10.10 with a revision date of October 2019, St. Michael's Psychogeriatric Resource Consultation (PRC) report for resident #004 and interviews with PSW #109, RPN #107, RPN #112, RN #106, RN #110. BSO Lead #113, Physician #119 and DOC #100.

An order was made by taking the following factors into account:

Severity: The resident was not immediately assessed by staff for reasons for the behaviours with the first incident documented on January 3, 2021, nor was the resident monitored for behaviours in the days that followed the incident. The resident's medication regimen was not utilized by staff, nor were the behaviours reported to the Physician for further direction in behaviour management. The resident posed an actual risk for harm as evidenced by grabbing onto other residents for walks and damaging equipment.

Scope: This was an isolated case as no other residents at the time of this inspection had worsening or new responsive behaviours.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg 79/10 s. 53. (4) (b) and a Voluntary Plan of Correction (VPC) was issued to the home. (522)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Aug 06, 2021(A1)

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 26th day of July, 2021 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by ALICIA MARLATT (590) - (A1)

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Service Area Office / Bureau régional de services : Toronto Service Area Office