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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Public Copy/Copie 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
Jan 10, 2020	2019_795735_0027	016696-19, 017403-19, 017563-19, 017930-19, 017936-19, 018448-19, 019106-19, 019107-19, 020197-19, 022065-19	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 2) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Maitland Manor
290 South Street GODERICH ON N7A 4G6

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

KRISTAL PITTER (735), AMANDA COULTER (694), KIM BYBERG (729), KIYOMI KORNETSKY (743)

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): December 2-6 and 9-11, 2019.

Sarah Inglis, Inspector #767, was part of this inspection.

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

Log # 016696-19, AH IL-69673-AH, CI # 0965-000048-19, Log # 017403-19, AH IL-70027-AH, CI # 0965-000050-19, Log # 017930-19, AH IL-70283-AH, CI # 0965-000054-19 related to responsive behaviours.

Log # 017563-19, IL-70104-AH, CI # 0965-000051-19, Log # 017936-19, AH IL-70295-AH, CI # 0965-000053-19, Log # 018448-19, AH IL-70522-AH, CI # 0965-000055-19, Log # 020197-19, CI # 0965-000060-19 related to responsive behaviours and prevention of abuse, neglect, and retaliation.

Log # 019106-19 Follow Up to CO #002 from inspection #2019_795735_0020 related to training and orientation.

Log # 019107-19 Follow Up to CO #001 from inspection #2019_795735_0020 related to medication.

Log # 022065-19, CI # 0965-000064-19 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Ward Clerk, Activity Aid, Behavioural Support Ontario Personal Support Worker (BSO PSW), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers, (PSWs), and residents.

The inspectors also toured resident home areas, observed resident care provision, resident staff interaction, dining services, reviewed relevant residents' clinical records, and relevant policies and procedures pertaining to the inspection.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 VPC(s)**
- **1 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. 131. (1)	CO #001	2019_795735_0020	729
LTCHA, 2007 S.O. 2007, c.8 s. 76. (2)	CO #002	2019_795735_0020	729

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. 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 failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents, including implementing interventions.

A) A Critical Incident Survey (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) regarding the alleged abuse of resident #005 by resident #011.

According to resident #011's plan of care, the resident had a history of responsive behaviours.

Progress notes indicated that prior to an alleged incident on a specified date between resident #005 and resident #011, resident #011 exhibited responsive behaviours towards staff and another resident on four separate occasions.

Documentation indicated that there were interventions to address resident #011's responsive behaviors during the provision of care, however, there were no specific interventions to address resident #011's responsive behaviours in terms of interactions with other residents and minimizing the risk for altercations.

Documentation noted that resident #011 was observed attempting to harm resident #005. Resident #011 was documented as discontinuing this behaviour after Activity Aid #116 intervened and removed resident #011 from the area.

When asked if new interventions were implemented after the altercation between resident #005 and resident #011, BSO#115 reported it appeared that no new interventions were added to the resident's plan of care.

Three days later, documentation in PCC noted that resident #011 and #005 were observed having an altercation in the dining room. Staff separated the two residents and the dining room seating plan was changed. [s. 54. (b)] (743)

B) A CIS report was submitted to the MLTC related to an alleged altercation between resident #006 and resident #005. Clinical records supported that there had been an altercation between the two residents.

According to BSO #115, resident #005 and resident #006 had identified responsive behaviours. Interactions with resident #005 were identified as a trigger for resident #006's responsive behaviours. Resident #005 was noted to respond to resident #006's responsive behaviours.

To address the identified trigger, a second intervention was introduced to mitigate the risk in another location.

On a specified date, it was observed that staff did not implement the second intervention.

According to ED #100, staff were aware of the responsive behaviour interventions in place for resident #006 and acknowledged that they were not being implemented to mitigate the risk of altercations. [s. 54. (b)] (743)

C) Resident #001 had identified responsive behaviours on their plan of care. The plan of care did not identify that resident #001 exhibited specific behaviours based on several altercations with other residents. There was no direction to staff in terms of strategies to minimize the risk of altercations. Socially inappropriate behaviours were identified, but the plan of care did not provide interventions to address this behaviour.

DOC #101, RPN #110, BSO PSW #115, and PSW #106, #107, and #108 said they were aware resident #001 had altercations with other residents, but were not aware of potential triggers, and had not developed or implemented strategies to address the behaviours.

On two specified dates, resident #001 was observed exhibiting the identified responsive behaviour and staff did not implement interventions to mitigate the risk of altercations with other residents. [s. 54. (b)] (694)

D) Residents #009 and #003 were involved in an altercation on a specified date. BSO PSW #115, RPN #110, and PSW #107 stated that residents #009 and #003 had identified responsive behaviors.

PSW #107 stated that resident #009 exhibited triggered responsive behaviours. BSO PSW #115 stated that resident #009 spent the majority of their time exhibiting a specific behaviour.

ED #100 stated that residents had complained about the specific behaviour that resident #009 exhibited. The plan of care and interviews with ED #100, RPN #110, and PSW #107 stated that staff took action when resident #009 exhibited this behaviour and intervened if an altercation took place, but aside from the action taken, there were no interventions implemented to address the behaviour and to prevent the altercations.

On a specified date, resident #009 was observed exhibiting the identified responsive behavior, and staff did not take action until 12 minutes after resident #009 began exhibiting the behaviour.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents, including implementing interventions for residents #001, #006, #009, and #011. [s. 54. (b)]

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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).

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).

Findings/Faits saillants :

1. The licensee failed to ensure that the provision of the care set out in the plan of care

was documented for residents #001, #003, #009, and #010.

ED #100 stated that when resident altercations occurred, it was the home's expectation that safety checks be completed. These safety checks were to be documented.

DOC #101 stated that a Wanderer's Hourly Checklist was initiated on admission or at any time that it was deemed necessary for residents that wandered. ED #100 indicated the Wanderer's Hourly Checklist was to be completed for residents who met specific criteria, and for a specified length of time for incidental situations, based on nursing assessment. ED #100 stated that when residents exhibit behaviours, the area on the Daily Care Flow Sheets related to behaviours was to be completed. DOC #101 stated an Observation Checklist for Behaviour Monitoring was implemented at the time of each incident of verbal and physical aggression. Documentation was to be completed every 30 minutes for 72 hours after any incident. [s. 6. (9) 1.] (735, 694)

A) Resident #001 initiated three altercations with other residents. The clinical record for resident #001 was reviewed.

The Wanderer's Hourly Checklist was initiated on admission for Resident #001. The checklist was to be completed hourly, but multiple entries were not completed during a specified week of time. DOC #101 said the forms were filed in the resident's chart, and there was no follow up with staff regarding the missing or blank entries.

The Daily Care Flow Sheet did not have any mood or behaviour indicators documented for resident #001, even on the dates altercations occurred.

On two specified dates, multiple entries were blank on the Observation Checklist for Behaviour Monitoring document for resident #001. An observation checklist was in place at the time of one incident, but the observation checklist did not indicate that there was a behavioural incident on that date. [s. 6. (9) 1.] (694)

B) Residents #009 and #010 were involved in an altercation on a specified date. The CIS report documented that 30 minute safety checks were implemented for 24 hours. The clinical records for residents #009 and #010 were reviewed.The documentation for these checks was incomplete for both residents. Multiple blank entries were found for residents #009 and #010 on the Observation Checklist for Safety document on the specified date.

PSW #107 stated that resident #009 exhibited a specific responsive behaviour. On a

specified date, resident #009 was observed exhibiting the identified behaviour. The Wanderer's Hourly Checklist for resident #009 for a specified week of time was incomplete. Multiple blank entries were found.

The Daily Care Flow Sheets for residents #009 and #010 for a specified week of time were incomplete. These sheets did not have any mood or behaviour indicators documented, even on the dates altercations occurred. [s. 6. (9) 1.] (735)

C) Residents #009 and #003 were involved in an altercation on a specified date. The CIS report documented that safety checks were implemented.

The clinical records for residents #009 and #003 were reviewed. Safety checks on the date of the altercation were not located for either resident.

The licensee failed to ensure that the provision of the care set out in the plan of care was documented for residents #001, #003, #009, and #010. [s. 6. (9) 1.]

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

A) Residents #009 and #010 were involved in an altercation on a specified date. The clinical records for residents #009 and #010 were reviewed.

Progress notes indicated that resident #009 was transferred to hospital. When they returned to the home, their locomotion status had changed.

The Kardex that was observed on the inner door of resident #009's closet had the incorrect staff support required for several activities of daily living. Mode of transfer, mode of locomotion, and a specific responsive behaviour exhibited by resident #009 were not identified on the Kardex.

PSW #107 stated that resident #009's transfer status and mode of locomotion were different than what was indicated in the Care Plan.

Resident #009 was observed to have a different mode of locomotion than what was documented in the Care Plan throughout the inspection.

An observed logo posted in resident #009's room provided incorrect direction to staff related to the level of support required to complete a specific activity of daily living. PSW #107 stated that the logo was incorrect and hadn't been changed yet. PSW #107 stated that they took their direction for resident care from the Kardex and Care Plan.

B) Residents #009 and #003 were involved in an altercation on a specified date. The clinical records for resident #003 were reviewed.

The Kardex observed on the inner door of resident #003's closet contained incorrect demographic information for the resident. A recent change in demographic information had occurred for resident #003. The Kardex and Care Plan did not identify a specific responsive behaviour nor did they identify interventions to address this behaviour.

PSW #107 stated that they took their direction for resident care from the Kardex and Care Plan.

ED #100 stated that the expectation was that the Kardex and Care Plan were current, and accurately reflected resident care needs and demographic information.

The licensee failed to ensure the plan of care for residents #003 and #009 was reviewed and revised when the care needs changed for these residents. [s. 6. (10) (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 the provision of the care set out in the plan of care is documented, and that the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents #003, #004, and #005 were protected from abuse by anyone.

Physical abuse is defined in the regulations as the use of physical force by a resident that causes physical injury to another resident.

A) A CIS report was submitted to the MLTC regarding the alleged abuse of resident #005 by resident #011.

Documentation noted that resident #011 was observed attempting to harm #005. At the time of the incident, resident #005 reported that resident #011 started hurting them after they behaved in a certain manner.

According to documentation in Point Click Care (PCC), resident #011 had a history of responsive behaviours. Progress notes indicated that prior to the alleged incident between resident #005 and resident #011, there were four other incidents where resident #011 exhibited responsive behaviours towards staff and another resident.

Activity Aid #116 reported they heard resident #005 yelling, and observed resident #011 attempting to harm resident #005. Activity Aid #116 said they were afraid resident #011 was going to harm resident #005. Progress notes documented that Activity Aid #116 intervened and resident #011 discontinued the harmful behaviour.

Progress notes on the date of the incident documented that resident #005 complained of pain.

The licensee failed to ensure that resident #005 was protected from abuse, when resident #011 exhibited responsive behaviours towards resident #005, resulting in injury. [s. 19. (1)] (743)

B) Two CIS reports were submitted to the Director on specified dates. The first related to an incident where resident #001 allegedly harmed resident #003. According to the CIS report, staff were to monitor resident #001 closely and intervene when they exhibited a specific responsive behaviour. The second CIS report was submitted for an incident where resident #001 allegedly harmed resident #004. Resident #001 then exhibited another responsive behaviour.

Resident #001's clinical record was reviewed. The resident's care plan identified socially inappropriate behaviours, but did not provide strategies or interventions for staff to manage these behaviours.

On two specific dates, resident #001 was observed exhibiting the identified responsive behaviour, and staff did not implement interventions to mitigate the risk of harm to other residents.

Resident #004 stated that they were fearful of resident #001. Resident #004 said they would obtain staff assistance when resident #001 exhibited the identified responsive behaviour because they did not want to be injured again.

DOC #101, RPN #110, BSO PSW #115, and PSW #106, #107 and #108 stated resident #001 had unpredictable behaviours.

The licensee failed to protect residents #003, #004, and #005 from abuse by residents #001 and #011. [s. 19. (1)]

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 are protected from abuse by anyone, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to resident #008 in accordance with the directions for use as specified by the prescriber.

Medication administration was being reviewed as part of the follow up to CO #001 from inspection #2019_795735_0020.

Resident #008 was prescribed a specific medication to be given every Tuesday at 0700 hours. They were also prescribed another medication to be given every day at 1700 hours.

A review of resident #008's electronic medication administration record (eMAR) for a specified month, showed that on a specified date, the resident did not receive their scheduled dose of medication at 0700 hours. On another date, they did not receive their scheduled medication at 1700 hours.

The registered staff documented the number ten in the signature box for these dates and times. The legend on the eMAR identified that the number "ten" meant the drugs were not available.

The progress notes for resident #008 were reviewed and there were notations that stated the drugs were not available.

RN #104 confirmed that the drugs were not available as documented on the eMAR and progress notes. The registered staff were to reorder the medication from the pharmacy and administer the medication as prescribed.

DOC #101 confirmed that the medications were documented as not available and stated that an incident report should have been completed.

The licensee has failed to ensure that drugs were administered to resident #008 in accordance with the directions for use as specified by the prescriber. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the medication incident for resident #008 was documented with a record of immediate actions taken to assess and maintain the resident's health and that the incident was reported to resident #008's substitute decision maker (SDM), the DOC, physician, and the pharmacy service provider.

Medication was inspected to follow up on CO #001 from inspection #2019_795735_0020.

A review of resident #008's electronic Medication Administration Record (eMAR) for a specified month, showed that on a specified date, the resident did not receive their scheduled dose of medication at 0700 hours. On another date, they did not receive their scheduled dose of medication at 1700 hours.

There was no documentation that resident #008 was clinically assessed in relation to the missed medication, nor was there any documentation that the physician was contacted.

RN #104 confirmed that when a drug was not available, the registered staff document the number ten on the eMAR, investigate why the medication was not available, and contact the physician, the resident's SDM, the pharmacist, and the DOC to report the incident. RN #104 shared that they would reorder the medication from the pharmacy and obtain further direction to administer the medication as prescribed.

RN #105 stated that when medication was not available, the registered staff would complete an entry on the home's document titled "Drug Record Book Sheet", they would fax this document to the pharmacy, and the drug would be delivered. The drug record book sheet did not have any entries for resident #008 for the medications that were not available.

DOC #101 stated that a medication incident report and resident assessment should have been completed, and the SDM, physician, and pharmacy should have been notified, but they were not in this case.

The licensee failed to ensure that the medication incident for resident #008 was documented with a record of immediate actions taken to assess the resident, and failed to report the incident to resident #008's SDM, the DOC, physician, and the pharmacy service provider. [s. 135. (1)]

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 every medication incident involving a resident and every adverse drug reaction is documented with a record of immediate actions taken to assess and maintain the resident's health, and that every incident is reported to the resident's substitute decision maker, the Director of Nursing, the resident's attending physician, and the pharmacy service provider, to be implemented voluntarily.

Issued on this 22nd day of January, 2020

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KRISTAL PITTER (735), AMANDA COULTER (694), KIM BYBERG (729), KIYOMI KORNETSKY (743)
Inspection No. / No de l'inspection :	2019_795735_0027
Log No. / No de registre :	016696-19, 017403-19, 017563-19, 017930-19, 017936-19, 018448-19, 019106-19, 019107-19, 020197-19, 022065-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 10, 2020
Licensee / Titulaire de permis :	CVH (No. 2) LP 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Maitland Manor 290 South Street, GODERICH, ON, N7A-4G6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tanya Adams

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 CVH (No. 2) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

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 : 901

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. 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.

Order / Ordre :

The licensee must be compliant with s. 54 (b) of the regulations.

Specifically, the licensee must:

a) Ensure residents #001, #006, #009, and #011, which are exhibiting responsive behaviours, have interventions developed and implemented to address those behaviours.

b) Ensure that responsive behaviour interventions recommended by the attending physician and/or psychogeriatric expert are implemented.

c) Ensure that new interventions are considered and implemented when current interventions are ineffective for residents #001, #006, #009, and #011, which are exhibiting responsive behaviours.

d) Develop, implement, and document an auditing system that is completed at regular intervals to ensure interventions to manage responsive behaviours are provided in accordance with the home's policies and procedures, and that evaluates the effectiveness of these interventions. The audit should include actions taken when the interventions have not been effective, who is responsible, and the dates it is completed.

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

Grounds / Motifs :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents, including implementing interventions.

A) A Critical Incident Survey (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) regarding the alleged abuse of resident #005 by resident #011.

According to resident #011's plan of care, the resident had a history of responsive behaviours.

Progress notes indicated that prior to an alleged incident on a specified date between resident #005 and resident #011, resident #011 exhibited responsive behaviours towards staff and another resident on four separate occasions.

Documentation indicated that there were interventions to address resident #011's responsive behaviors during the provision of care, however, there were no specific interventions to address resident #011's responsive behaviours in terms of interactions with other residents and minimizing the risk for altercations.

Documentation noted that resident #011 was observed attempting to harm resident #005. Resident #011 was documented as discontinuing this behaviour after Activity Aid #116 intervened and removed resident #011 from the area.

When asked if new interventions were implemented after the altercation between resident #005 and resident #011, BSO#115 reported it appeared that no new interventions were added to the resident's plan of care.

Three days later, documentation in PCC noted that resident #011 and #005 were observed having an altercation in the dining room. Staff separated the two residents and the dining room seating plan was changed. [s. 54. (b)] (743)

B) A CIS report was submitted to the MLTC related to an alleged altercation between resident #006 and resident #005. Clinical records supported that there had been an altercation between the two residents.

According to BSO #115, resident #005 and resident #006 had identified responsive behaviours. Interactions with resident #005 were identified as a trigger for resident #006's responsive behaviours. Resident #005 was noted to respond to resident #006's responsive behaviours.

To address the identified trigger, a second intervention was introduced to mitigate the risk in another location.

On a specified date, it was observed that staff did not implement the second intervention.

According to ED #100, staff were aware of the responsive behaviour interventions in place for resident #006 and acknowledged that they were not being implemented to mitigate the risk of altercations. [s. 54. (b)] (743)

C) Resident #001 had identified responsive behaviours on their plan of care. The plan of care did not identify that resident #001 exhibited specific behaviours based on several altercations with other residents. There was no direction to staff in terms of strategies to minimize the risk of altercations. Socially inappropriate behaviours were identified, but the plan of care did not provide interventions to address this behaviour.

DOC #101, RPN #110, BSO PSW #115, and PSW #106, #107, and #108 said they were aware resident #001 had altercations with other residents, but were not aware of potential triggers, and had not developed or implemented strategies to address the behaviours.

On two specified dates, resident #001 was observed exhibiting the identified responsive behaviour and staff did not implement interventions to mitigate the risk of altercations with other residents. [s. 54. (b)] (694)

D) Residents #009 and #003 were involved in an altercation on a specified date. BSO PSW #115, RPN #110, and PSW #107 stated that residents #009 and #003 had identified responsive behaviours.

PSW #107 stated that resident #009 exhibited triggered responsive behaviours.

BSO PSW #115 stated that resident #009 spent the majority of their time exhibiting a specific behaviour.

ED #100 stated that residents had complained about the specific behaviour that resident #009 exhibited. The plan of care and interviews with ED #100, RPN #110, and PSW #107 stated that staff took action when resident #009 exhibited this behaviour and intervened if an altercation took place, but aside from the action taken, there were no interventions implemented to address the behaviour and to prevent the altercations.

On a specified date, resident #009 was observed exhibiting the identified responsive behavior, and staff did not take action until 12 minutes after resident #009 began exhibiting the behaviour.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents, including implementing interventions for residents #001, #006, #009, and #011. [s. 54. (b)]

The severity of this issue was determined to be a level 2 as there was minimal harm to residents. The scope of the issue was a level 3 widespread as 4 out of 4 residents reviewed were negatively affected. The home had a level 2 compliance history with previous NC to a different subsection in the last 36 months. (735)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 19, 2020

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:

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

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 10th day of January, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kristal Pitter

Service Area Office /
Bureau régional de services : Central West Service Area Office