Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Original Public Report

Report Issue Date: June 1, 2023	
Inspection Number: 2023-1083-0001	
Inspection Type: Complaint Critical Incident System	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Thorntonview, Oshawa	
Lead Inspector Diane Brown (110)	**Inspector Digital Signature** Diane Brown Digitally signed by Diane Brown Date: 2023.06.20 11:15:29 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 1- 5, 8, 9, 2023.

A complaint intake was inspected related to the management of a resident's responsive behaviors.

Two critical incidents (CI) were inspected related to alleged resident to resident physical abuse.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary

1. A Critical Incident Report (CIR) was submitted to the Director, related to alleged resident-to-resident physical abuse where a resident went into a co-resident's room and physically assaulted them. Registered Practical Nurse (RPN) #105 initiated Behavioral Support Ontario -Dementia Observation System (BSO-DOS) behavior mapping which remained in place for four days.

The home's policy, entitled Resident Non-Abuse, directed using the results of behavior mapping, with possible triggers to responsive behaviors, in the resident's plan of care. RPN #105 and the Behavioral Support Ontario (BSO) -RPN lead confirmed there was no assessment of the resident's BSO-DOS behavior mapping as required. The BSO-RPN lead stated it was their responsibility to review the resident's DOS monitoring. The resident continued to have responsive behaviors towards the same resident and other co-residents.

The failure to follow the home's policy on Resident Non-Abuse, specifically assessing the results of behavioral tracking, may have mitigated further altercations between the resident aggressor and co-residents.

Sources: Home's policy entitled Resident Non-Abuse, effective date August 31, 2016, index: ADMIN1-010.04, CIR, resident's health record and interviews with PSW #102, RPN #105, BSO- RPN.

Rationale and Summary

2. A CIR was submitted to the Director, where a resident was observed with multiple areas of altered skin integrity on parts their body. Resources available at the time of the incident were utilized by the former DOC and during an interview with them, they shared their investigation results. The former DOC concluded that an identified resident entered a co-resident's room and an altercation between residents resulted. In a written statement by the PSW who first identified the resident with multiple areas of altered skin integrity, documented the resident stating a resident had entered their room was physical towards them and they were afraid of the resident.

The RPN who first assessed the resident could not recall the conversation with the resident, however

the RPN's documentation revealed the resident stated, a resident had entered their room and was physical towards them. A PSW shared with the Inspector that even a few days later and for about a week the resident spoke of a resident entering their room and being physical with them.

The home's policy directed that when a resident who had been abused, staff were to offer appropriate interventions including counseling services through a social worker, CCAC social worker or other services as available. There was no documented evidence of counseling services provided.

An interview with the former DOC confirmed that at the site level they had spoken with the resident but there was no structured follow-up targeted at looking at the resident victim.

The failure to follow the home's policy on Resident Non-Abuse; specifically, not providing counselling services, may have negatively affected the resident's quality of life.

Sources: Home's policy entitled Resident Non-Abuse, effective date August 31, 2016, index: ADMIN1-010.04, CIR, resident's health record, written statement from PSW #100 and interviews with PSW #102, RPN #105 and #016, BSO RPN #109 and former DOC. [110]

WRITTEN NOTIFICATION: LICENSEE MUST INVESTIGATE, RESPOND and ACT

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

The licensee has failed to immediately investigate an allegation of physical abuse reported by a resident.

Rationale and Summary

RPN #105 stated that PSWs heard a resident in distress and then saw them exiting quickly from their room. The resident stated a co-resident had entered their room while they were sleeping and was physical towards them. The resident sustained altered skin integrity to their parts of their body as a result. RPN #105 stated it was resident to resident physical abuse and could not recall if they had communicated the incident to the registered nurse on duty. The former DOC and Associate Director of Care (ADOC) had no knowledge of a second incident, and an investigation was not initiated.

There was no documented evidence of an investigation.

Failing to ensure an immediate investigation of an alleged resident to resident physical abuse by the resident placed residents at risk of continued physical abuse and fear.

Sources: Home's internal investigation notes, resident's health record, interviews with RPN #105,

former DOC #103 and ADOC. [110]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by another resident that resulted in harm or a risk of harm to the resident, was immediately reported to the Director.

Rationale and Summary

RPN #105 stated that PSWs heard a resident in distress and then saw them exiting quickly from their room. The resident stated a co-resident had entered their room while they were sleeping and was physical towards them. The resident sustained altered skin integrity to parts of their body as a result. RPN #105 further stated it was resident-to-resident physical abuse and could not recall if they communicated the incident to the registered nurse on duty. The former Director of Care (DOC) and Associate Director of Care shared they had no knowledge of a second incident of resident aggression towards a co-resident. There was no documented evidence the Director was notified.

Failing to ensure the Director was immediately notified of alleged resident to resident physical abuse did not have an immediate impact or risk to the resident's health, safety, or quality of life.

Sources: CIR system, health record of residents, interviews with RPN #105, former DOC #103, associate DOC [110]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIORS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The license failed to ensure that strategies were developed and implemented for a resident who demonstrated responsive behaviours.

Rationale and Summary

A CIR was submitted to the Director related to a harmful physical interaction of a resident towards a co-resident.

A further incident was documented 10 days later, whereby the same resident was seen demonstrating a harmful physical interaction towards another resident. The resident aggressor was given, as needed, sedating medication with no effect.

An interview with the BSO-RPN lead revealed they thought they had placed a referral to Ontario Shores Centre for Mental Health Sciences for the resident aggressor around the time of the second incident but realized they had not.

The same resident continued to have two further altercations with co-residents; one leading to a second CIR submitted to the Director. There was no documented evidence a referral was sent to Ontario Shores Centre for Mental Health Sciences until after two further harmful resident altercations had occurred. The resident aggressor was accepted to Ontario Shores and left the home a few weeks later.

Failing to ensure that strategies were developed and implemented to respond to the resident's responsive behavior of wandering into resident rooms and physical aggression, resulted in resident's sustaining injuries and co-residents being fearful of the resident.

Sources: CIRs, resident's health record, interviews with BSO RPN #109. [110]

WRITTEN NOTIFICATION: ALTERCATIONS AND OTHER INTERACTIONS BETWEEN RESIDENTS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)

The licensee has failed to ensure steps were taken to minimize the risk of altercations and potentially harmful interactions between a resident and co-residents including other non-identified residents, by identifying and implementing interventions.

Rationale and Summary

RPN #105 stated that PSWs heard a resident in distress and then saw them exiting their room quickly. The resident stated a co-resident entered their room while they were sleeping and was physical towards them. The resident sustained altered skin integrity to parts of their body as a result. RPN, #105, who heard the distressed resident stated the resident aggressor was placed on one-to-one (1:1) for a few hours after the incident. Documentation revealed once the 1:1 left that evening shift the resident was up wandering again and opening resident's doors.

Ten days later a further incident was documented, whereby the same resident was seen demonstrating a harmful physical interaction towards another resident. The resident aggressor was given, as needed, sedating medication with no effect. A few days later another incident between the same resident and a co-resident, whereby the resident went into co-resident's room while they were sleeping and was physically aggressive. The co-resident was scared and frightened and sustained areas of altered skin integrity to portions of their body. Days later a CIR was submitted to the Director, where a resident was observed with multiple areas of altered skin integrity to portions of their body. Resources available at the time of the incident were utilized by the former DOC and during an interview with the former DOC, they shared their investigation results. The former DOC concluded that the same resident aggressor had entered a co-resident's room and an altercation between residents resulted. In a written statement by the PSW who first identified the resident with multiple areas of altered skin integrity, the resident stating a resident entered their room was physical towards them and that they were afraid of them.

Over a three-week period there were ongoing incidents whereby the same resident entered co-resident rooms and negatively interacted with them. Documentation revealed residents expressed feeling unsafe related to the resident's behaviors. Personal Support Workers (PSW) advised that barriers such as wander guards, and physically closing resident doors were ineffective in preventing the resident from entering other resident's rooms.

A review of the Behavioral Supports Ontario-Dementia Observation Sheet (BSO-DOS) identified two, four day periods where resident #001's behaviors were tracked and monitored. A review of the tracking sheets with the BSO-RPN lead identified a 1.5-hour period where the resident had 1:1. Progress notes identified a shift on two days where 1:1 was provided. PSWs #101, #102 and #108 identified the resident was not regularly provided with 1:1 and required it as they could not keep their eyes on one resident. The BSO-RPN lead and RPN #105 stated that after the resident's first incident of physical aggression, they should have been placed on 1:1 to manage the risk to other residents.

Failing to implement the interventions of continuous 1:1 monitoring for resident continued to place residents at risk from further altercations.

Sources: CIRs, resident's health records, interviews with PSWs #101, #102, #108, RPN #105, BSO- RPN lead #109, written statement from PSW #100. [110]

WRITTEN NOTIFICATION: NOTIFICATIONS RE: INCIDENTS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (2)

The licensee had failed to ensure that the substitute decision-maker (SDM) of a resident was notified of the results of the investigation immediately upon the completion of the investigation.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director, related to an alleged resident-to-resident physical abuse of a resident towards a co-resident. The home conducted an investigation, but there was no evidence to indicate the SDM of co-resident was notified of the results. The Associate Director of Care was unable to confirm that the SDM of the resident was notified when the investigation was completed.

The home's failure to provide follow-up with the SDM around the investigation could result in the SDM not being aware of the outcome and actions taken by the home to prevent a recurrence.

Sources: CIR, resident's health record, home's investigation records, interview with ADOC #104. [110]