Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 5, 2020	2020_715672_0011	003604-20, 004100-20, 009806-20	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

The Village of Taunton Mills
3800 Brock Street North WHITBY ON L1R 3A5

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

JENNIFER BATTEN (672)

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): September 10, 11, 14, 15 and 18, 2020

The following intakes were inspected during this Critical Incident System inspection:

One intake regarding a Critical Incident Report related to an allegation of staff to resident abuse.

One intake regarding a Critical Incident Report related to an allegation of improper/incompetent care of a palliative resident.

One intake regarding a Critical Incident Report related to a resident fall which resulted in an injury, transfer to hospital and significant change in status.

During the course of the inspection, the inspector(s) reviewed: Critical Incident Reports, resident health records including medication administration records and lab results, falls history reports, head injury routines, dietary assessments and internal investigation notes, observed residents and staff to resident interactions and reviewed the following policies: Falls Prevention and Management, Head Injury Routine and Prevention of Abuse and Neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Recreation Aides (RA), Cooks, Registered Dietitian (RD), Food Services Manager (FSM), Personal Care Aides (PCA), Registered Practical Nurses (RPN), Kinesiologist and residents

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Pain
Prevention of Abuse, Neglect and Retaliation

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

- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the internal Head Injury Routine policy was complied with.

According to LTCHA, 2007. O. Reg. 79/10, r. 48 (1) the falls prevention and management program is a required organized program in the home.

O. Reg. 79/10, r. 49 (2) states that every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Review of the internal policy related to head injury routines indicated that when a resident was placed on head injury routine assessment, staff were to follow the time frames indicated on the form unless specific physician’s orders were received which stated otherwise. Once the head injury routine was completed, the resident was to be checked once per shift for 24hrs and the assessments were to be documented in the resident's progress notes.

Resident #004 was noted to be at high risk for falls and sustained an identified number of falls during a specified time period, some of which resulted in the resident being placed on head injury routine (HIR). On an identified date, resident #004 sustained a fall which resulted in a specified injury, therefore they were placed on head injury routine. Following the fall, resident #004 was noted to be confused and not able to follow instructions. Upon

review of the head injury routine assessments. Inspector #672 observed it had not been completed after the first assessment of the resident at the time of the fall and staff had documented that resident was sleeping. Inspector #672 reviewed the other head injury routine assessments completed for resident #004 and observed that none of them had been completed as directed in the internal policy. The DOC reviewed the HIRs completed for resident #004 and verified they had not been completed in full. By not completing head injury routine assessments appropriately, residents were placed at risk of head injuries not being identified and/or treated appropriately.

Sources: An identified Critical Incident Report, internal policies related to head injury routines, resident #004's Head Injury Routine SV1-V3 assessments, interviews with DOC and other staff.

Inspector #672 expanded the scope of the inspection to include head injury routine assessments completed for residents #006 and #007.

Related resident #006:

Resident #006 sustained falls on identified dates, which resulted in head injury routines being initiated. Upon review of the head injury routine assessments, Inspector #672 observed they had not been completed in full, as directed in the internal policy. Staff documented in an identified HIR form that the resident was sound asleep, they tried to wake the resident but were unsuccessful and as a result, the HIR assessment was not completed. The DOC reviewed the HIRs completed for resident #006 and verified they had not been completed as directed in the internal policy. By not completing head injury routine assessments appropriately, residents were placed at risk of head injuries not being identified and/or treated appropriately.

Sources: Internal policies related to head injury routines, resident #006's Head Injury Routine SV1-V3 assessments, interviews with DOC and other staff.

Related to resident #007:

Resident #007 sustained a fall on an identified date which resulted in a head injury routine assessment being initiated. Upon review of the HIR assessment, Inspector #672 observed it had not been completed in full, as directed in the internal policy. During an interview, the DOC verified that the HIR assessments were not fully completed. The DOC also indicated that the expectation in the home was for HIR assessments to be

completed as per the internal policy. By not completing head injury routine assessments appropriately, residents were placed at risk of head injuries not being identified and/or treated appropriately.

Sources: Internal policies related to head injury routines, resident #004's Head Injury Routine SV1-V3 assessments, interviews with DOC and other staff. [s. 8. (1) (a),s. 8. (1) (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 plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #2: 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 resident #002 was protected from an incident of verbal abuse by PCA #109.

For the purposes of the Act and Regulation, “verbal abuse” is defined as:

“any form of verbal communication of a threatening or intimidating nature, or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity, or self-worth, that is made by anyone other than a resident” O. Reg. 79/10.

On an identified date, resident #002 was being assisted with transferring by an identified number of staff, when an incident occurred and they called out in pain. Resident #002 indicated that PCA #109 was verbally abusive and made them feel upset and degraded. During an interview, PCA #109 confirmed the interaction with the resident during the transfer. Review of the internal investigation notes into the incident indicated PCA #109 verified the incident had occurred.

Sources: Internal policy related to the prevention of abuse and neglect, internal investigation notes, interviews with resident #002, PCA #109 and the DOC. [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 incidents of abuse, to be implemented voluntarily.

Issued on this 6th day of October, 2020

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

Original report signed by the inspector.