Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 17, 2019	2019_746692_0027	012981-19	Critical Incident System

Licensee/Titulaire de permis

Lakeland Long Term Care Services Corporation
6 Albert Street PARRY SOUND ON P2A 3A4

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

Lakeland Long Term Care Services
6 Albert Street PARRY SOUND ON P2A 3A4

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

SHANNON RUSSELL (692)

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): October 9-11, 2019.

The Following intake(s) was inspected upon during this Critical Incident System Inspection:
-One log, which was related to a critical incident that was submitted to the Director regarding an incident of resident to resident physical abuse.

Inspector, David Schaefer (757) attended this inspection during orientation.

A Critical Incident System Inspection #2019_746692_0026 for Lakeland Long Term Care (Eldcap) was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Behavioural Support Ontario (BSO) Responsive Behavioural Lead, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions and resident to resident interactions, reviewed relevant health care records, internal investigation notes, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. 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 for each resident that demonstrated responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions, and that the resident's responses to interventions were documented.

A Critical Incident System (CIS) report was submitted to the Director related to an incident of resident to resident physical aggression that had occurred on an identified date. The CIS report indicated that resident #004 had been witnessed exhibiting a responsive behaviour towards resident #005, causing them to sustain an injury. The CIS report further indicated that in response to the incident, both resident #004 and #005, were to have a specified intervention completed at specific time intervals.

A review of resident #004's electronic health care records by Inspector #692, identified a progress note, dated on an identified date, at a specific time, which indicated that the resident was to have a specified intervention completed at specific time intervals. A further review of the resident's records, by the Inspector, identified a progress note, dated five days later, at a specific time, that identified that the specified intervention for resident #004 was to be discontinued.

Inspector #692 reviewed the home's policy titled, "Responsive Behaviour Management Program", #RSL-SAF-040, last reviewed June 2019, which indicated that screening assessment tools were used to identify the level of risk associated with the behaviour and to have identified behavioural triggers, patterns, contributing factors, and the types of behaviours exhibited. The policy further identified that an identified document was used

a screening tool to document the observations to assist the caregivers to understand the cause of a resident's responsive behaviours and to track the patterns of those behaviours.

Inspector #692 reviewed the identified document for resident #004, for the five days indicated, in the resident's paper chart. Of the five days reviewed, the following documented entries were missing:
-the first date, for a period of 30 minutes;
-the second date, for a total period of three hours;
-the third date, for a total period of three hours;
-the fourth and fifth date, for a period of 30 minutes; and,
-the sixth date, for a period of four hours.

In separate interviews with Personal Support Worker (PSW) #103 and Registered Practical Nurse (RPN) #106, they both indicated to Inspector #692 that when a resident exhibited a responsive behaviour, staff would have completed the specified intervention, which was to be documented on an identified document. Both PSW #103 and RPN #106, identified that if the sepcified document had missing documentation, that would indicate that the specified intervention was not completed when it was required to be.

In an interview with Inspector #692, RPN #105, who was the Behavioural Support Ontario (BSO) lead for the home, identified that they would have initiated the specified intervention, to be documented on the identified document for three to five days, depending on the exhibited responsive behaviour. RPN #105 identified that they would have reviewed the completed identified document in order to determine the times and frequency of the exhibited responsive behaviour. They indicated that if there were too many blank spaces, that would indicate that the specified intervention was not completed accurately, and there would not be enough information to determine what was happening. RPN #105 identified that they had initiated the identified document to be completed for five days for resident #004 after the incident that had occurred involving resident #005.

In an interview with Registered Nurse (RN) #111, they indicated to Inspector #692 that they had recalled the incident that had occurred involving residents #004 and #005 on the identified date, and that resident #004 was to have the specified intervention completed at specific time intervals. They indicated that staff were to document what had occurred with the residents at that time on the identified document, and that the document was to be completed thoroughly, with all time intervals having an entry.

Together, RN #111 and the Inspector, reviewed the identified document for resident #004 for the five day period, and RN #111 indicated that the identified document had not been filled out in its entirety.

During an interview with Inspector #692, the Director of Nursing (DON), indicated that the identified document would be initiated for residents who displayed responsive behaviours in order to assess them, gather more information and to assess the efficacy of the interventions that had been put into place. The DON indicated that the benefit of the identified document was to determine the times, patterns and triggers of specific responsive behaviours, and should have been filled out in its entirety once initiated. Together, the DON and the Inspector, reviewed the identifed document for resident #004 for the indicated five day period, and the DON indicated that the identified document had not been filled out in its entirety, and it should have been. [s. 53. (4) (c)]

2. A CIS report was submitted to the Director related to an incident of resident to resident physical aggression that had occurred on an identified date.

Please see WN #1, finding #1, for further details.

A review of resident #005's electronic health care records by Inspector #692, identified a progress note, on an identified date, at a specific time, which indicated that the resident was to have a specified intervention completed at specific time intervals for three days; documented on an identified document.

Inspector #692 reviewed the identified document for resident #004, for a three day period, in the resident's paper chart. Of the three days reviewed, the following documented entries were missing:
-the first date, for a period of 30 minutes;
-the second date, for a period of over three hours; and,
-the third date, for a period of five hours.

In separate interviews with PSW #103 and RPN #106, they both indicated to Inspector #692 that when a resident was to have the specified intervantion, it was to be documented on the identified document. Both PSW #103 and RPN #106, identified that if the identified document had missing documentation, that would indicate the specified intervention was not completed when they were required to be. They both recalled that resident #005 was to have the identified document completed at specific time intervals, for three days after the incident involving resident #004.

In an interview with Inspector #692, RPN #105, who was the BSO lead for the home, identified that they would have initiated the specified intervention, to be documented on the identified document for three to five days, depending on the exhibited responsive behaviour. RPN #105 identified that they would have reviewed the completed identified document in order to determine the times and frequency of the exhibited responsive behaviour. They indicated that if there were too many blank spaces, that would indicate that the specified intervention was not completed accurately, and there would not be enough information to determine what was happening. RPN #105 identified that they had initiated the identified document to be completed for three days for resident #004 after the incident that had occurred involving resident #005.

In an interview with RN #111, they indicated to Inspector #692 that they had recalled the incident that had occurred involving residents #004 and #005 on the identified date and that resident #005 was to have a specified intervention completed. They indicated that staff were to document what had occurred with the residents at that time on the identified document, and that the document was to be completed thoroughly, with all time intervals having an entry. Together, RN#111 and the Inspector, reviewed the identified document for resident #005 for the three day period, and RN #111 indicated that the identified document had not been filled out in its entirety.

During an interview with Inspector #692, the DON, indicated that the identified document would be initiated for residents who displayed responsive behaviours in order to assess them, gather more information and to assess the efficacy of the interventions put into place. The DON indicated that the benefit of completing the identified document was to determine the times, patterns and triggers of specific responsive behaviours, and should have been filled out in its entirety once initiated. Together, the DON and the Inspector, reviewed the identified document for resident #005 for the three day period, and the DON indicated that the identified document had not been filled out in its entirety, and it should have been. [s. 53. (4) (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 for each resident that demonstrated responsive beahviours, 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, to be implemented voluntarily.

Issued on this 18th day of October, 2019

[redacted]

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

Original report signed by the inspector.