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_0026	012872-19, 014095-19	Critical Incident System

Licensee/Titulaire de permis

West Parry Sound Health Centre
6 Albert Street PARRY SOUND ON P2A 3A4

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

Lakeland Long Term Care (Eldcap)
6 Albert Street PARRY SOUND ON P2A 3A4

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

SHANNON RUSSELL (692), AMANDA BELANGER (736)

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) were inspected upon during this Critical Incident System Inspection:
-One log, which was related to a critical incident that the home submitted to the Director regarding an incident of resident to resident physical abuse; and
-One log, which was related to a critical incident that the home submitted to the Director regarding an incident of improper care of resident.

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

A Critical Incident System Inspection #2019_746692_0027 for Lakeland Long Term Care 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 Behaviour 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:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse was complied with.

A Critical Incident System (CIS) report was submitted to the Director on an identified date, which indicated that on that date, resident #001 had been found to not have received the care they required. The home had amended the CIS report to indicate that during the course of the investigation, it had been identified that Personal Support Worker (PSW) #110 had not completed the required care during their shift, and had not completed a final check on resident #001 before the end of their shift.

Neglect is defined within the Ontario Regulations 79/10 of the Long-Term Care Homes Act (LTCHA) as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

a) Inspector #736 reviewed the home's internal investigation notes, which identified that resident #001 had been placed in a specified area at an identified time; however staff were not aware that the resident was in that area, and that the resident had not been checked for over five hours. The investigation notes further indicated that the resident had not been assisted with care, and had been found by staff on the next shift. A further review of the home's internal investigation notes by Inspector #736, identified that PSW #110 had not checked on the resident during the duration of their shift, and had not completed a final check on resident #001 prior to leaving the home area.

A review of the home's policy titled, "Abuse Policy-Definition", 5.0 ADM-R.F., last reviewed January 2018, indicated that zero tolerance meant that behaviour or conduct that was detrimental to the resident would not be tolerated under any circumstances, and for any reason.

In an interview with PSW #110, they indicated to Inspector #736 that they were working with resident #001 on the identified shift, and had failed to check on the resident prior to the end of their shift. The PSW further indicated that as a result of staff not completing the required care for the resident, the staff did not comply with the home's zero tolerance of abuse policy.

In an interview with the Director of Nursing (DON), they indicated to the Inspector that based on the home's internal investigation, the incident with resident #001 had been determined to be improper care of the resident.

b) Inspector #736 further reviewed the home's internal investigation notes and resident #001's progress notes, and noted that Registered Nurse (RN) #111 did not immediately inform the DON of the allegation of improper/incompetent care of resident #001.

A review of the home's policy titled, "Abuse Policy-Investigation", 5.1 ADM-R.F., last reviewed January 2018, indicated any person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident, was to report immediately to the Nurse Manager or a member of the Leadership Team. The policy further indicated that the Nurse Manager was to immediately contact the Administrator, Director of Nursing, and/or the Manager on call immediately for any reasonable grounds to suspect that an instance of abuse/neglect had taken place.

In an interview with RN #111, they indicated to the Inspector that they had been notified on the identified date, that resident #001 had not been provided care and had been found in the specified area during the first rounds of the next shift. The RN further indicated that they had documented on the resident chart, and informed the DON of the findings the following morning. The RN also indicated that the home's zero tolerance for abuse policy indicated that staff were to inform the DON immediately of an allegation of improper/incompetent care.

In an interview with the DON, they indicated to the Inspector that the RN on duty should have informed the DON immediately, when it had been discovered that resident #001 had not received proper care on the identified date. The DON further indicated that the RN did not comply with the home's zero tolerance of abuse policy. [s. 20. (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 the home's written policy to promote zero tolerance of abuse is complied with, to be implemented voluntarily.

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, 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 CIS report was submitted to the Director related to resident #002 exhibiting a responsive behaviour towards resident #003 on an identified date.

A review of resident #002's electronic health care records by Inspector #736, identified a progress note, on an identified date, documented by Registered Practical Nurse (RPN) #109, that indicated that the resident was to have a specified intervention completed for a seven day period.

A review of 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 indicated that an identified document was used as a screening tool to document the specified intervention, to assist the caregivers to understand the cause of a resident's responsive behaviours and to track the patterns of those behaviours.

The Inspector located the identified document for resident #002, for the seven day period, in the resident's paper chart. Of the seven days on the document, three of the 24-hour time periods were blank, and had no documentation. Of the other four days, the following entries were blank:
-the first date and second date, for an eight hour period; and,
-the third date, for a 14 hour period.

In an interview with RPN #105, who was the Behavioural Support Ontario (BSO) lead for the home, they indicated to Inspectors #692 and #757, that the identified document would be initiated for a resident at times as a nursing measure to determine patterns for a resident with responsive behaviours. The RPN further indicated that the identified documnet was used to determine times, and frequencies of a resident's behaviour.

In an interview with Inspector #736, RPN #104 indicated that the identified document would be initiated for residents who displayed responsive behaviours. The RPN indicated that the identified document should have been filled out in its entirety, and was the responsibility of both the PSWs and RPNs on the unit. Together, the RPN and the Inspector, reviewed the identified document for resident #002 for the seven day period, and RPN #104 indicated that the identified document was not filled out in its entirety. The RPN indicated that, as the identified document was not completed in its entirety, the assessment of the resident with responsive behaviours was not completed, and it should have been.

In an interview with Inspector #736, RPN #106 indicated that they were present on the home area after the interaction between resident #002 and #003. The RPN further indicated that they recalled resident #002 being started on the identified document as a result of the interaction.

In an interview with the DON, they indicated to Inspector #736 that the identified

document was to be initiated at times in order to identify triggers and trends related to responsive behaviours, or to monitor for effectiveness of strategies and interventions. The DON indicated that if there were blank spaces on the identified document, it indicated that the PSW did not document. Together, the DON and Inspector reviewed resident #002's identified document for the seven day period; the DON indicated that the document was not filled out in its entirety; therefore, it was not a full assessment related to the resident's responsive behaviours. [s. 53. (4) (c)]

2. a) Inspector #736 reviewed the progress notes for resident #003 and noted that the resident was to have the specified intervention initiated and to document on an identified document on an identified date, related to exhibiting responsive behaviours, and was discontinued three days later.

The Inspector reviewed the identified document for the three day period, and noted that the assessment lacked documentation for the following times:
-the first date, for a period of two hours; and,
-the second date, for a period of two and a half hours.

b) Inspector #736 further reviewed progress notes for resident #003, and noted that the resident was started on the identified document on an identified date, for a seven day period.

The Inspector reviewed the identified document for the seven day period, and noted that the assessment lacked documentation for the following times:
-the first date, for an eight and a half hour period;
-the second date, for an eight hour period;
-the third date, for 12 hours; and,
-the fourth, fifth and sixth dates, lacked any documentation of the assessment.

c) Inspector #736 completed a further review of resident #003's progress notes, which indicated that the identified document was initiated on an identified date and was to continue for seven days.

The Inspector reviewed the identified document for the seven day period, and noted that the assessment lacked documentation for the following times:
-the first date, for a 16 hour period;
-the second, third and fourth dates, for an eight hour period;
-the fifth date, for a total of 19 hours; and,

-the sixth date, for a total of three and a half hours.

In an interview with RPN #105, they indicated to Inspectors #692 and #757, that the identified document would be initiated for a resident at times as a nursing measure to determine patterns for a resident with responsive behaviours. The RPN further indicated that identified document was used to determine times, and frequencies of a resident's behaviour.

In an interview with Inspector #736, RPN #104 indicated that the identified document would be initiated for residents who displayed responsive behaviours. The RPN indicated that the identified document should have been filled out in its entirety, and it was the responsibility of both the PSWs and RPNs on the unit. Together, the RPN and the Inspector, reviewed the identified document for resident #003 for the three separate dates, and RPN #104 indicated that the identified document had not been completed as it was required to be.

In an interview with the DON, they indicated to the Inspector that the identified document was to be initiated at times to monitor a resident for triggers and trends related to responsive behaviours, or to monitor for effectiveness of strategies and interventions. The DON indicated that if there were blank spaces on the document, it indicated that the PSW did not document. Together, the DON and Inspector reviewed resident#003's identified document for the aforementioned dates; the DON indicated that the documents were not filled out in its entirety, and therefore, it was not a full assessment related to the resident's responsive behaviours. [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 ensuring for each resident that demonstrated responsive behaviours, 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.

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident.

A CIS report was submitted to the Director related to the improper/incompetent treatment of resident #001 on an identified date. The CIS report indicated that the resident was to have a specified intervention put into place when the resident was in a specific area, and, when the resident was found in that specific area, the specified intervention was not in place.

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

Inspector #736 reviewed resident #001's care plan, which indicated that the resident was to be put in a specific area, with the specified intervention in place, as a fall prevention measure.

Inspector #736 reviewed the home's internal investigation notes provided by the home, which indicated that the resident was found in the specific area on the identified date, with the specified intervention not in place.

In an interview with RPN #107, they indicated to the Inspector that they had brought the resident to the specified area on the identified date, but could not recall if the specified intervention was put into place as per the plan of care.

In an interview with RN #111, they indicated to the Inspector that resident #001's plan of care directed staff to ensure that the specified intervention was put in place when they were located in the specific area. The RN further indicated that on the identified date resident #001 was found in the specific area, without the specified intervention in place, and therefore, care was not provided as per the plan of care.

In an interview with the DON, they indicated to Inspector #736 that resident #001's plan of care indicated for staff to ensure the specified intervention was to in place when the resident was in the specific area. The DON further indicated that the resident was found on the identified date, in the specific area, without the specified intervention in place, and as a result, care was not provided to resident #001 as per the plan of care. [s. 6. (7)]

Issued on this 18th day of October, 2019

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

Original report signed by the inspector.