Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection 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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 2, 2018	2018_532590_0008	026966-17, 004811-18	Complaint

Licensee/Titulaire de permis

Corporation of the City of Windsor
1881 Cabana Road West WINDSOR ON N9G 1C7

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

Huron Lodge Long Term Care Home
1881 Cabana Road West WINDSOR ON N9G 1C7

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

ALICIA MARLATT (590)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 3 and 4, 2018.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Manager of Resident Services, the Manager of Resident and Corporate Services, one Registered Nurse, two Personal Support Workers, the Laboratory Manager of Medical Laboratories of Windsor, the Quality Coordinator of Medical Laboratories of Windsor and the Microbiology Supervisor of Medical Laboratories of Windsor and one family member.

During the course of the inspection, the inspector(s) observed a residents room for identified interventions, residents interactions with each other and resident and staff interactions.

During the course of the inspection, the inspector(s) reviewed two residents' clinical records, relevant policies related to inspection topics, email correspondence, occurrence reports and communication/concern forms.

The following Inspection Protocols were used during this inspection:
Personal Support Services
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	Legendé 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. 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).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

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

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) related to resident #025's behaviours affecting other residents.

Review of resident #025's clinical record showed that the resident was severely cognitively impaired. The resident used an assistive device for ambulation around the unit.

Review of resident #025's progress notes for a four month time period shows that the resident exhibited these responsive behaviours on 25 occasions. The progress notes also documented that behaviour mapping was initiated on several occasions as a result of the behaviours, specifically on four identified time periods in 2018, each for a one week time period.

Review of resident #025's care plan, showed that behaviour mapping was initiated on a specified date in 2018, for a week then extended one more week. The care plan also documented that a specific medication was initiated on a specified date, and that the residents' behaviour was to be monitored continuously.

Out of the four month time period reviewed, it showed that resident #025 was supposed to be monitored for a total of 42 days, requiring 2016 documented entries regarding the monitoring of this residents' behaviours. Of the 42 days of behaviour mapping reviewed there were a total of 1086 entries completed, showing a 54% incompletion rate of the documents.

In an interview with a Personal Support Worker (PSW) they shared that when residents behaviours bother other residents the PSW's report this to the registered staff and try to keep an eye on the resident so they don't continuously bother the other residents. The PSW shared that when behaviour mapping is initiated, it is usually for a week time period and they have areas to document every half hour or so, what the resident is doing during the monitoring period. The PSW further shared that behaviour mapping is usually directed by the registered staff when the PSW's were to complete it.

In an interview with a Registered Nurse (RN) they shared that after an incident or with a new behaviour or increase in current behaviours, behaviour mapping would be started and communicated to the PSW's to complete.

Review of the homes policy titled Responsive Behaviours – Prevention and Management, last reviewed on May 16, 2017, documented that responsive behaviours are actions that may include a resident exhibiting physically non-aggressive or non-protective behaviours such as pacing, undressing, handling objects, and further documents that upon the initiation of any new behaviour, the behaviour mapping tool is to be initiated to identify trends, triggers and develop interventions.

In an interview with the Executive Director (ED) #100 they said that the behaviour mapping had not been completed as required and would be following up with staff. [s. 6. (7)]

2. The licensee had failed to ensure that staff and others who provided direct care to a resident were kept aware of the contents of the plan of care and given convenient and immediate access to it.

A complaint was received by the MOHLTC from resident #020's Substitute Decision Maker (SDM) about another residents' behaviours, however when the inspector spoke with resident #020's SDM, another care concern was described, in that the home did not follow the plan of care related to ambulation assistance.

Resident #020's SDM shared with the inspector that their loved one is able to walk in and outside the home using a walker and that five times they have come to visit and found a wheelchair in the residents' room. The SDM said that an Occupational Therapist completed an assessment on the resident and determined that they did not need a wheelchair. The SDM shared that they had communicated this ambulation concern to the nursing staff, the first time they found a wheelchair in the room, and still found the wheelchair in the room on subsequent visits. The SDM shared that a meeting was held with the management team in the home and a plan was developed and implemented, to encourage independent ambulation and the use of the walker instead of a wheelchair. The SDM further shared that the plan was not followed that very night, in that staff told the resident that their family member wanted the wheelchair taken away, resulting in the resident being mad at their family member.

In separate interviews with the SDM and ED #100, they both stated that a meeting was held on a specified date, and a plan was developed to encourage the use of the walker, and both communicated the same plan.

The plan was when resident #020 asked for a wheelchair, that staff would tell the resident that their wheelchair was sent away for repairs and that they would have to use the walker until the repairs were finished. If the resident was having troubles walking, or with the walker, a temporary and uncomfortable wheelchair would then be provided, that the resident would not want to sit in for long periods of time, to encourage them to use the walker as they were able to. The SDM communicated at the meeting, to have staff call them if they were having troubles implementing this with the resident.

The next day after the meeting, resident #020's SDM explained to the inspector that their loved one had called them last night, very angry at them, telling them that staff told them that their children did not want them to use a wheelchair. The SDM said that when they asked three different staff members who were working that night about the plan, they all told the SDM that they were not aware of the plan.

In an interview with the ED #100, they shared that the plan had been communicated to staff, however it had not been followed. The ED explained that the resident had requested the wheelchair, and that the home would provide one as requested by the resident if the original plan of telling them that their wheelchair was being repaired did not work and if the resident was upset about it, as the home had to respect the residents' rights. The ED said that the resident was upset and that is why the wheelchair was given

to them, however the staff should have been more persistent and followed the developed plan, which was communicated to staff. The ED shared that the registered staff working that evening had been disciplined regarding communication issues. [s. 6. (8)]

3. The licensee had failed to ensure that if the resident was being reassessed and the plan of care was being revised because care set out in the plan had not been effective, had different approaches been considered in the revision of the plan of care.

A complaint was received by the MOHLTC related to resident #025's behaviours that were affecting other residents', specifically resident #020.

In an interview with the resident #020's SDM on a specified date, they shared that they have had meetings with the management staff at the home several times, and the problem of resident #025 's behaviours still persisted after the meetings and the homes implemented interventions.

Review of resident #020's progress notes for a five month time period, showed that this resident complained to staff and management and about resident #025's behaviours affecting them or making them feel upset on numerous occasions. At one time this resident was upset enough to threaten violence to resident #025 if they did not leave them alone. There were several notes made about meeting with the Social Worker and management team to provide support to resident #020 and to discuss interventions that may be implemented.

Review of the homes Communication/Concern Forms related to resident #020 showed multiple concerns were raised by the SDM about resident #025's behaviours. The concern forms detailed the following:
- A Communication/Concern Form was completed about food issues on a specific date in 2017, however when the home was following up with resident #020's SDM about the food concern, the SDM questioned about the other resident's behaviours. Staff had shared with the SDM that they had interventions in place and that they had spoken with resident #020 and they denied having any concerns at this time. The SDM was not satisfied with the interventions in place at that time.
- A Communication/Concern Form was completed on a specified date in 2018, about resident #025's behaviours, from resident #020's SDM. The management followed up with the SDM the next day, and the SDM shared with management that the other resident was still displaying the behaviours.
- A Communication/Concern Form was completed on a specified date in 2018, about

resident #025 's behaviours. A meeting was held with resident #020, their SDM and the management staff at the home to discuss appropriate interventions. Resident #020 and their SDM, declined two suggested interventions at that time. The SDM and the resident wanted interventions in place that resident #020 would not have to deal with or change their routine for. The SDM was upset that they had a meeting in 2017, about this same issue, however it had not been resolved with the interventions put into place at that time.
- A Communication/Concern Form was completed on a specified date in 2018, about following up with resident #020’s SDM about interventions in place for resident #025's behaviours, which affect their loved one. The SDM was informed that a specific intervention had been initiated and would continue throughout the weekend. The intervention would be re-evaluated on the Monday and the home would follow up again with resident #020’s SDM then.
- A Communication/Concern Form was completed on a specified date in 2018, and the home informed resident #020’s SDM that the specific intervention will continue for resident #025. The SDM wanted to be informed when the intervention was stopped to discuss interventions that will be put into place.

Review of resident #025’s clinical record showed that the resident is severely cognitively impaired and is very confused. The resident used an assistive device to mobilize around the unit and the home independently.

Review of resident #025’s progress notes from a specific day in 2017, to a specific day in 2018, shows that the resident exhibited responsive behaviours, on 25 occasions. The progress notes also documents interventions that were trialled.

In a specific month in 2017, resident #025 exhibited specific responsive behaviours affecting others four times and one of those times involved resident #020 on an identified day. Twice staff documented that resident #025 was displaying behaviours and that current interventions were not effective and had notified the physician.

Resident #025 did not exhibit the specific responsive behaviours in a specified month of 2017.

In a specific month in 2018, resident #025 exhibited specific responsive behaviours five times and one of those times involved resident #020 on an identified date. Staff documented three times that resident #025 was displaying behaviours and that current interventions were not effective. Medications were reviewed and changed by the physician, and specific monitoring was put into place.

The next month in 2018, resident #025 exhibited specific responsive behaviours 13 times and one of those times involved resident #020 on an identified date. Staff documented 13 times that the current interventions in place were not effective. Behaviour monitoring was occurring at specific times during this month and monitoring was also increased this month. Several medication changes were made by the physician.

The next month in 2018, resident #025 exhibited the specific responsive behaviour three times, and of those 3 times, twice involved resident #020; both times in one day. Three times staff documented the resident was exhibiting responsive behaviours and was re-directed with no effect. Increased monitoring of behaviours took place during this time, along with implementation of other interventions, which were observed to be effective when utilized. Staff also documented that the resident was found without the newly implemented interventions a few days after the interventions had been added to the residents' care plan. Medication changes occurred as well this month. On an identified day in the evening a specific intervention was trialled and the resident was calm and fell asleep.

In an interview with PSW #138, they shared that resident #025 was confused, and had been exhibiting the responsive behaviours around the unit bothering other residents for a while, however since the resident had a specific intervention put into place, the responsive behaviour really hasn't been a problem anymore. They stated that re-direction was usually not effective.

In an interview with Manager of Resident and Corporate Services #141, they answered that they thought the internal Behaviour Support Ontario (BSO) team should be following this resident, if complaints were received about their behaviours bothering other residents. They shared that the homes internal BSO team had not formally been following the resident, as a referral had never been made to them. She further added that the RN working days on this residents unit was the BSO team lead and the one to one staffing that was initiated, was also provided by a BSO team member. The RN had told this manager that they felt the staff on the floor had implemented all interventions that the BSO team would have recommended. The manager said that interventions had been implemented earlier in November, the wander strip and a medication review, and that the staff documented that the resident was re-directed with good effect. [s. 6. (11) (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 care set out in the plan of care is provided to the resident as specified in the plan, to ensure that staff and others who provide direct care to a resident are kept aware of the contents of the plan of care and given convenient and immediate access to it, and to ensure that if the resident is being reassessed and the plan of care is being revised because care set out in the plan had not been effective, that different approaches have been considered in the revision of the plan of care, to be implemented voluntarily.

Issued on this 22nd day of August, 2018

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

Original report signed by the inspector.