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

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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
Nov 19, 2018	2018_643111_0015	016387-18	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Cobourg
130 New Densmore Road COBOURG ON K9A 5W2

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

LYNDA BROWN (111)

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): August 1 to 3, 2018

A complaint inspection (Log #016387-18) was completed related to management of responsive behaviours.

In addition, six critical incidents were inspected concurrently that were related to resident to resident physical abuse:
- Log #004963-18 (CIR), Log #005879-18 (CIR), Log #006155-18 (CIR), Log #007800-18 (CIR), Log #009221-18 (CIR) and Log #015101-18 (CIR).

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and the Behaviour Support Ontario (BSO) RPN.

During the course of the inspection, the inspector observed residents, resident rooms, reviewed health care records of residents and reviewed the licensee policy on Responsive Behaviours.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Prevention of Abuse, Neglect and Retaliation
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. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by (b) identifying and implementing interventions.

An anonymous complaint (Log # 016387-18) was received by the Director on a specified date for resident #001, regarding managing the responsive behaviours of resident #001 and other residents.

There were also six critical incident reports (CIR's) submitted to the Director in 2018 for resident to resident abuse that involved resident #001 as follows:
1) CIR-Log #004963-18: was submitted to the Director on a specified date, for a resident to resident abuse incident involving resident #001 and resident #004. The CIR indicated on a specified date and time, resident #004 reported to PSW #100 that resident #001 had entered resident #004's room and had been abusive towards resident #004, resulting in a fall with an injury to a specified area. The incident was reported to RPN #102.
2) CIR-Log #005879-18: was submitted to the Director on a specified date, for a resident to resident abuse incident involving resident #001 and resident # 002. The CIR indicated on a specified date and time, PSW #107 reported resident #001 had engaged in an altercation with resident #002 and when the PSW attempted to intervene, resident #001 then became abusive towards resident #002, but no injuries were sustained. The PSW reported the incident to RPN #101.
3) CIR-Log #006155-18: was submitted to the Director on a specified date, for resident to resident abuse involving resident #001 and resident # 002. The CIR indicated on a specified date and time, PSW #108 and RPN #109 witnessed resident #002 engage in an altercation towards resident #001 and no injuries were sustained by either resident.
4) CIR-Log #007800-18: was submitted to the Director on a specified date, for resident to resident abuse incident involving resident #001 towards resident # 002. The CIR indicated on a specified date and time, PSW #100 witnessed resident #002 engaging in abuse towards resident #001, in a specified area. Resident #002 then became engaged in an altercation with resident #001, resulting in resident #002 sustaining a fall. Resident #002 sustained an injury to a specified area as a result. The CIR indicated RN #106 responded to the incident.
5) CIR-Log #009221-18: was submitted to the Director on a specified date, for resident to

resident abuse incident involving resident #001 and resident #002. The CIR indicated on a specified date and time, RPN #101 witnessed resident #001 engaging in abuse with #002 in a specified area, resulting in resident #002 sustaining an injury to a specified area. The RPN notified RN #110.
6) CIR-Log #015101-18: was submitted to the Director on a specified date, for resident to resident abuse incident involving resident #001 and resident #003. The CIR indicated on a specified date and time, a visitor for resident #003 reported to RPN #102 witnessing resident #001 engaging in abuse with resident #003, in a specified area. Resident #003 sustained an injury and pain to a specified area as a result.

Observation of resident #001 on a specified date and time by the Inspector, indicated the resident was being monitored one to one by a PSW and was later observed wandering the unit with the one to one staff member present. Resident #002 was not in the home at the time of the inspection. Both resident #001 and resident #022's rooms were in close proximity with each other. Resident #003 was observed on a specified date and time and also noted to be cognitively impaired.

Review of the progress notes for resident #001 indicated the resident was re-admitted to the home, with specified interventions to be used to manage resident #001's responsive behaviours. On a specified date, the resident was discharged from the BSO (Behavioural Ontario Support) and PASE (Psychiatric Assessment of Elderly) as the resident was determined to be effectively managed by staff. The progress notes indicated the resident then began having ongoing altercations with residents, especially resident #002 as follows:
-on a specified date (1st CIR), there was an altercation with resident #002, in a specified area and staff implemented two of the identified interventions for resident #001.
-on a specified date (2nd CIR), there was an altercation with resident #002 and staff implemented one of the identified interventions for resident #001.
-on a specified date, an RN heard resident #001 engaged in an altercation with resident #002, in a specified area, when the RN intervened and no injuries were sustained by either resident.
-on a specified date, at a specified time, RPN #111 indicated there was an altercation between resident #001 and resident #005, in a specified area. No injuries were sustained by either resident. No other interventions were identified.
-on a specified date, at a specified time, the Substitute Decision Maker (SDM) of resident #001, reported witnessing resident #002 engage in an altercation with a mobility aide towards resident #001, in a specified area. The SDM was able to intervene and no injuries were sustained.

-on a specified date, PASE completed a follow-up assessment for resident #001 and recommended to continue with current medication and identified interventions to manage the responsive behaviours in place.
-on a specified date (3rd CIR), there was an altercation with resident #002, in a specified area and one of the interventions were used for resident #001. Staff indicated to ensure that both residents were kept apart and monitored closely (as per the care plan), to ensure that no further incidences occurred.
-on a specified date, the resident had medication dosage increased "due to recent episodes of responsive behaviours".
-on a specified date, at a specified time, BSO reminded staff to ensure that all the identified interventions were utilized prior to initiating any personal care.
-on a specified date, a Cohen Mansfield Agitation Inventory Assessment was completed for resident #001. Staff identified specified responsive behaviours, specified triggers and indicated some improvement was noted with use of increased medication.
-on a specified date (4th CIR), there was a physical altercation between resident #001 towards resident #003 in a specified area. Staff had requested resident #001 be more closely monitored and notified the Administrator. The Administrator recommended a DOS (Dementia Observation System) to be implemented and frequent monitoring.
-on a specified date, the DOC contacted resident #001's SDM to discuss the most recent CIR, explained that PASE and the hospital (GABU) was contacted due to ongoing responsive behaviours. The SDM immediately declined consent for re-admission to hospital and indicated staff were inconsistently implementing the interventions in the care plan.
-on a specified date, at a specified time, Nurse Practitioner (NP) assessed the resident and indicated the new plan of care to manage the resident's responsive behaviours was effective for awhile, but over time, the resident had again become less predictable. Resident #001 would likely always require one to one observation until was less ambulatory, as behaviour is unpredictable and potential to injure staff and other residents. The NP indicated the resident would benefit from a reassessment from PASE team. The NP indicated the resident had a history of failure to respond to medications and would only increase fall risk without altering the behaviour. The resident was placed on one to one monitoring. Later, staff overheard an altercation and found resident #002 engaged in an altercation with resident #001, using a specified item (while PSW on one to one monitoring with resident #001) and the PSW was able to intervene and prevent any injuries to either resident.
-on a specified date, at a specified time, the resident had an altercation with an unidentified resident and both residents were separated with no injuries.
-on a specified date, PASE re-assessed the resident.

on a specified date, resident remained with one to one monitoring and the PSW reported an incident where resident #002 had engaged in a physical altercation with resident #001but no injuries were sustained.

Review of the current written care plan for resident #001 indicated the resident demonstrated identified responsive behaviours related to cognitive impairment. There was also specified triggers for the responsive behaviours. There were specified interventions provided by the PASE team that were to be implemented to prevent the responsive behaviours towards staff and other residents, which included keeping resident #001 separated from resident #002, especially in a specified area, due to ongoing altercations. There were additional interventions put in place by the home which included keeping resident #001 separated from resident #002, especially in a specified area.

During an interview with PSW #100, the PSW indicated resident #001 would demonstrate specified responsive behaviours and/or engage in altercations when identified triggers were present The PSW indicated resident #001 altercations usually occurred towards other resident in a specified area. The PSW indicated staff tried to monitor the resident's whereabouts and immediately intervene when any residents came too close to resident #001, when they were able to. The PSW recalled witnessing the altercation between resident #001 and #002 on a specified date (3rd CIR). The PSW indicated the one to one monitoring of resident #002 had only been in place after the fifth CIR. The PSW indicated resident #002 disliked resident #001 and because their rooms were in close proximity to one another, it made it difficult to keep both residents separated. The PSW indicated resident #001 had not had any further altercations since admission of resident #002 to the hospital. The PSW was not aware that resident #001 had physical altercations with other residents.

During an interview with PSW #105, the PSW indicated they were the assigned staff for one to one monitoring of resident #001 due to ongoing altercation with other residents. The PSW was unable to indicate which other residents were involved in the altercations due to being a newer staff member. The PSW confirmed resident #002 was currently in hospital. The PSW indicated they had not received any information during report regarding which residents were involved in previous incidents or whether any other residents or staff were at risk for altercations with the resident #001.

During an interview with RPN #104, indicated resident #001 had specified responsive behaviours towards staff during specified times and towards other residents when specified triggers were present. The RPN indicated resident #001 was also very

unpredictable. The RPN indicated another resident (resident #002) was also an identified trigger for resident #001, resulting in altercations. The RPN indicated most of the altercations involved resident #001 and resident #002, usually occurred in a specified area and had been ongoing for several months. The RPN indicated resident #001was placed on one to one monitoring due to altercations towards other residents. The RPN indicated resident #001 is also monitored by the BSO staff (RPN #103) in the home and had also been assessed by (PASE). The RPN indicated the resident did not respond well to changes in medications.

During an interview with RPN #103 (BSO), indicated the RPN had only been in the role after the third CIR for resident #001 was submitted. The RPN indicated prior to that time, a previous RPN was in the role but not currently available. The RPN indicated the progress notes were reviewed for any residents with high risk responsive behaviours, obtained additional information from staff and discussed with management (Administrator/DOC), strategies to manage the responsive behaviours. The RPN indicated a list of residents demonstrating high risk responsive behaviours was identified on the BSO Metrics Tracking Tool. The RPN indicated they also completed any assessment tools for responsive behaviours or for staff to implement and completes referrals for additional services/assessments. The RPN indicated resident #001 had specified responsive behaviours towards residents and staff and specified triggers.The RPN indicated the altercations between resident #001 and other residents, usually occurred in a specified area, and especially with resident #002. The RPN indicated awareness of an altercation with resident #003. The RPN indicated resident #001 had been assessed multiple times by PASE as well as assessment in hospital. The RPN indicated resident #002 was currently in hospital which has resulted in no further resident to resident altercations involving resident #001 and since the one to one monitoring was started. The RPN indicated the SDM of resident #001 refused consent to any further hospital assessments.

During an interview with the DOC, the DOC indicated, the one to one monitoring was put in place for resident #001 after the fifth critical incident, due to ongoing incidents, due to the severity of the fifth incident. The DOC indicated the one to one monitoring was increased after discussion with SDM of resident #001, (after the sixth critical incident) and determined that resident #001 required monitoring the entire time the resident was awake, to protect all residents.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #001 and other residents

(especially resident #002) by implementing interventions that were identified, by both the GABU/BSO staff and the one to one monitoring was not considered until after the fifth resident to resident altercation.

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 steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by implementing the identified interventions., to be implemented voluntarily.

Issued on this 3rd day of December, 2018

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

Original report signed by the inspector.