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
Jan 24, 2020	2020_780699_0002	016506-19, 018054-19	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Main Street Terrace
77 Main Street TORONTO ON M4E 2V6

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

PRAVEENA SITTAMPALAM (699), BABITHA SHANMUGANANDAPALA (673)

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): November 21, 22, 25; December 4,5,6, 10, 11, 13, 16, 17 and 20, 2019.

Log #018054-19 / CI 2589-000022-19 related to Falls
Log #016506-19 / CI 2589-000018-19 related to Prevention of Abuse and Neglect, and Responsive Behaviours.

During the course of the inspection, the inspector(s) spoke with the director of care (DOC), associate directors of care (ADOC), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), nurse practitioner (NP), physiotherapist (PT), resident services coordinator (RSC), residents and family members.

During the course of the inspection, the inspector observed staff to resident interactions and the provision of care, reviewed the home's policies, conducted record review of residents'
medical records and completed staff interviews.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **6 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment, development and implementation of the plan of care so that their assessments and different aspects of care were integrated, consistent with and complemented each other.

CIS report related to an unwitnessed fall involving resident #003 was submitted to the Ministry of Long Term Care (MLTC).

A review of resident #003's admission progress note indicated that they were prone to falls due to a specific disease. A Fall Risk Assessment completed on a specific date indicated that resident #003 had a history of falls and was at immediate risk for falls due to significant risk factors. A Fall Risk Screen completed on a specific date indicated that

the resident was at low risk for falls.

A review of the progress notes indicated that resident #003 was referred to PT #110 for a reassessment of their mobility and possible need for an identified mobility device due to a change in status. PT #110's progress note indicated that the resident was to be assisted with a specific level of assistance at all times with ambulation/transfers with their identified mobility device and that a lack of assistance included risk for falls. PT #110 further noted that resident #003 would benefit from the nursing rehab program for assistance with specific aspects of their mobility. A review of the Physiotherapy Assessment indicated that PT#110 had assessed the resident to be at high risk for falls based on the Tinnetti score. They identified physiotherapy/exercise as interventions to improve the risk for falls.

A review of resident #003's progress note indicated that they had been admitted into the restorative care nursing program for specific aspects of their mobility, but not for continence and in this assessment, they were noted to have a specified level of continence.

A review of resident #003's records indicated that they had falls on the specified dates with the following actions/outcomes:

-A review of the post fall assessment indicated that it was an unwitnessed fall and resident #003 was found at an identified location at with no injury. A Fall Risk screen was completed however, the significant risk factor of unsafe mobility was not checked off; therefore, it was determined that a fall risk assessment was not required to be completed. The resident was assessed to be at low risk and universal precaution strategies were to be implemented. Post fall assessment completed by PT #110 indicated that resident #003 was at high risk for falls and included specific fall prevention recommendations. A review of the plan of care in effect at this time indicated that the resident was at medium risk for falls and did not indicate that either recommendation had been implemented.

-A review of the post fall assessment, fall risk screen and fall risk assessment on the same day indicated resident had an unwitnessed fall and was found on the floor and that the floor was wet. Resident #003 verbalized that they had tried to go to the identified area and slipped. The fall risk screen indicated that the resident was at medium risk for falls and that there had been a change in their gait/balance/mobility. A review of the post fall assessment by PT #110 on after the fall indicated that resident #003 was at high risk for

falls, and their recommendations included increasing an identified fall intervention, and placing the resident on an identified plan. A review of the plan of care in effect at this time indicated that the resident was at medium risk for falls and did not indicate that either recommendation had been implemented.

-A review of the post fall assessment indicated that the resident reported to staff that they had slid from an identified area and fell and were concerned of pain to specific areas of their body. Resident #003 was transferred to the hospital for further assessment. The fall risk screen indicated that resident #003 was at low risk for falls. The resident returned to the home with an identified diagnosis and they started using a specific mobility aide as per progress note. A review of PT #110’s quarterly assessment indicated that resident #003 was at high risk for falls. A review of the plan of care in effect at this time indicated that the resident was at medium risk for falls and the implemented interventions were not revised to include those recommended by the PT.

-A review of a progress note described an unwitnessed fall with no injury on a specified date. It further stated that the resident reported falling while trying to complete an ADL. A review of the fall risk screen indicated that the resident was medium risk; however, gait/balance/mobility impairment was not checked off in this assessment. A review of PT #110’s physiotherapy assessment indicated that that resident #003 was at high risk for falls. A review of the plan of care in effect at this time indicated that the resident was at medium risk for falls and did not indicate that either of PT #110's recommendations from the previous falls had been implemented. A review of the restorative assessment was noted to have been opened in Point Click Care (PCC) but not completed.

-A review of the post fall assessment, fall risk assessment and fall risk screen indicated that resident had gone to an identified area without their specific mobility aide and lost their balance, fell and hit an identified area of their body resulting in a specific injury. A review of the progress note dated indicated that resident #003 was sent to hospital as per advise of the physician. A fall risk screen identified the resident to be at medium risk for falls. A review of the PT #110’s post fall assessment completed during this month indicated resident #003 was at high risk for falls and recommendations included specific fall interventions. It further stated that the recommendations were discussed with primary nurse. A review of the plan of care in effect at this time indicated that the resident was at medium risk for falls did not indicate that either recommendation had been implemented. A review of restorative assessment completed identified that resident specific level of continence of bladder and that they had several falls in the last quarter; however, continence was not identified as a focus area nor was the connection to the falls and

level of continence made or interventions to address these falls identified.

A review of resident #003's continence assessment indicated that that they had an identified level of continence during all shifts, they used a specific continence product, and that identified level of assistance was required for resident to access the toilet.

A review of resident #003's written plan of care from admission to did not indicate that the resident had specific continence interventions.

In interviews, RN #111 and PT #110 stated that referrals to the physiotherapist were made in the case that further assessments and interventions were required for a resident who had or were at risk for falls. In an interview, PT #110 stated that there were different tests that could be completed with residents, and they chose which one to complete based on their expertise as a physiotherapist, and the resident's needs, history and diagnoses. PT #110 stated that the Tinetti Test was used to assess gait and balance and to assess perception of balance and stability during activities of daily living and fear of falling and that they had chosen to asses resident #110's risk for falls with this test due to their specific diagnosis. PT #110 confirmed that based on their assessments, #003 was at high risk for falls and that their assessments differed from the assessed fall risk levels completed by nursing staff. PT #110 acknowledged that the interdisciplinary team's assessments related to resident #003's risk level for falls were not integrated, not consistent, nor did they complement each other.

Furthermore, RN #111 and PT #110 stated that all staff, but nurses in particular were responsible for reviewing the PT's assessments and making required changes to residents' plan of care. PT #110 acknowledged that continence assessments for resident #003 should have been completed more often and that resident #003 should have been included in the nursing rehab program to develop and implement a plan of care in relation to continence and toileting issues considering that these were a repeatedly identified contributing factor to the resident's falls.

In an interview, DOC #103 acknowledged that the staff involved in the aspects of falls, continence, nursing and PT did not collaborate with each other in the development and implementation of the plan of care of resident #003 so that different aspects of their care were integrated and were consistent with and complemented each other. [s. 6. (4)]

2. Due to noncompliances identified related to resident #003, the sample was expanded to include resident #005. A review of resident #005's records indicated that they had a

history of three falls between identified period of time. On a specific date, they were assessed to be at medium risk for falls; however, no outcomes or actions were identified, and the Fall risk assessment was left incomplete. Resident #005 experienced the following falls and related outcomes are noted:

- A review of the post fall assessment indicated that resident #005 had an unwitnessed fall on a specific day and was found on the floor. A review of the fall risk screen on this date indicated that the resident was assessed to be at high risk for falls and that a falling star was to be placed above the head of their bed. A review of the fall risk assessment on this date indicated that the resident is to be offered rest periods when tired/fatigued. A review of the plan of care indicated that this was not updated into the plan of care until a specified date. A review of the PT post fall assessment indicated that based on their assessment, they recommended specified fall interventions. A review of the written plan of care did not include updates to reflect the specified fall interventions.

-The post fall assessment was incomplete. A review of this document indicated that resident #005 had an unwitnessed fall in a specified area but there was no further description, and there was no outcome/action indicated. The fall risk screen was also incomplete. It identified the resident to be at low risk for falls but did not capture the resident’s specified diagnosis or medications that would impact risk of falls in the assessment and there was no outcome/action documented. Review of the fall risk assessment contained the same content from the fall risk analysis from the previous fall and was also incomplete. A review of the PT post fall assessment indicated that their recommendations included several fall interventions.

-A review of the post fall assessment indicated that a specific fall intervention was to be implemented. A review of the fall risk screen indicated that the resident was at high risk for falls and a falling star logo was required to be posted. A review of the fall risk assessment was incomplete as all of the sections were empty. A review of the PT post fall assessment indicated the same recommendations from the previous assessment.

A review of the plan of care in effect following each fall did not indicate that it was revised to include the identified fall interventions. Furthermore, a review of HIR assessments were not completed after two falls for resident #005.

There was also no falling star logo observed above the head of resident #005’s bed nor was there an identified fall intervention present during observations conducted by the inspector. On December 10, 2019, observations indicated that there was no identified fall

interventions for resident #005 either.

In an interview, DOC #103 acknowledged that the staff involved in the different aspects of care had not collaborated with each other in the assessment, development and implementation of the plan of care for resident #005 as the PT's recommendations had not been updated and/or implemented in the resident's plan of care. [s. 6. (4) (b)]

3. The licensee has failed to ensure that care was provided to the resident as specified in the plan of care.

CIS report related to an unwitnessed fall involving resident #003 that was submitted to the MLTC.

A review of resident #003’s records and plan of care indicated that they required a specific level of assistance to the washroom due to risk for falls and that on a specified date, they had an unwitnessed fall resulting in an injury to an identified area of their body.

In an interview, PSW #109 stated that they assisted resident #003 to the washroom only after their first fall with injury. PSW #109 further stated that resident #003 was going to the washroom on their own before that fall and that they were not assisting them with this. They stated that resident #003 had a different level of assistance prior to their fall.

A review of resident #003’s written plan of care indicated that resident #003 required a specific level of assistance for toileting since admission.

In an interview, PSW #109 acknowledged that the care set out in the plan of care for resident #003 had not been followed. [s. 6. (7)]

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

CIS report related to an unwitnessed fall involving resident #003 was submitted to the MLTC.

In an interview, DOC #103, who was the lead of the Falls Prevention and Management Program, stated that staff are kept aware of residents’ level of risk for falls through a falling star placed above the head of their bed for those assessed to be at high risk. DOC

#103 stated that the risk levels were also identified in residents' Kardex/Point of Care (POC), written plan of care and during report at the time of shift change.

A review of resident #003's plan of care indicated that they were at medium risk for falls. A review of their care guide in POC identified them to be at risk for falls, but did not indicate their assessed level of risk. During observations, resident #003 was observed to be sitting on their identified mobility device, sleeping and leaning to one side. PSW #109 noted inspector observing and came by to check on resident.

In an interview, PSW #109 stated that they were not aware of the level of risk for falls for resident #003. Furthermore, they stated they could ask the nursing staff for this information but other than that, they did not know where to find the information. They did not know how to access the POC care guide and stated they only use the POC for documentation and that they had never seen the care plan or guide for resident #003. They stated they had ten residents as part of their assignment that day and was not aware which residents were at risk for falls and what level of risk they were. They also stated that this information was also not shared during report. Based on PSW #109's assignment that day, a record review indicated that three residents were at low risk, three were at medium risk and one was at high risk for falls.

In an interview, PSW #121 stated that the falling star program had been used in the past but did not know whether it was still an active program. In an interview PSW #108 stated that they became aware of residents' level of risk for falls when nurses reported it to them or through the care guide on POC. PSW #108 could not identify which residents that were a part of their assignment, including resident #003, were assessed to be at risk for falls, or their level of risk. They stated that this was not shared at shift change that day. Upon review of resident #003's care guide, PSW #108 confirmed that risk for falls was identified; however, the level of risk was not specified. Furthermore, PSW #108 did not know where to locate the written care plan for their assigned residents, could not identify what kind of sign was placed above resident's beds to identify if they were at risk for falls, nor what it meant.

In interviews, PSW #108, #109 and #121 acknowledged that knowing residents' level of risk would be helpful in providing care and preventing falls [s. 6. (8)]

5. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change.

Due to noncompliances identified related to resident #003, the sample was expanded to include resident #008. A review of resident #008's identified assessment records indicated that they experienced the following falls with no injuries and the related outcomes as noted:

- The post fall assessment stated that the resident was reported to have fallen on a specified date. It stated that the post fall huddle was completed, and the outcome/action was that the resident had a change in their specific level of consciousness recently. The fall risk screen identified the resident to be at medium risk for falls.

-A quarterly fall risk screen indicated the resident was at low risk for falls; however, the assessment was incomplete as it did not include the medication profile of the resident.

A review of the resident's plan of care indicated that the resident was at high risk for falls and was last updated on a specified date.

-The post fall assessment stated that the resident fell on a specified date as witnessed by a staff member while they were trying to get up and fell. It did not result in an injury. The fall risk screen identified the resident to be at medium risk. It stated that the fall risk was discussed at the interdisciplinary team huddle and that the outcome/action was that the resident was educated on universal fall precautions; however, the same assessment indicated that the resident's an identified cognitive status. A review of the PT post fall assessment indicated recommendations including a specific fall intervention.

-The post fall assessment indicated that the resident had an unwitnessed fall on a specified date. The fall risk screen identified the resident to be at medium risk due to specific health conditions.

-The post fall assessment stated that the resident had an unwitnessed fall on a specified date. The fall risk screen indicated that the resident was at high risk for falls and that the falling star logo was required. A review of the PT post fall assessment indicated recommendations including a specific fall intervention.

-The post fall assessment stated that the resident had an unwitnessed fall on a specified date with no injury. The fall risk screen and fall risk assessment were not completed during review of records. A review of the PT post fall assessment indicated recommendations including a specific fall intervention.

Observations conducted did not indicate a falling star above resident #008's head of the bed. A review of the resident's current plan of care reviewed on indicated that the resident was at medium risk for falls. The careplan had not been updated to include the falls prevention intervention. Furthermore, a review of HIR assessments were not completed for three falls.

In an interview, DOC #103 acknowledged that resident #008 had not been re-assessed on a specified date as the fall risk screen was not accurately or fully completed. DOC #103 also stated that the written plan of care was not revised after the fall risk screen completed on a specified date to indicate that resident #008 was at high risk for falls, and that it wasn't revised to include the specific fall intervention. [s. 6. (10) (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 ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment, development and implementation of the plan of care so that their assessments and different aspects of care are integrated, consistent with and complemented each other; ensure that care is provided to the resident as specified in the plan of care; and 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 have convenient and immediate access to it, 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 has failed to ensure that residents were protected from abuse.

For the purposes of the definition of “abuse” as per subsection 2 (1) of the Act, physical abuse is the use of physical force by a resident that causes physical injury to another resident.

CIS report related to an incident involving resident #001 and #002 was submitted to the MLTC. Review of the CIS indicated a physical altercation between resident #001 and resident #002 had occurred. Resident #002 reported that resident #001 had hit an identified part of their body multiple times but resident #001 denied this allegation. Resident #002 sustained identified injuries and resident #001 sustained an identified injury.

A review of resident #001's progress notes and plan of care one month previous to the date of the altercation indicated that they exhibited specific responsive behavior. It further indicated that this behavior was disruptive to co-residents on the unit and that co-residents had complained to the staff regarding this issue.

In an interview, resident #002 stated that resident #001 had become upset when they had asked resident #001 to refrain from their behaviour, and this is what led to the physical altercation. Resident #002 denied hitting resident #001. They further stated that resident #001 would exhibit a responsive behavior impacting them and other residents'. They, along with other residents, had complained about resident #001's behavior to the staff in the home who had told them that they were doing everything they could to address the issue. Resident #002 stated that there had been no assessments or interventions. Resident #002 stated that resident #001 continues to exhibit this responsive behavior which continues to be a problem for them and other residents, and that they still sometimes tell resident #001 to stop.

In interviews, DOC #103 acknowledged that although interventions had been implemented to address resident #001's responsive behaviors at night continued to be a problem. They further acknowledged that there had been no steps taken to address the residents whose sleep was impacted including for resident #002, and that resident #002 and #001 had not been protected from abuse. [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 ensure that residents are protected from abuse by anyone, to be implemented voluntarily.

WN #3: 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 that promotes zero tolerance of abuse and neglect of residents was complied with.

CIS report related to an incident involving resident #001 and #002 was submitted to the MLTC. A review of the CIS indicated an altercation between resident#001 and resident #002.

A review of resident #001's progress notes and plan of care indicated that they exhibited an identified responsive behavior. It further indicated that this behavior was disruptive to coresidents on the unit and that co-residents had complained to the staff regarding this issue.

A review of resident #001's progress notes by RN #102 indicated that resident #001 was exhibiting a responsive behavior and made an allegation that a co-resident had hit them. The documentation did not indicate whether the alleged incident of abuse was investigated or reported to anyone else.

A review of the home's policy ADMIN1-P10-ENT, Resident Non-Abuse, Resident Non-Abuse Program, dated March 31, 2019, indicated that anyone who becomes aware of or suspects abuse or neglect of a resident must immediately report that information to the Executive Director or, if unavailable, to the most senior supervisor on shift.

A review of the home's policy ADMIN1-010.02, Resident Non-Abuse, Investigation of Abuse or Neglect, reviewed March 31, 2019, indicated that an immediate and thorough investigation of the reported alleged, suspected or witnessed abuse or neglect will be initiated by the Home's ED/designate and that they will maintain documentation related to, or generated by, the investigation.

In an interview, RN #102 stated that it was not common for resident #001 to make allegations of abuse against co-residents. RN #102 stated that they thought that they had reported the incident to the nurse in charge at the time but had not documented this anywhere.

In interviews, DOC #103 acknowledged that the home's policies related to zero tolerance of abuse and neglect of residents had not be complied with as the abuse allegation by resident #001 incident had not been reported to them or ED #104 nor had it been investigated. [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 ensure that the home's written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the interdisciplinary falls prevention and management program in the home was evaluated and updated at least annually in accordance with evidence based practices and that a written record of this evaluation was kept including the date of the evaluation, names of the persons who participated, summary of the changes made and the date those changes were implemented.

CIS report related to an unwitnessed fall involving resident #003 was submitted to the MLTC.

A review of the home’s policy CARE5 - P10, reviewed and modified March 31, 2019, stated that the fall prevention and injury reduction program is evaluated annually, and one of the tools indicated on the policy was the Fall Prevention and Injury Reduction Program Audit Spreadsheet.

A review of the home’s Falls Intervention Risk Management Program Evaluation for the period between January and December 2018, dated January 2019, did not identify a summary of the changes made and the date that those changes were implemented. The only committee member identified in the evaluation was DOC #103.

In an interview, DOC #103 acknowledged that the evaluation of the licensee’s interdisciplinary falls prevention and management program did not identify the names of an interdisciplinary team participating in the evaluation, the specific date that the evaluation was completed nor the dates that identified when changes and improvements were implemented. DOC #103 also acknowledged that the Fall Prevention and Injury Reduction Program Audit Spreadsheet had not been used to complete audits of the program. [s. 30. (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 ensure that the interdisciplinary falls prevention and management program in the home is evaluated and updated at least annually in accordance with evidence-based practices and that a written record of this evaluation is kept including the date of the evaluation, names of the persons who participated, summary of the changes made and the date those changes were implemented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least annually, the responsive behaviours program is evaluated and updated in accordance with evidence-based practices and if there are none, with prevailing practices and that a written record of this evaluation is kept.

CIS report related to an incident involving resident #001 and #002 was submitted to the MLTC. A review of the CIS indicated an altercation between resident#001 and resident #002.

In an interview, DOC #103 and RPN #100, the responsive behavior program lead, stated that they had not completed an evaluation of the responsive behaviour program for 2018, and did not have a written record to provide. [s. 53. (3) (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 ensure that at least annually, the responsive behaviours program is evaluated and updated in accordance with evidence-based practices and if there are none, with prevailing practices and that a written record of this evaluation is kept, to be implemented voluntarily.

WN #6: 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 :

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

CIS report related to an incident involving resident #001 and #002 was submitted to the MLTC. Review of the CIS indicated an altercation between resident #001 and resident #002 had occurred. Resident #002 reported that resident #001 had hit an identified part of their body multiple times but resident #001 denied this allegation. Resident #002 sustained identified injuries and resident #001 sustained an identified injury.

A review of resident #001’s progress notes and plan of care one month previous to the date of the altercation indicated that they exhibited a specific responsive behavior. It further indicated that this behavior was disruptive to co-residents on the unit and that co-residents had complained to the staff regarding this issue. Interventions for resident #001's responsive behaviours were implemented.

In an interview, resident #002 stated that resident #001 had become upset when they had asked resident #002 to refrain from their behaviour, and this is what led to the altercation. Resident #002 denied hitting resident #001. They further stated that resident #001 would exhibit a specific responsive behavior impacting them and other residents’. They, along with other residents, had complained about resident #001’s behavior to the staff in the home who had told them that they were doing everything they could to address the issue. When resident #002 was asked if there was any intervention in place they stated they had a specific interventions in place. However, resident #002 stated that they were unable to use it as staff kept laundry items on top of the table where the specific intervention was kept, making it inaccessible. Resident #002 stated that resident #001 continues to exhibit this responsive behavior which continues to be a problem for them and other residents, and that they still sometimes tell resident #001 to stop.

A review of resident #002’s progress notes on the day of the incident indicated that at the time of the incident, they had been presumably agitated due to resident #001's responsive behavior. Steps taken by the Registered Nurse included notifying the manager on call. There was no documentation by the manager on call related to further investigation or actions taken to confirm the reason for or address the agitation of resident #002 presumed to be as a result of resident #001’s responsive behavior. Further assessments by RPN #100, the responsive behavior lead, and NP #101 also did not follow up the resident #002’s concerns or indicate ways to prevent recurrence of such an altercation.

A review of the home's policy ADMIN1-010.02, Resident Non-Abuse, Investigation of Abuse or Neglect, reviewed March 31, 2019, indicated that the priority is to ensure the safety and comfort of the abuse victim(s) including completion of full assessments to determine the residents' needs and documenting them on the resident's plan of care.

In an interview, resident #002 stated that no one had asked them about how to help them.

A review of resident #001's plan of care indicated that revisions were made to their plan of care to address the identified behaviors but the responsive behaviors continued. A review of resident #002's progress notes and plan of care following the incident did not indicate any revisions nor interventions to help them related to the issue of resident #001's responsive behavior.

In interviews, DOC #103 and RPN #100 acknowledged that by not assessing for the needs of resident #002 and identifying and implementing interventions during follow up, they had failed to minimize the risk of altercations and potentially harmful interactions between resident #001 and #002. Furthermore, they acknowledged that this is something that should have been done for other residents impacted by resident #001's responsive behaviors. [s. 54. (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 ensure that take steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is, (a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)

(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the contact information of the Director, or the contact information of a person designated by the Director to receive complaints; 2017, c. 25, Sched. 5, s. 21 (1)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(g.1) a copy of the service accountability agreement entered into in accordance with section 20 of the Local Health System Integration Act, 2006 or section 22 of the Connecting Care Act, 2019;
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(l.1) a written plan for achieving compliance, prepared by the licensee, that the Director has ordered in accordance with clause 153 (1) (b) following a referral under paragraph 4 of subsection 152 (1); 2017, c. 25, Sched. 5, s. 21 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the long-term care home's policy to promote zero tolerance of abuse and neglect of residents was posted in the home.

CIS report related to physical altercation involving resident #001 was submitted to the MLTC.

A review of resident #001's progress notes by RN #102 indicated that resident #001 had made an allegation that a co-resident had hit them. The documentation did not indicate whether the alleged incident of abuse was investigated or reported to anyone else.

In an interview, RN #102 stated that they thought that they had reported the incident to the nurse in charge at the time but had not documented this anywhere. RN #102 could not identify where to locate the home's policy to promote zero tolerance of abuse and neglect of residents.

In an interview, ADOC #105 stated that the abuse policy should be posted with all the other required information near the entrance of the home. Upon observation, ADOC #105 confirmed that this policy was not posted in the home. [s. 79. (3) (c)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents and that results of the analysis of every incident of abuse or neglect of a resident at the home was considered in this evaluation.

A review of the home's CIS binder indicated multiple reports related to abuse including resident to resident abuse incidents.

A review of the home's Resident Abuse Program Evaluation for the period between January and December 2018, dated March 2019, indicated that only one report of staff to resident abuse was considered in the evaluation, with no further details noted.

In an interview, DOC #103 acknowledged that the evaluation of the licensee's policy had not considered the results of the analysis undertaken of every incident of abuse or neglect of a resident in the home as it did not include any resident to resident abuse incidents. [s. 99. (c)]

2. The licensee has failed to ensure that at least once every calendar year, the evaluation to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents includes a documented record of the date of the evaluation, identified changes and improvements required to prevent further occurrences, and the date that these changes and improvements were promptly implemented.

A review of the home's CIS binder indicated multiple reports related to abuse including resident to resident abuse incidents.

A review of the home's written record of the Resident Abuse Program Evaluation for the period between January and December 2018, was dated March 2019, and it did not identify changes and improvements that had been implemented nor their dates of implementation.

In an interview, DOC #103 acknowledged that that evaluation document did not identify the specific date that the evaluation was completed nor the dates that identified changes and improvements were implemented. [s. 99. (e)]

Issued on this 18th day of February, 2020

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

Original report signed by the inspector.