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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 24, 2020	2020_556168_0008	024450-19, 000030-20, 000032-20	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

Hamilton Continuing Care
125 Wentworth Street South HAMILTON ON L8N 2Z1

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

LISA VINK (168)

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): February 18, 19 and 21, 2020.

This inspection was conducted related to the following logs:
024450-19 - related to Critical Incident System (CIS) Report #2706 000012-19 for abuse of a resident by anyone;
000030-20 - related to CIS Report #2706 000013-20 for abuse of a resident by anyone; and
000032-20 - related to CIS Report #2706 000014-20 for abuse of a resident by anyone.

During the course of the inspection, the inspector(s) spoke with the General Manager (GM), Director of Care (DOC), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW) and residents.

During the course of the inspection, the inspector observed the provision of care and services, reviewed records including but not limited to: investigative notes, clinical health records, meeting minutes, training and training records and policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **1 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. 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 failed to ensure that residents were protected from abuse from resident

#010.

i. Based on record review and an interview with RPN #102, on an identified date in December 2019, resident #012 was found with resident #010 who demonstrated a responsive behaviour. Staff did not witness if resident #010 was able to engage in the activity towards resident #012; however, resident #010 made a statement when the RPN approached them.
The RPN reorientated resident #010 following the incident and redirected them away from the co-resident.
Based on the assessment conducted on resident #012 they were not in any discomfort nor did they display distress following the incident.
Resident #012 was not protected from abuse by resident #010.

ii. Based on record review and an interview with PSW #108, on an identified date in December 2019, resident #011 was seated when resident #010 displayed a behaviour. Resident #010 verbally attempted to get resident #011's attention while demonstrating the behaviour.
PSW #108 approached the two residents, at which time, resident #010 stopped the activity.
The PSW intervened and reinstructed resident #010.
Resident #011 did not appear to be aware of the incident nor upset.
Resident #011 was not protected from abuse by resident #010.

iii. Based on record review and an interview with the GM and resident #013, on an identified date in December 2019, resident #013 reported that resident #010 demonstrated a responsive behaviour which resulted an area of altered skin integrity, a few days prior. The exact date of the incident was unclear; however, resident #013 was consistent in their report that resident #010 caused the area. The area was assessed by RN #105 and the resident reported it was mildly sore.
Resident #013 identified that resident #014 was a witness to the incident and that they reported it to RPN #103 at the time of the occurrence.
Resident #014 was interviewed by the Inspector and confirmed resident #013's account of the incident.
Interview with resident #010, at the time of the report of the incident, denied the specific behaviour.
RPN #103 denied awareness of the incident between the two residents.
A review of the clinical record identified that the two residents had a previous interaction, which was managed by RPN #103.

Interview with the GM identified that in their opinion resident #013 was reliable in their reporting of the incident.
Resident #013 was not protected from abuse by resident #010. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the procedure included in the required Responsive Behaviours program was complied with.

In accordance with Ontario Regulation 79/10, section 53(1)1 and 3 the licensee was required to develop written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours and resident monitoring and internal reporting protocols.

Specifically, the licensee failed to comply with their Personal Expression Program, 04-84, which was not dated. This program provided a procedure to be followed "as soon as the environment is safe, the neighbourhood team may initiate The Personal Expressions Neighbourhood Observation Tool on PCC (point click care) prior to the end of their shift. This tool should support team members to stop, look and listen when personal expressions are occurring in the neighbourhood as we use the 5W's. This is the critical first step and whenever possible should be completed in a huddle by the entire team as

everyone's perspective and observations matter".

According to the DOC, staff in the home were informed of the need to follow the Personal Expression Program and initiate the Personal Expressions Neighbourhood Observation Tool, if any personal expressions were presented on their shift. This information was communicated electronically on an identified date in December 2019, by the Personal Expression Response Team (PERT) lead, RN #107.
The DOC clarified that incidents of attempted or actual inappropriate responsive behaviours, towards residents, would be considered a personal expression.

A review of the clinical record for resident #010 identified that they had a history of responsive behaviours prior to their admission to the home. A plan of care was initiated, with a focus statement for inappropriate personal expressions the day after admission. Staff interviews identified that the resident's personal expressions were managed effectively from the date of admission until shortly after they had a room change, approximately four months later.
i. According to the progress notes, written by RPN #104, on an identified date in December 2019, a PSW reported that the resident was found socially inappropriate and was not easy to alter.
Interview with the RPN identified that it was reported by a PSW that the resident had attempted to complete an activity and that other residents were present in the room at the time of the incident. The RPN confirmed that they did not report the incident nor interview or assess the resident following the incident; however, documented it in the progress notes.
Interview with PSW #108, during the course of the inspection, identified that they had previously found the resident in a situation where they had attempted to verbally get the attention of a co-resident, before the situation was corrected, in the presence of the staff member.
The PSW could not recall the exact date of the incident; however, confirmed that they reported it to the RPN, likely RPN #104.
A review of PCC did not include a clear description of the incident nor a Personal Expressions Neighbourhood Observation Tool for the time frame of the incident.
The resident demonstrated additional inappropriate responsive behaviours days later at which time RPN #102 initiated a referral to the PERT lead and initiated a Personal Expressions Neighbourhood Observation Tool.
RN #107, the identified PERT lead, confirmed that when they assessed resident #010, based on the referral, they had no recall of the incident.
Interview with the DOC, following a review of the clinical record confirmed that RPN

#104, who was new to the role, did not follow the procedure in the program for Personal Expression.
ii. According to the progress notes resident #010 displayed inappropriate responsive behaviours on an identified date in December 2019. Staff responded to this incident immediately and initiated a referral to the PERT lead as a result.
A review of the assessment tab, in PCC did not include a Personal Expressions Neighbourhood Observation Tool initiated at the time of the incident.
A review of the clinical record, by the DOC, confirmed that the Personal Expressions Neighbourhood Observation Tool was not initiated as required in the procedure.

The procedure was not complied with. [s. 8. (1) (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 procedure is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone occurred or might have occurred, immediately report the suspicion and the information upon which it was based to the Director.

i. According to CIS Report 2706 000013-19 and the clinical record, on an identified date in December 2019, resident #010 allegedly abused resident #012.
The report was submitted, by the Director of Care, four days later, and included documentation that the after hours pager was not contacted about the incident, of resident to resident abuse.
Interview with RPN #102 identified that they reported the information to the charge nurse immediately following the incident.
According to the DOC, the charge RN in the home, had the authority to contact the after hours pager.
The DOC confirmed that the incident of abuse was not reported to the Director immediately as required.

ii. According to CIS Report 2706 000014-19, on an identified date in December 2019, resident #010 allegedly abused resident #011.
The report was submitted, by the Director of Care, two days later, and included documentation that the after hours pager was not contacted about the incident, of resident to resident abuse.
Interview with RPN #103 identified that they reported the incident to the GM the day the incident occurred.
The DOC confirmed that the incident of abuse was not reported to the Director immediately as required. [s. 24. (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 person who has reasonable grounds to suspect that abuse of a resident by anyone occurred or may occur immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

Issued on this 12th day of March, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA VINK (168)
Inspection No. / No de l'inspection :	2020_556168_0008
Log No. / No de registre :	024450-19, 000030-20, 000032-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 24, 2020
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	Hamilton Continuing Care 125 Wentworth Street South, HAMILTON, ON, L8N-2Z1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kelly Younger

To Schlegel Villages Inc., you are hereby required to comply with the following order (s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with section 19(1) of the LTCHA.

Specifically the licensee must:
1. Ensure that resident #010 does not abuse resident #013 or any other resident in the home; and
2. Ensure that resident #010 does not abuse residents #011 and #012 or any other resident in the home.

Grounds / Motifs :

1. 1. The licensee failed to ensure that residents were protected from abuse from resident #010.

i. Based on record review and an interview with RPN #102, on an identified date in December 2019, resident #012 was found with resident #010 who demonstrated a responsive behaviour. Staff did not witness if resident #010 was able to engage in the activity towards resident #012; however, resident #010 made a statement when the RPN approached them.
The RPN reorientated resident #010 following the incident and redirected them away from the co-resident.
Based on the assessment conducted on resident #012 they were not in any discomfort nor did they display distress following the incident.
Resident #012 was not protected from abuse by resident #010.

ii. Based on record review and an interview with PSW #108, on an identified date in December 2019, resident #011 was seated when resident #010 displayed a behaviour.
Resident #010 verbally attempted to get resident #011's attention while

demonstrating the behaviour.
PSW #108 approached the two residents, at which time, resident #010 stopped the activity.
The PSW intervened and reinstructed resident #010.
Resident #011 did not appear to be aware of the incident nor upset.
Resident #011 was not protected from abuse by resident #010.

iii. Based on record review and an interview with the GM and resident #013, on an identified date in December 2019, resident #013 reported that resident #010 demonstrated a responsive behaviour which resulted an area of altered skin integrity, a few days prior. The exact date of the incident was unclear; however, resident #013 was consistent in their report that resident #010 caused the area. The area was assessed by RN #105 and the resident reported it was mildly sore.
Resident #013 identified that resident #014 was a witness to the incident and that they reported it to RPN #103 at the time of the occurrence.
Resident #014 was interviewed by the Inspector and confirmed resident #013's account of the incident.
Interview with resident #010, at the time of the report of the incident, denied the specific behaviour.
RPN #103 denied awareness of the incident between the two residents.
A review of the clinical record identified that the two residents had a previous interaction, which was managed by RPN #103.
Interview with the GM identified that in their opinion resident #013 was reliable in their reporting of the incident.
Resident #013 was not protected from abuse by resident #010. [s. 19. (1)]

The severity of this issue was determined to be a level 2 as there was minimal harm to the residents.
The scope of the issue was a level 3, widespread, as it related to three of three residents reviewed.
The home had a level 3 compliance history as they had previous non compliance to the same section, specifically a Compliance Order issued December 4, 2018, in inspection report 2018_543561_0018, which was complied in March 2019. (168)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Apr 15, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 24th day of February, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LISA VINK

Service Area Office /
Bureau régional de services : Hamilton Service Area Office