Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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119, rue King Ouest, 11iém étage
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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
August 17, 18, 19, 20, 2010	2010_141_901_16Aug170103	Critical Incident H-00252 and H-00664

Licensee/Titulaire
King Nursing Home Ltd. 49 Sterne Street, Bolton, Ontario, L7E 1B9

Long-Term Care Home/Foyer de soins de longue durée
King Nursing Home 49 Sterne Street, Bolton, Ontario. L7E 1B9

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

Sharlee McNally, Compliance Inspector –Nursing #141

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection related to resident abuse.

During the course of the inspection, the inspector spoke with: the Administrator, Director of Care, registered staff, personal support workers (PSWs), and resident family member.

During the course of the inspection, the inspector: reviewed resident records, observed the resident, reviewed the homes policy on abuse.

The following Inspection Protocols were during this inspection:
Prevention of Abuse and Neglect
Continence Care and Bowel Management
Responsive Behaviours

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

4 WN
2 VPC
1 CO: CO #001,

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with the *LTC Homes Act, 2007,* S.O 2007, c. 8, s.24(1)2

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: (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.

Findings:

1. An identified resident was observed by home staff to have aggressive behaviour directed toward another resident. The police were contacted and visited the home as a result of the behaviour. A critical incident was not reported to the director.

Inspector ID #:	#141

WN #2: The Licensee has failed to comply with the *LTC Homes Act, 2007,* S.O 2007, c. 8, s.3(1)2

s.3(1): Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted: 2. Every resident has the right to be protected from abuse.

Findings:

1. Inappropriate responsive behaviours were observed to be made toward resident A by resident B. During this time resident B was not being monitored by staff as the plan of care directed.

Inspector ID #:	#141

Additional Required Actions:

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

Required Action Date: Immediate

WN #3: The Licensee has failed to comply with O. Reg. 79/10, s. 51(2)(a)

s. 51(2): Every licensee of a long-term care home shall ensure that, (a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of

incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

Findings:

1. An identified resident's continence level changed to incontinent of bladder and bowel. There is no assessment of casual factors, patterns, type of incontinence completed at the time of change in status.

Inspector ID #:	#141

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 in ensuring all residents identified as incontinent have an assessment completed that includes causal factors, patterns, type of incontinence and potential to restore function with specific interventions using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O. Reg. 79/10, s.53(4)(c)

s.53(4): The licensee shall ensure that, for each resident demonstrating responsive behaviours, (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

Findings:

1. An identified resident's progress notes indicate initial responsive behaviours occurred on January 2010 with several responsive behaviours directed toward another resident. The written plan of care for risk of this responsive behaviour was initiated on November 2009. The Resident Assessment Protocol (RAPs) for January, April, and June, 2010 do not include assessment or statements related to resident's identified responsive behaviour.

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 in ensuring all residents are assessed when exhibiting responsive behaviours to identify possible to triggers, to be implemented voluntarily.

Inspector ID #:	#141

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**

Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). May 13, 2011

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Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

	☐ Licensee Copy/Copie du Titulaire	☒ Public Copy/Copie Public	
Name of Inspector:	Sharlee McNally	**Inspector ID #**	#141
Log #:	H-00252 and H-00664		
Inspection Report #:	2010_141_901_16Aug170103		
Type of Inspection:	Critical Incident		
Date of Inspection:	August 17, 2010		
Licensee:	King Nursing Home Ltd. 49 Sterne Street, Bolton, Ontario, L7E 1B9		
LTC Home:	King Nursing Home 49 Sterne Street, Bolton, Ontario. L7E 1B9		
Name of Administrator:	Janice King		

To King Nursing Home Ltd. you are hereby required to comply with the following order by the date set out below:

Order #:	001	**Order Type:**	*LTC Homes Act, 2007,* S.O 2007, c. 8, s.3(1)2
Pursuant to: s.3(1): **Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted: 2. Every resident has the right to be protected from abuse.**			
Order: The licensee shall prepare, submit and implement a plan for achieving compliance to meet the requirement that ensures that every resident is protected from abuse by others.			
Grounds: 1. Inappropriate responsive behaviours were observed to be made toward resident A by resident B. During this time resident B was not being monitored by staff as the plan of care directed.			

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This order must be complied with by:	Immediate

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 service for the Licensee.

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

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
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 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 group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Issued on this day of , 2010.	
Signature of Inspector:	Lisa Vink for S McNally July 21/11
Name of Inspector:	Lisa Vink for Shar McNally