Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 25, 2016	2016_168202_0001	005942-15	Complaint

Licensee/Titulaire de permis

KRISTUS DARZS LATVIAN HOME
11290 Pine Valley Drive Woodbridge ON L4L 1A6

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

KRISTUS DARZS LATVIAN HOME
11290 Pine Valley Drive Woodbridge ON L4L 1A6

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

VALERIE JOHNSTON (202)

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): January 06, 07, 08, 22, 2016.

During the course of the inspection, the inspector(s): reviewed clinical records, reviewed the home policies related to responsive behaviours, resident abuse, reporting and complaints and relevant email correspondence pertaining to the inspection.

During the course of the inspection, the inspector(s) spoke with the executive director (ED), director of care (DOC), substitute decision-maker (SDM), registered nursing staff and personal support workers.

The following Inspection Protocols were used during this inspection:
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

A review of the resident #001's plan of care identified the resident with identified responsive behaviours that posed a challenge to staff when redirecting the resident.

Resident #001's progress notes were reviewed from an identified 12 month period of time, which revealed the following:

-Month A: Resident #001 was found in co resident rooms on five identified dates. On an identified date within this month, the resident was found in a co resident's bed.

-Month B: Resident #001 was found in co resident rooms on six identified dates and in a co resident's bed on one occasion.

-Month C: Resident #001 was found in co resident rooms on thirteen identified dates. On an identified date within this month, resident #001 was found in resident #002's room in an altercation resulting in an identified injury to resident #002. On another identified date within this month, resident was found in multiple resident rooms and staff were unsuccessful in redirecting the resident and later resident #001 was found in resident #003's room. Resident #003 was observed to be trying to hit resident #001, which initiated resident #001 to become agitated.

-Month D and E: Resident #001 was found in co resident rooms on 14 identified dates. On an identified date within Month E, resident #001 was found in resident #004's room. Resident #001 became upset and responded at staff when staff attempted to redirect him/her out of resident #004's room.

-Month F: Resident #001 was found in co resident rooms on eleven identified dates. On an identified date within this month, the resident was observed to be "chased" out of three co resident rooms by three residents. On another identified date within this months, the resident was found by staff to be in resident #005's room in a verbal

altercation.

-Month G: Resident #001 was found in co resident rooms on 20 identified dates. On an identified date, resident #001 was found by staff to be in resident #005's room and refused to leave. Two days after the above mentioned identified date, the resident was found to be very agitated and in resident #006's room. On another identified date within this month, resident #001 was found sleeping in resident #006's bed and resident #006 became upset and agitated.

-Month H: Resident #001 was found in co resident rooms on 16 identified dates. On an identified date within this month, resident #001 was found on the floor outside resident #005's room and in a verbal altercation with the resident.

-Month I: Resident #001 was found in co resident rooms on eight identified dates.

-Month J: Resident #001 was found in co resident rooms on 13 identified dates. On five identified dates within this month, resident #001 refused to leave co resident rooms with staff and became verbally and physically aggressive toward residents and staff.

-Month K: Resident #001 was found in co resident rooms on 14 identified dates. On three identified dates within this month, resident #001 was agitated, refused to leave co resident rooms and was observed trying to physically grab other residents.

-Month L: Resident #001 was found in co resident rooms on nine identified dates and refused to leave resident #008's room on one identified date.

Interviews with RN #102, RN #103, PSW #100, PSW #105 and RPN #106 revealed that resident #001 has demonstrated identified responsive behaviours from the time of his/her admission. The staff indicated that resident #001's identified behaviours can be challenging and the resident can be difficult to redirect when in co-resident rooms. The staff stated that when resident #001 enters a co resident's room, co residents have become upset and will attempt to remove resident #001 from their room. Staff indicated that this has resulted in identified responsive behaviours between and among residents that has placed both resident #001 and the co resident at risk.

The above mentioned staff further indicated that the residents of the identified home area have verbalized frustration with resident #001 entering their rooms. The staff revealed that some of the cognitively well residents, at times have minimal patience and

understanding for a resident that is cognitively impaired, putting resident #001 at even greater risk for a harmful interaction.

When asked of PSW #100, PSW #105 and RPN #106 of the strategies that they use to redirect resident #001 from co resident rooms, the staff indicated that they will try to distract the resident. The staff indicated that this does not always work and revealed that the resident will refuse to move initiating a responsive behaviour. Staff indicated that they have been injured as a result of trying to redirect resident #001 out of co resident rooms.

The above mentioned staff also indicated that resident #001 does not like to be touched by certain staff and will only respond to identified staff members. The staff indicated that this has also created a concern for redirecting the resident out of harms way as the resident will not always listen to certain staff.

When asked further of the above mentioned staff, if they feel that resident #001 is safe, all staff indicated that the resident is safe until he/she enters another resident's room. The staff further indicated that they monitor resident #001's whereabouts as much as possible and hope that resident #001 does not end up in a co resident's room, especially when they are busy assisting other residents.

A review of resident #001's written plan of care within the focus section indicated that the resident had identified responsive behaviours. The intervention section of the written plan of care reads as generic and provides minimal direction, such as redirect and encourage activities. Staff have also been directed to approach the resident from the front, document all behavioural episodes in the progress notes, if the resident is resistive leave the resident for five minutes and monitor hourly.

A review of the plan of care with the DOC confirmed that resident #001's plan of care did not include any of the above mentioned strategies as indicated by the direct care staff in interviews. The plan of care did not reflect the entire resident's identified behaviours, or the associated risks. The DOC further confirmed that procedures and interventions had not been fully developed and implemented to assist residents and staff who are at risk of harm from resident #001's responsive behaviours, including the associated risks. [s. 55. (a)]

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 procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #2: 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. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents, (d) shall contain an explanation of the duty under section 24 to make mandatory reports; and (e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents.

A review of the home's policy, Zero Tolerance for Abuse and Neglect, revised December 01, 2015, states, "any 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 their Supervisor, the Director of Care or the Administrator:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the home or staff that resulted in harm or risk of harm to the resident.
3. Unlawful conduct that resulted in harm or risk of harm to a resident.
4. Misuse or misappropriated of resident's money.
5. Misuse or misappropriated of funding provided to the home.

The policy does not contain any procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents.

An interview with the ED confirmed that the above mentioned policy does not contain a full explanation of the duty under section 24 such that “a person” is obligated to make mandatory reports under section 24 and did not contain any procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents. The ED revealed that during the most recent policy revision of December 01, 2015, the above mentioned legislative requirements had been missed. [s. 20. (2) (d)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

An interview with the ED revealed that he/she received a call on an identified date, from the SDM for resident #001 expressing care concerns. The ED indicated that after the phone call with resident #001's SDM, an email was sent to the DOC revealing the conversation and the expressed care concerns raised by the SDM. A review of the above mentioned email revealed that resident #001's SDM requested to know what transpired on an identified date, regarding resident #001's care.

An interview with the DOC confirmed receipt of the above mentioned email and indicated that he/she had called resident #001's SDM three days after the initial identified date, to discuss the concerns. The DOC indicated that there was a verbal agreement made between resident #001's SDM and him/herself to hold a meeting to discuss the above mentioned care concerns at the end of the following month.

An interview with resident #001's SDM indicated that home responded to his/her care concerns one month after the concerns were raised, which was unacceptable. An interview with the ED revealed that he/she had no knowledge as to why the concerns raised on the identified date, had been discussed with the SDM a month later. The ED confirmed that a response to the SDM's concerns mentioned above had not been provided to the SDM within 10 business days. [s. 101. (1) 1.]

2. The licensee has failed to ensure that a documented record is kept in the home that includes,(a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

An interview with the ED revealed that he/she received a call on an identified date, from the SDM for resident #001 expressing care concerns. The ED indicated that after the phone call with resident #001's SDM, an email was sent to the DOC revealing the conversation and the expressed care concerns raised by the SDM. A review of the above mentioned email revealed that resident #001's SDM requested to know what transpired on an identified date, regarding resident #001's care.

An interview with the DOC confirmed receipt of the above mentioned email and indicated that he/she had called resident #001's SDM three days after the identified date, to discuss the concerns. The DOC indicated that there was a verbal agreement made between resident #001's SDM and him/herself to hold a meeting to discuss the above mentioned care concerns approximately one month later.

A review of resident #001's progress notes revealed that a care conference with resident #001's SDM, the physician, ED, DOC and RN #103 had been held approximately one month after the initial concern was raised. The progress notes indicated that the care concerns raised by the SDM on the initial identified date had been discussed.

An interview with the ED confirmed that the verbal care concerns received from resident #001's SDM on an identified date, had not been documented as a formal complaint. The ED indicated that other than the email sent to the DOC from him/herself, indicating the SDM's concerns and the written progress note wrote one month after the initial concern, there is no documented record in the home that includes the above legislated requirements. [s. 101. (2)]

Issued on this 5th day of February, 2016

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

Original report signed by the inspector.