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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 30, 2016	2016_431527_0010	000026-15	Critical Incident System

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

Hawthorn Woods Care Community
9257 Goreway Drive BRAMPTON ON L6P 0N5

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

KATHLEEN MILLAR (527)

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): May 25, 26, 30, 31 and June 1, 3, 7 and 8, 2016

The following Critical Incidents were inspected:

Log #000026-15 - alleged verbal abuse
Log #001831-15 - alleged verbal abuse
Log #008809-15 - alleged resident to resident abuse
Log #009484-15 - alleged resident to resident abuse
Log #029012-15 - alleged abuse
Log #034321-15 - alleged neglect
Log #011836016 - alleged resident to resident abuse
Log #015279-16 - alleged resident to resident abuse

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Minimum Data Set - Resident Assessment Instrument (MDS-RAI) Coordinator, Behavioural Support Officer (BSO), Registered Nurses (RN), Registered Practical Nurses (RPN) and Personal Support Workers (PSW)

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

During the course of this inspection, Non-Compliances were issued.
3 WN(s)
3 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 LTCHA, 2007, 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 by anyone, and to ensure that residents were not neglected by the licensee or staff.

A) Resident #008 sustained an injury in December 2015, when the Personal Support Worker (PSW) #114 left the resident unsupervised, when the resident required extensive assistance. The resident was interviewed and confirmed that the PSW had left them unsupervised and they were injured. The resident's plan of care, and interviews with the registered staff #116, #119 and the PSW #115 confirmed the resident required extensive assistance. The Director of Care (DOC) and the Executive Director (ED) confirmed the incident occurred. The home did not protect resident #008 from neglect, which resulted in an injury to the resident.

B) Resident #013 had exhibited responsive behaviours when co-residents wandered into their room. In May, June, and August 2015, resident #013 was involved in five critical incidents involving the physical abuse of resident #007, #015, #016 and #017. There was harm to other residents as a result of resident #013's behaviours. They included the following:

- In May, 2015, resident #007 was injured by resident #007. Subsequently in June, 2015, resident #007 sustained another injury after an altercation with resident #013.

- On another specific date in May, 2015, resident #015 reported to the home that resident #013 had injured them. There was no injuries noted at the time of the head-to-toe assessment by the registered staff on the same date. Resident #015 also identified that they were afraid for their safety.

- In June, 2015 resident #016 initiated an altercation with resident #013. Resident #013 retaliated and injured resident #016. Resident #016 had injuries observed by the registered staff for approximately nine days after the incident. RN #116, the DOC and ADOC #113 were interviewed and confirmed the incident occurred and the actual harm to resident #016.

- In August, 2015, resident #017 sustained an injury as a result of an altercation with resident #013. Resident #017 had wandered into resident #013's room, which triggered resident #013's responsive behaviours.

The written plan of care was reviewed for resident #013 and not all strategies / interventions to respond to the resident's responsive behaviours were developed and implemented. The DOC, ADOC #103, the Behavioural Support Officer (BSO), registered staff #104, and PSWs #107, #108, and #115 confirmed the abuse of the residents. The home did not mitigate or minimize the risk of harm by resident #013; therefore not

protecting other residents 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 to ensure that all resident will be protected from abuse by anyone, and to ensure that residents will not be neglected by staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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 failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents, was complied with.

A) Resident # 005 was verbally abused in January, 2015. The unit staff were aware of the verbal abuse; however the Executive Director (ED) and the management team were not aware of the alleged verbal abuse and once they were informed, the home subsequently notified the Ministry of Health (MOH) the same day. The home's policy called "Abuse and Neglect Resident", number V3-010, and revised April 2013, directed staff to immediately report if any employee suspected or knew of any incident of abuse or neglect to the Director and the Administration or designate in the home at the time of the incident. The policy further detailed the internal reporting structure whereby the charge nurse on the unit was expected to contact the on call Manager and to call the Ministry of Health (MOH) After Hours number. The registered staff #104 was interviewed and confirmed that they were expected to immediately notify the on call Manager and the MOH After Hours number, if the incident occurs after regular business hours. The ED

and the Director of Care (DOC) were interviewed and confirmed that the registered staff #111 did not comply with the home's policy for immediately reporting alleged abuse to the MOH.

B) Resident #001 was allegedly abused verbally by PSW #105 in December, 2014. The registered staff #104 was aware of the alleged verbal abuse; however the ED and the management team were not aware of the alleged verbal abuse, and once they were informed the home subsequently notified the Ministry of Health (MOH) the same day. The home's policy called "Abuse and Neglect Resident", number V3-010, and revised April 2013, directed staff to immediately report if any employee suspected or knew of any incident of abuse or neglect to the Director and the Administration or designate in the home at the time of the incident. The policy further detailed the internal reporting structure whereby the charge nurse on the unit was expected to contact the on call Manager and to call the MOH After Hours number. The registered staff #104 was interviewed and confirmed that they were expected to immediately notify the on call Manager and the MOH After Hours number, if the incident occurs in the evening. The ED and the Director of Care (DOC) were interviewed and confirmed that the registered staff #104 did not comply with the home's policy for immediately reporting alleged abuse to the MOH.

C) Resident #008 had notified the Physiotherapy Aide (PTA) #118 on several occasions in October, 2015 that one of the PSWs was allegedly rough with them. The Executive Director (ED) and the management team were not aware of the alleged abuse, and when they were informed the home subsequently notified the Ministry of Health (MOH) the same day. The home's policy called "Abuse and Neglect Resident", number V3-010, and revised April 2013, directed staff to immediately report if any employee suspected or knew of any incident of abuse or neglect to the Director and the Administration or designate in the home at the time of the incident. The PTA #118 was interviewed and confirmed the resident had informed her two or three times of allegations of abuse by one of the PSWs; however she did not report it to their supervisor or the charge nurse until the third time the resident spoke with them. The ED and the Director of Care (DOC) were interviewed and confirmed that the PTA #118 did not comply with the home's policy for immediately reporting alleged abuse.

D) Resident #017 wandered into resident #013's room on a specific date in August 2015, which triggered resident #013's responsive behaviours. Registered staff #116 was interviewed and confirmed the incident occurred and after viewing the video surveillance, they observed resident #013 taking resident #017's wheelchair out of their room and

harming resident #017. Registered staff #116 also confirmed that they did not immediately report the alleged abuse as outlined in the home's policy called "Abuse and Neglect Resident", number V3-010, and revised April 2013, which directed staff to immediately report if any employee suspected or knew of any incident of abuse or neglect to the Director and the Administration or designate in the home at the time of the incident. The DOC was interviewed and confirmed that the registered staff #116 did not comply with the home's policy of immediately reporting the allleged abuse.

E) Resident #012 wandered into resident #015's room on a specific date in May 2016. The PSW #108 observed resident #012 exhibiting responsive behaviours. The registered staff #104 confirmed the incident occurred and was unsure if resident #012 had harmed resident #015. Resident #012 was suspected of abuse of another resident #011 and was known to wander into residents' rooms. The DOC, ADOC #103 and the BSO were interviewed if resident #012 had abused resident #015. The DOC identified that the home did not report the incident of suspected abuse to the Director because they didn't think anything happened; however the DOC confirmed that the home should have reported it as outlined in their policy "Abuse and Neglect" #V3-010, which was last revised April 2013. [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 to ensure that the written policy to promote zero tolerance of abuse and neglect of residents will be complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(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. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, (b) strategies were developed and implemented to respond to the responsive behaviours being demonstrated by resident #013.

Resident #013 was exhibiting responsive behaviours. The home had identified the behavioural triggers for the resident as a result of their assessments and reassessments of responsive behaviours; however not all strategies were developed and implemented to respond to these behaviours. Resident #013 was involved in a total of five resident to resident abuse incidents. These incidents occurred in May, June, and August 2015. In each incident the resident's responsive behaviours were triggered as a result of other residents wandering into resident #013's room. The following strategies were not developed and implemented until after the fifth incident of resident to resident abuse:

- A wanderguard was not applied to the resident's door at all times until June, 2015. This strategy may have been a deterrant for co-residents wandering into resident #013's room.
- Staff to make rounds to resident #013's room when other wandering residents were present, which could be a risk of triggering resident #013's responsive behaviour. Staff were to gently re-direct co-residents from resident #013's room. This strategy was not implemented until June, 2015.
- A door chime was not applied to the resident's door until August, 2015. The door chime would have automatically notified staff when co-residents were wandering into resident #013's room.
- Hourly safety checks were not implemented until May, 2016.

The home did not develop and implement strategies that would assist in responding to resident #013's responsive behaviours. [s. 53. (4) (b)]

2. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, (c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Resident #006 had a history of responsive behaviours, which resulted in the resident harming other residents. The behavioural strategies/interventions identified included hourly safety checks and monitoring of their mood and behaviours. The PSWs were responsible to document these interventions in the Point of Care (POC) tool on Point Click Care (PCC). The home's policy called "Documentation - Resident Record", number VII-J-10.00, and revised January 2015 directed the PSWs to record electronically all pertinent resident care delivery information prior to the end of their shift on the resident's individual record, which included all applicable resident tasks into the POC documentation tool. The PSWs #105 and #115 confirmed they were expected to document in POC the interventions for monitoring resident #006's mood, behaviour and hourly safety checks on each shift. The BSO and the DOC confirmed the PSWs were expected to document the resident's behaviour, mood and hourly safety checks in POC and they did not follow the home's policy. [s. 53. (4) (c)]

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, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident will be identified, where possible; (b) strategies will be developed and implemented to respond to these behaviours, where possible, and (c) actions will be taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions will be documented, to be implemented voluntarily.

Issued on this 9th day of August, 2016

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

Original report signed by the inspector.