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
Nov 16, 2021	2021_704682_0018	000115-21, 005183-21, 013411-21	Critical Incident System

Licensee/Titulaire de permis

Niagara Health System
63 Third Street Welland Hospital Site Welland ON L3B 4W6

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

Niagara Health System, Welland Hospital Site, Extended Care Unit
65 Third Street Welland ON L3B 4W6

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

AILEEN GRABA (682)

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): October 25, 26, 27, 28, 29, November 1, 2, 3, 4, 2021.

The following Critical Incident System inspection(s) were completed:
000115-21 related to the prevention of abuse and neglect
005183-21 related to the prevention of abuse and neglect
013411-21 related to falls prevention.

The following Complaint inspection was completed concurrently:
016014-21 related to plan of care and falls prevention.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Program Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapist (PT), Recreation Therapy Aides (RTA), Housekeeping staff, Personal Support Workers (PSW) and residents.

During the course of this inspection, the inspector observed Infection Prevention and Control (IPAC) procedures, the provision of resident care and reviewed clinical health records, investigation notes, staff training records, staffing schedules, meeting minutes, program evaluations and policy and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **2 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. 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 all residents were protected from abuse by anyone.

A) Ontario Regulation 79/10 (O.Reg. 79/10), s. 2 (1) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

A resident sustained injuries during a physical altercation with another resident. Previous verbal altercations involving the same resident were documented prior to their physical altercation.

A personal support worker (PSW) and registered practical nurse (RPN) confirmed that the resident that caused the injury had specific triggers for their responsive behaviour. A PSW, RPN and a registered nurse (RN) all confirmed that they were aware that the resident involved in the incident had previous altercations. A resident sustained an injury when the home failed to protect them from physical abuse by a co-resident.

Sources: Critical Incident Submission (CIS), electronic medical record (EMR), Interviews with PSWs, RPNs, RNs and other staff.

B) Ontario Regulation 79/10 (O.Reg. 79/10), s. 2 (1) defines verbal abuse as any form of verbal communication of a threatening or intimidating nature that is made by anyone other than a resident. Emotional abuse is defined as any threatening, insulting, intimidating or humiliating gestures, actions or behaviours that are performed by anyone other than a resident.

A PSW was involved in a verbal and physical altercation with a resident. A recreational therapy aide (RTA) witnessed the incident. Another PSW was present but stated that they did not see what happened as they were facing the opposite direction. The PSW stated they did hear the verbal altercation. A RN was made aware of the incident and reported the incident to the Administrator and Director of Care (DOC). The RN stated that they felt the incident characterized resident abuse. The DOC confirmed that their investigation into the incident met the definition of verbal and emotional abuse of the resident. The resident was at risk for harm when the home failed to protect them from verbal and emotional abuse by the PSW.

Sources: CIS, electronic medical records, Interviews with the DOC and other staff. [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 residents are protected from abuse by anyone, 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. (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 the written policy to promote zero tolerance of abuse and neglect of residents was complied.

A PSW was involved in a verbal and physical altercation with a resident.

The licensee's Zero Tolerance Abuse and Neglect policy directed all staff to immediately report all abuse and or neglect incidents to the registered nurse in charge who will immediately report to the Administration.

An electronic correspondence (email) identified that a registered nurse (RN) informed the DOC and Administrator of an incident of alleged abuse between a resident and PSW staff that occurred previously. The RN confirmed that the incident was not immediately reported to them by staff who witnessed the incident. The RN also stated that there were other staff in the area that witnessed the incident and did not report the incident to the charge nurse. The Director of Care (DOC) stated that the incident of alleged abuse between the PSW staff and a resident should have been reported immediately within the same shift so they could take action. The resident was at further risk of abuse, when staff did not immediately report the incident of alleged verbal and emotional abuse and comply with the written policy to promote zero tolerance of abuse of residents.

Sources: CIS, Zero tolerance Abuse and Neglect Policy,, email sent to Administrator and DOC from RN, Interview with the DOC, RN and other staff. [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 is complied with, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care related to responsive behaviours for aresident that sets out the planned care for the resident.

Resident #005 had a history of verbal and physical aggression towards co-residents. The current written care plan did not identify possible triggers for the aggression and responsive behaviour. The care plan also did not identify any strategies associated with the prevention of responsive behaviour in relation to the possible triggers.

The licensee's "Responsive Behaviour Management" policy directed staff to develop a care plan identifying possible triggers and planned actions for the prevention of the responsive behaviour.

A RPN stated that the resident's care plan should be updated to reflect the resident care needs. A PSW and RPN both stated that a resident's responsive behaviour was related to specific triggers. The DOC and Program Manager acknowledged that a written responsive behaviour plan of care that identified the resident's possible triggers that set out the planned care had not been developed and implemented.

By not developing a written plan of care that set out the planned care that included possible triggers for responsive behaviours, the resident and co-residents were at risk for altercations and potentially harmful interactions.

Sources: Resident's care plan, progress notes, Responsive Behaviour Management policy, interviews with PSW, RPN, DOC, Program Manager and other staff. [s. 6. (1) (a)]

WN #4: 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 failed to ensure that the responsive behaviour program was evaluated annually and updated in accordance with evidenced-based practices or prevailing practices and that there was a written record of the evaluation.

The Inspector made a request to review a written record of everything provided for in the annual evaluation related to the responsive behaviour program. The program manager stated that the home did not complete an annual evaluation of the responsive behaviour program and did not have any written records to review.

Sources: Interview with Program Manager [s. 53. (3) (b)]

WN #5: 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 failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents and that there was a written record of the evaluation.

The Inspector made a request to review the written record of the annual evaluation of the licensee's policy to promote zero tolerance of abuse and neglect of residents. The DOC stated that the home did not complete an annual evaluation related to the prevention of abuse and neglect and did not have any written records to review.

Sources: Interview with DOC. [s. 99. (b)]

Issued on this 17th day of November, 2021

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

Original report signed by the inspector.