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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
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Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 20, 2017	2017_570528_0018	023667-16, 027407-16, 030883-16, 000756-17, 002672-17, 009199-17	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

THE VILLAGE OF TANSLEY WOODS
4100 Upper Middle Road BURLINGTON ON L7M 4W8

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

CYNTHIA DITOMASSO (528)

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 19, 23, 24, 25, 26, and 29, 2017

This inspection included critical incident system log# 023667-16 and 027407-16 related to allegations of staff to resident abuse; 030883-16, 000756-17, 002672-17, and 007008-17 related to responsive behaviours, 009199-17 related to falls; and was completed concurrently with complaint inspection # 2017_570528_0017 and follow up inspection # 2017_570528_0019.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, Neighbourhood Coordinators, the Kinesiologist, registered nurses, registered practical nurses, personal support workers, residents and families.

During the course of the inspection, the inspector also observed the provision of care and services, reviewed relevant policies and procedures, clinical health records, investigation notes, staff schedules, education records, and audit records.

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

During the course of this inspection, Non-Compliances were issued.
4 WN(s)
3 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	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. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

A. The plan of care for resident #016 identified that the resident had responsive behaviours with identified triggers. Interventions included but were not limited to, remove the resident from certain situations, monitor interactions with co-residents and re-direct away from others if having conflict/arguments .

i. A progress note from December 2016, revealed that the resident was referred to a site behavioural program due to responsive behaviours. The incidents continued in January 2017, with an altercation with staff resulting in injury to a co-resident. Additional incidents of physical altercations with co-residents occurred over the next week.
ii. A second incident occurred where resident #016 was in an altercation with co-resident #018 and was injured as a result.
iii. Interview with RPN #101 and review of investigation notes confirmed that there were altercations between resident #018 and resident #016. RPN #101 confirmed that there were no staff present to de-escalate the situation or monitor resident #016's whereabouts, as required in the plan of care.
iv. Furthermore, interview with Neighbourhood Coordinator #107 and the ADOC confirmed that prior to the incidents listed above, the resident was referred for alternative placement due to ongoing high risk behaviours.

Since there were no staff monitoring resident #016's interactions with co-residents, an altercation occurred, resulting in injury to resident #016. Interventions were not implemented to monitor, redirect and de-escalate resident #016 who demonstrated risk of harming self and others. (528)

B. Resident #010 was admitted to the home in 2016. As a result of ongoing conflict with their roommate and an altercation with no injury in February 2017, the roommate was moved out of the shared room. On a specified date, resident #011 was admitted to the home into the room with resident #010. Interview with the Neighbourhood Coordinator staff #110 confirmed that within an hour conflict was identified when resident #010 yelled at resident #011 and their family.
i. Review of progress notes and critical incident report identified documented episodes of altercations, including allegations of physical altercations. Resident #011 and family

reported concerns of the resident to resident altercations. An incident with physical aggression occurred the following month, and resulted in an injury to resident #011. The resident's were not separated until six days later..
ii. Interview with PSW staff #106, PSW staff #109, RPN #104, and RPN #105, confirmed that the team were aware that resident #010 and resident #011 did not get along.
iii. Steps were not taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions when the home identified ongoing conflict between resident #010 and resident #011. (528) [s. 54. (b)]

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 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 free from neglect by the licensee or staff in the home.

Ontario Regulation 79/10 defines neglect as "failure to provide a resident with treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety, or well-being of one or more residents"

On an identified day in August 2016, staff reported to the home that resident #014 was not provided continence care.

i. Review of the investigation notes confirmed that on the identified day resident #014 was assisted back to bed that afternoon, at which time, no continence care was provided.

ii. The home's investigation interviews with PSW staff #112, #113, and #115, and #116 confirmed that staff did not provided continence care to resident #014 for approximately seven hours.
iii. As a result, resident #014 reported pain in their lower abdomen and the resident was observed to be incontinent of stool.
v. Resident #014 was interviewed during this inspection and was able to recall the incident. They denied feeling neglected by the staff but did state that the incident made them feel horrible.

Interview with the DOC confirmed that neglect was substantiated as a result of the incident, when PSW staff # 112 failed to provide continence care when they assisted resident #014 back to bed on the identified afternoon, as a result, the resident was not provided with care until they reported being in pain approximately seven hours later. (528) [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 residents are free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who was incontinent had an individualized plan to promote and manage bladder and bowel continence and that plan was implemented.

The plan of care for resident #014 identified that the resident had required total assistance of two staff members to provide continence care every four hours.

On an identified day in August 2016, staff reported to the home that resident #014 was not provided continence care. Investigation interviews conducted by the home with PSW staff #112, #113, and #115, confirmed that staff did not provide continence care to the resident every four hours as required in the resident's plan of care, and instead waited approximately seven hours until staff on the next shift checked on the resident.

Interview with the DOC confirmed that resident #014's individualized plan to manage bowel and bladder continence was not implemented. (528) [s. 51. (2) (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 resident is incontinent has an individualized plan to promote and manage bladder and bowel continence and that plan is implemented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident’s pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The home's "Pain Management Program", directed registered staff to complete and document a pain assessment, including but not limited to, on admission, quarterly, when there were personal expressions exhibited by the resident that may be an indicator for the onset of pain, with diagnosis of painful disease, when resident reports any pain or symptoms.

In December 2016, resident #010 was admitted to the home with multiple co-morbidities, including a diagnosis effecting the resident's pain control. The home documented that the resident required communication interventions.

i. A consultation report from September 2016, identified that the resident had advanced disease and was on an analgesia for pain. When the resident was admitted to the home, medications ordered did not include routine analgesia. An anti-inflammatory was ordered on an as needed basis.
ii. The Minimum Data Set (MDS) assessment from December 2016, coded the resident having mild pain less than daily. From January to April 2017, the resident began to display aggression towards co-residents.
iii. In February 2017, the resident was documented as complaining of pain as outlined in the progress notes.
iv. Review of the plan of care did not include a clinically appropriate assessment instrument specifically designed for pain until four months after admission, when the interdisicplinary team identified that the resident's behaviours may be related to pain from diagnosis.

Interview with the ADOC confirmed that there were no pain assessments completed in the resident's plan of care, as required in the home's policy. (528) [s. 52. (2)]

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 when a resident's pain is not relived by initial interventions, the resident is reassessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

Issued on this 22nd day of June, 2017

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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 Homes Division
Long-Term Care Inspections Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CYNTHIA DITOMASSO (528)
Inspection No. / No de l'inspection :	2017_570528_0018
Log No. / Registre no:	023667-16, 027407-16, 030883-16, 000756-17, 002672-17, 009199-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 20, 2017
Licensee / Titulaire de permis :	Schlegel Villages Inc 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	THE VILLAGE OF TANSLEY WOODS 4100 Upper Middle Road, BURLINGTON, ON, L7M-4W8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JO-ANNA GURD

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, including but not limited to:
a. identifying all residents who are at high risk of harming themselves or others
b. any residents who have been assessed at being an actual risk of injuring themselves or others, requiring alternate placement, are continuously monitored appropriate to the risk level
d. all interventions in place for residents who are a potential or actual risk of harming themselves or others are re-evaluated at regular intervals, as determined by the home

Grounds / Motifs :

1. Judgement Matrix
- Non-Compliance Severity: Actual harm or risk for actual harm
- Non-Compliance Scope: Pattern
- Compliance History: Previous non compliance (unrelated)

A. The plan of care for resident #016 identified that the resident had responsive behaviours with identified triggers. Interventions included but were not limited to, remove the resident from certain situations, monitor interactions with co-residents and re-direct away from others if having conflict/arguments .

i. A progress note from December 2016, revealed that the resident was referred to a site behavioural program due to responsive behaviours. The incidents continued in January 2017, with an altercation with staff resulting in injury to a co-resident. Additional incidents of physical altercations with co-residents occurred over the next week.
ii. A second incident occurred where resident #016 was in an altercation with coresident #018 and was injured as a result.
iii. Interview with RPN #101 and review of investigation notes confirmed that there were altercations between resident #018 and resident #016. RPN #101 confirmed that there were no staff present to de-escalate the situation or monitor resident #016's whereabouts, as required in the plan of care.
iv. Furthermore, interview with Neighbourhood Coordinator #107 and the ADOC confirmed that prior to the incidents listed above, the resident was referred for alternative placement due to ongoing high risk behaviours.

Since there were no staff monitoring resident #016's interactions with co-residents, an altercation occurred, resulting in injury to resident #016. Interventions were not implemented to monitor, redirect and de-escalate resident #016 who demonstrated risk of harming self and others. (528)

B. Resident #010 was admitted to the home in 2016. As a result of ongoing conflict with their roommate and an altercation with no injury in February 2017, the roommate was moved out of the shared room. On a specified date, resident #011 was admitted to the home into the room with resident #010. Interview with the Neighbourhood Coordinator staff #110 confirmed that within an hour conflict was identified when resident #010 yelled at resident #011 and their family.
i. Review of progress notes and critical incident report identified documented episodes of altercations, including allegations of physical altercations. Resident #011 and family reported concerns of the resident to resident altercations. An incident with physical aggression occurred the following month, and resulted in an injury to resident #011. The resident's were not separated until six days later..

ii. Interview with PSW staff #106, PSW staff #109, RPN #104, and RPN #105, confirmed that the team were aware that resident #010 and resident #011 did not get along.
iii. Steps were not taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions when the home identified ongoing conflict between resident #010 and resident #011. (528) [s. 54. (b)] (528)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Aug 31, 2017

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 or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 20th day of June, 2017

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Cynthia DiTomasso

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