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

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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 13, 2018	2018_687607_0002	027276-17, 027542-17	Follow up

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 Taunton Mills
3800 Brock Street North WHITBY ON L1R 3A5

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

JULIET MANDERSON-GRAY (607)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): January 24, 25 and 26, 2018

A Critical Incident inspection (# 2018_687607_0003) (Log #s 017509-17, 022140-17 and 028003-17) was also completed concurrently during this Follow up inspection and non-compliance was identified for the Follow up inspection and was issued under inspection #2018_687607_0002.

In addition, the following Logs were inspected and reviewed during this Follow up inspection:
Log #'s: 027276-17 and 02542-17.

Summary of Logs:
1) Log # 027276-17 - Follow up to a Compliance Order, specific to LTCHA, 2007, c. 8, s. 19 (1).
2) Log # 02542-17 - Follow up to a Compliance Order, specific to O. Regulation 79/10, s. 54.

During the course of the inspection, the inspector(s) spoke with the Assistant General Manager, Director of Nursing Care (DON), Neighbourhood Coordinators (NC), a Social Worker, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Attendants (PCA), and residents.

During the course of this inspection, the Inspector reviewed clinical health records, observed staff to resident interactions, reviewed the homes investigations notes, reviewed home specific policies related Resident Abuse Prevention and Responsive Behaviours.

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

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2017_687607_0016	607
O.Reg 79/10 s. 53. (4)	CO #002	2017_687607_0016	607

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.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident when the resident was reassessed, the plan of care was revised, because care set out in the plan had not been effective, and different approaches were being considered, in the revision of the plan of care.

Related to Log # 027542-17 involving resident #001, #003 and #009:

A review of resident #003's current written plan of care indicated the resident had several interventions in place related to responsive behaviours. Further review of the written care plan for resident #003 indicated the identified interventions related to responsive behaviours were in place was since an identified date and month.

A review of the progress notes for resident #003 indicated there were three incidents of identified responsive behaviours by resident #003 that was directed at resident #001 and resident #009. The incident involving resident #009 had no documented evidence that resident #009 was assessed for injury.

During an interview, resident #003 indicated to the Inspector that at times the resident gets very upset when other residents go into the resident's identified personal area. The resident also indicated preventing other residents from going into the resident's (#003) identified area.

During an interview, PCA #104 indicated that resident #003 can be territorial of the area the resident resides and often thinks that residents were going to go into the residents identified area, and would tend to push or go after these residents. PCA #104 indicated that staff manage this behaviour by monitoring resident #003 and keep the resident in recreational programs.

During an interview, RPN #114 indicated that resident #003 was on an identified observation tool, and further indicated that resident #003 would go into other residents personal space and would take their belongings. RPN #104 also indicated that other residents had interventions in place to prevent resident #003 from going into their personal identified areas. The RPN further indicated that resident #003 did not have an identified intervention to prevent other residents from going into the residents personal identified area.

During an interview, RPN #105 indicated that an identified interview would be

implemented as an intervention for resident #003, to prevent other residents from going into resident #003's identified personal area, and indicated that the RPN would update the care plan to reflect that intervention.

The licensee failed to ensure that when resident #003 was being reassessed, the plan of care was revised when the care set out in the plan had not been effective, and had not ensure that different approaches had been considered in the revision of the plan of care. Specifically related to when resident #003 was know to be territorial of the residents space and had been repeatedly preventing other residents from ambulating along the identified area the resident resides. The plan of care was not revised with new interventions, specifically related to preventing other residents from going into resident #003's personal identified area or to prevent resident #003 from going into other residents' personal identified areas. [s. 6. (11) (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 Ensuring that the resident when the resident was being reassessed, the plan of care was revised because care set out in the plan had not been effective, and different approaches had been considered in the revision of the plan of care, specifically related to resident #003, 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 has failed to ensure that its written policy which promotes zero tolerance

of abuse and neglect of residents was complied with.

A review of the Schelegel Villages Prevention of Abuse and Neglect policy #Tab04-06 directs:

Abuse- Any action that involves the misuse of power and/or betrayal of trust, respect or intimacy by a person against a resident and the person knew, or ought to have known, that their action may cause physical, emotional and/or sexual or financial harm to the residents health, safety or well being.

Sexual abuse
Any non-consensual touching, behaviour, or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or team member.

All team members, students and volunteers who witnessed or suspect the abuse of a resident, or receive complaints of abuse, are required to report the matter immediately to any supervisor including the charge nurse or any member of the leadership team.

Related to Log #027276-17 involving resident #001 and #007:

Resident #001 and #007's clinical health records were reviewed in regards to a follow up to compliance order related to LTCHA, s.19, duty to protect.

Resident #007 had diagnoses which included cognitive impairment.

Resident #001 had diagnoses which included Unspecified symptoms and signs related cognitive impairment.

A review of resident #001’s progress notes for a three month time period , indicated there were three incidents where resident #001 and #007 exhibited an identified responsive behaviours towards each other, where both residents were separated and were reminded not to be an identified area alone.There was no documented evidence to indicate that either resident was assessed at the time of each incident for consent to this identified responsive behaviour.

During an interview, resident #007 indicated being aware of who resident #001 was, and had no recollection of being in an identified area with resident #001.

During an interview, resident #001 indicated that having no recollection of the identified responsive behaviours that involved resident #007.

During an interview, RPN #108 indicated that on three identified dates, the RPN had worked on the unit where resident #001 and #007 resided, when the above identified incidents occurred, and had documented the incidents related to resident #001 and #007. RPN #108 indicated that staff were monitoring residents #001 and #007 and noticed that both residents were not located in the area being observed. Resident #001 was later found in an identified area belonging to resident #007. RPN #108 indicated that the RPN did not complete an assessment on either residents and did not notify the charge nurse or a member of the management team as resident #007 was noted to be fully clothed when the residents were found. The RPN indicated at the time of each incident, resident #007 was not noted to be exhibiting an identified responsive behaviours towards resident #001.

During an interview, the Administrative General Manager (AGM) indicated that both the AGM and the DOC reviewed the progress notes, and was not aware of the above identified incidents. The AGM indicated that the expectation was that if a resident was found exhibiting an identified responsive behaviour, while in another resident's identified area, that a supervisor or a member of the leadership team be notified.

The licensee failed to ensure that its written Schelegel Villages Prevention of Abuse and Neglect policy #Tab 04-06, which promotes zero tolerance of abuse and neglect of residents was complied with, specifically related to RPN #108 who had reasonable grounds to suspect abuse had occurred between resident #001 and #007 on three separate dates, and did not report the suspicion immediately to any supervisor, including the charge nurse or any member of the leadership team.

At the time that these incidents occurred a Compliance Order was in place related to LTCHA s. 19 related to duty to protect with an identified compliance date. Further review of both resident #001 and #007's clinical health records indicated there had not been any further incidents involving either resident since. [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 ensuring that its is a written policy that promotes zero tolerance of abuse and neglect of residents is complied with, specifically related to #001 and #007, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Related to Log #027276-17 involving resident #001 and #007:

A review of resident #001's progress notes for five month period, indicated there were three incidents where resident #001 was found in resident #007's room partially undressed (See WN # 2 for details).

During an interview, RPN #108 indicated that on three identified dates, staff were monitoring residents #001 and #007 and noticed that both residents were not in area being observed. Resident #001 was later found in an identified area of resident #007, partially dressed. RPN #108 indicated that the RPN did not complete an assessment on either residents and did not notify resident #001 and #007, family members, as there was no indication that either residents were exhibiting an identified responsive behaviour towards each other.

During an interview, the AGM indicated that both the AGM and the DOC reviewed the progress notes, and was not aware of the above identified incidents. The AGM indicated that the expectation was that if a resident resident was found partially undressed in another resident's identified area, that both family members were notified.

The family members were not notified within 12 hours upon becoming aware of the suspected incidents of abuse, when resident #001 was found on three identified dates partially undressed in an identified area belonging to resident #007.

At the time that these incidents occurred a Compliance Order was in place related to LTCHA, 2007, c. 8, s. 19, related to duty to protect with an identified compliance date. Further review of both resident #001 and #007's clinical health records indicated there had not been any further incidents involving either residents since. [s. 97. (1) (b)]

Issued on this 20th day of February, 2018

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

Original report signed by the inspector.