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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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 public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 6, 2014	2014_247508_0008	H-000167-13	Follow up

Licensee/Titulaire de permis

BARTON RETIREMENT INC.
1430 UPPER WELLINGTON STREET, HAMILTON, ON, L9A-5H3

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

THE WELLINGTON NURSING HOME
1430 UPPER WELLINGTON STREET, HAMILTON, ON, L9A-5H3

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

ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

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

This inspection was conducted on the following date(s): February 25, February 26, February 27, 2014

This follow up inspection was conducted concurrently with complaint inspection #2014_247508_0007

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Director of Care(ADOC), registered staff, Personal Support Workers(PSW'S), Resident Assessment Instrument Co-ordinator(RAI) Co-ordinator and residents.

During the course of the inspection, the inspector(s) toured the home,observed provision of care and services provided, and reviewed relevant documents including,but not limited to: policies and procedures and clinical records.

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

Findings of Non-Compliance were found during this inspection.

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 did not ensure steps were taken to minimize the risk of altercations between residents and potentially harmful interactions between and among residents including identifying and implementing interventions.

Previously identified as non-compliant with a Compliance Order on June 8, 2012 and March 21, 2013.

Staff in the home did not identify and implement interventions to reduce the risk of potentially harmful interactions between resident #004 and co-residents. According to the clinical records, resident #004 had a physical altercation with a co-resident on an unidentified date in 2013. Resident #004's plan of care was reviewed but not revised to identify responsive behaviours towards co-resident's, and interventions were not developed or implemented to minimize a re-occurrence.

According to the clinical records, on an unidentified date later in 2013, resident #004 was having periods of agitation towards staff and co-residents. An assessment was completed identifying that resident #004 was high risk for responsive behaviours. The resident's plan of care was not revised to identify this risk and interventions were not developed or implemented.

Another incident occurred later in 2013, when resident #004 had a physical altercation with a co-resident. Resident #004's plan of care had not been revised to identify that there was a potential for responsive behaviours towards co-residents since the incident. Interventions have not been developed or implemented to minimize a re-occurrence.

Staff confirmed that resident #004 continues to demonstrate responsive behaviours including altercations with co-residents. It was confirmed by the Assistant Director of Care (ADOC) that there are no interventions documented on the resident's plan of care to minimize or reduce further incidents of physical aggression towards co-residents. [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 did not ensure that residents were protected from abuse by resident #004

Previously identified as non compliant with a Written Notification on April 6, 2011, and as a Voluntary Plan of Corrective Action on June 8, 2012, and as a Compliance Order on March 21, 2013.

Resident #004 had a physical altercation with a co-resident on an unidentified date in 2013. According to the clinical records, after the altercation, later in 2013, resident #004 was having periods of agitation towards staff and co-residents. An assessment was completed identifying that resident #004 was high risk for the potential for responsive behaviours, however the plan of care was not revised to identify the risk.

Another incident occurred on a later date in 2013, when resident #004 had a physical altercation hitting a co-resident.

Staff confirmed that resident #004 continues to demonstrate responsive behaviours including altercations with co-residents. It was confirmed by the Assistant Director of Care (ADOC) that there are no interventions documented on the resident's plan of care to minimize or reduce further incidents of physical aggression towards co-residents. [s. 19. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Ontario

Ministry of Health and Long-Term Care

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THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
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 #004	2012_205129_0006	508
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #006	2012_205129_0006	508
O.Reg 79/10 s. 50. (2)	CO #002	2012_205129_0006	508
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #005	2012_205129_0006	508

Issued on this 10th day of March, 2014

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

Roxanne Western

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ROSEANNE WESTERN (508)
Inspection No. / No de l'inspection :	2014_247508_0008
Log No. / Registre no:	H-000167-13
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Mar 6, 2014
Licensee / Titulaire de permis :	BARTON RETIREMENT INC. 1430 UPPER WELLINGTON STREET, HAMILTON, ON, L9A-5H3
LTC Home / Foyer de SLD :	THE WELLINGTON NURSING HOME 1430 UPPER WELLINGTON STREET, HAMILTON, ON, L9A-5H3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LISA BRENTNALL

To BARTON RETIREMENT INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

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

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2012_205129_0006, CO #003;

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 resident #004 and co-residents, and potentially harmful interactions between and among residents including identifying and implementing interventions.

Grounds / Motifs :

1. The licensee did not ensure steps were taken to minimize the risk of altercations between residents including resident #004 and co-residents, and potentially harmful interactions between and among residents including identifying and implementing interventions.

Previously identified as non-compliant with a Compliance Order on June 8, 2012 and March 21, 2013.

Staff in the home did not identify and implement interventions to reduce the risk of potentially harmful interactions between resident #004 and co-residents. According to the clinical records, resident #004 had a physical altercation with a co-resident on an unidentified date in 2013. Resident #004's plan of care was reviewed but not revised to identify responsive behaviours towards co-resident's, and interventions were not developed or implemented to minimize a re-occurrence.

According to the clinical records, on an unidentified date later in 2013, resident #004 was having periods of agitation towards staff and co-residents. An assessment was completed identifying that resident #004 was high risk for responsive behaviours. The resident's plan of care was not revised to identify this risk and interventions were not developed or implemented.

Another incident occurred later in 2013, when resident #004 had a physical altercation with a co-resident. Resident #004's plan of care had not been revised to identify that there was a potential for responsive behaviours towards co-residents since the incident. Interventions have not been developed or implemented to minimize a re-occurrence.

Staff confirmed that resident #004 continues to demonstrate responsive behaviours including altercations with co-residents. It was confirmed by the Assistant Director of Care (ADOC) that there are no interventions documented on the resident's plan of care to minimize or reduce further incidents of physical aggression towards co-residents. [s. 54. (b)] (508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 28, 2014

Ontario

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that residents are protected from physical abuse by anyone including resident #004 and shall ensure that residents are not neglected by the licensee or staff.

Grounds / Motifs :

1. The licensee did not ensure that residents were protected from abuse by anyone including resident #004 and did not ensure that residents were not neglected by the licensee or staff.

Previously identified as non compliant with a Written Notification on April 6, 2011 and as a Voluntary Plan of Corrective Action on June 8, 2012, and as a Compliance Order on March 21, 2013.

Resident #004 had a physical altercation with a co-resident on an unidentified date in 2013. According to the clinical records, after the altercation, later in 2013, resident #004 was having periods of agitation towards staff and co-residents. An assessment was completed identifying that resident #004 was high risk for the potential for responsive behaviours, however the plan of care was not revised to identify the risk.

Another incident occurred on a later date in 2013, when resident #004 had a physical altercation hitting a co-resident.

Staff confirmed that resident #004 continues to demonstrate responsive behaviours including altercations with co-residents. It was confirmed by the Assistant Director of Care (ADOC) that there are no interventions documented on the resident's plan of care to minimize or reduce further incidents of physical aggression towards co-residents. [s. 19. (1)] (508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 28, 2014

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
Performance Improvement and Compliance 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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
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.

Ontario

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

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
Direction de l'amélioration de la performance et de la conformité
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 6th day of March, 2014

Signature of Inspector / Signature de l'inspecteur : Roseanne Western

Name of Inspector / Nom de l'inspecteur : Roseanne Western

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