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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 2, 2018	2018_558123_0011	004797-18	Resident Quality Inspection

Licensee/Titulaire de permis

St. Peter's Care Centres
125 Redfern Avenue HAMILTON ON L9C 7W9

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

St. Peter's Residence at Chedoke
125 Redfern Avenue HAMILTON ON L9C 7W9

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

MELODY GRAY (123), CAROL POLCZ (156), LEAH CURLE (585), LESLEY EDWARDS (506)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): March 21, 22, 23, 26, 28, April 3, 4, 5, 12, May 16, 17, 22, 23, 24, 25, 28, 29, 30, 31, June 5, 11, 26 and 28, 2018.

The following complaint inspections were completed during this inspection: #009945-17 related to resident to resident altercations and #002746-18 related to medications.

The following critical incident inspections were completed during this inspection:

#009541-17 related to fall;
#011359-17 related to alleged abuse;
#015830-17 related to fall;
#024572-17 related to alleged abuse;
#027028-17 related to alleged abuse;
#027510-17 related to fall;
#027513-17 related to fall;
#002592-18 related to fall;
#004138-18 related to alleged abuse;
#006336-18 related to alleged abuse;
#008325-18 fall and
#008838-18 related to disease outbreak.

The following follow-up inspection was included in this inspection: #012734-17 related to resident to resident altercations.

The following intakes were completed during this inspection:
#003991-18 related to alleged abuse and #005146-17 related to hospitalization.

During the course of the inspection, the inspector(s) spoke with residents, family members, housekeeping staff, Personal Support Workers (PSWs), maintenance staff, Dietary Aide, registered nursing staff, Stores Manager, Behavioural Support Ontario (BSO) staff, Occupational Therapist (OT), Registered Dietitian (RD), Resident Care Supervisor (RCS), Manager Resident Services/Social Worker, Coordinator of Volunteer Services, Director of Care (DOC) and the Administrator.

During the course of this inspection the inspector(s): toured the home; observed dining service; observed resident-staff interactions; observed infection prevention and control practices; reviewed the infection prevention and control program; observed medication administration; reviewed the medication management program; reviewed policies and procedures; reviewed staff education records and reviewed program evaluation records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **9 WN(s)**
- **6 VPC(s)**
- **2 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 residents were protected from abuse by anyone.

In accordance with Ontario Regulation 79/10, 2007, s. 2. (1) sexual abuse is defined as any non-consensual touching, behaviour or remarks of a sexual nature or exploitation directed towards a resident by a person other than the licensee or staff member.

A. Critical Incident (CI) reports submitted to the MOHLTC on identified dates in March 2018, October 2017 and June 2017, were reviewed.

i. The home's incident record was reviewed. It was noted that on an identified date in March 2018, an incidence of sexual abuse occurred involving residents #020 and #022. Resident #022 demonstrated a responsive behaviour with resident #020. The staff redirected resident #020 to their room. The staff followed-up with resident #020 about the incident and the police and the residents' substitute decision-makers (SDMs) were notified of the incident.

The health record of resident #022 was reviewed and it was noted that they had a history of cognitive impairment with responsive behaviours towards residents and staff. The resident's documented history indicated multiple incidences of alleged abuse including prior to and after being admitted to the home.

The health record of resident #020 was reviewed. It was noted that they were cognitively impaired and had a history of responsive behaviours.

Behavioural Support Ontario (BSO) staff #141 and #142 were interviewed and confirmed resident #022 had a history of responsive behaviours.

Resident Care Supervisor (RCS) #103 was interviewed and confirmed the accuracy of the information in the home's record and the residents' records. They also confirmed resdent #020 was abused by resident #022.
The home did not protect resident #020 from abuse by resident #022.

Please note this area of non-compliance was identified during CI inspection, #006336-18, conducted during this inspection.

ii. The home's incident record was reviewed. It was noted on an identified date in October 2017, an incidence of sexual abuse occurred involving residents #022 and #024. Staff observed resident #022 demonstrate a responsive behaviour with resident

#024. The staff removed resident #022 from the area. The police and the residents' SDMs were notified of the incident.

The health record of residents #024 and #022 were reviewed. It was noted that resident #024 had a history of impaired decision making. Resident #022 had a history of responsive behaviours towards residents and staff.

RCS #103 was interviewed and confirmed the accuracy of the information in the home's and the residents' records including resident #024 was cognitively impaired. They also confirmed resident #024 was abused by resident #022.
The home did not protect resident #024 from abuse by resident #022.

Please note this area of non-compliance was identified during CI inspection, #024572-17, conducted during this inspection.

iii. The home's incident record was reviewed. It was noted that on an identified date in June 2017, an incidence of sexual abuse occurred involving residents #022 and #023. Staff witnessed resident #022 demonstrating a responsive behaviour with resident #023. Resident #023 did not react. The previous week staff observed resident #022 wandering the home area and getting close to specified vulnerable residents and the staff intervened. The police and the residents' SDMs were informed of the incident.

The health records of resident #022 and #023 were reviewed and included information as noted above. Resident #023 was noted to have a history of cognitive impairment. Resident #023 also had a history of responsive behaviours.

RCS #103 was interviewed and confirmed accuracy of the information as noted in the home's record including the CI report and the residents' records. They reported resident #023 was cognitively impaired. They confirmed resident #023 was abused by resident #022.
The home did not protect resident #023 from abuse by resident #022.

Please note this area of non-compliance was identified during CI inspection, #011359-17, conducted during this inspection. [s. 19. (1)]

2. The Licensee failed to ensure that residents were protected from abuse by anyone.

In accordance with Ontario Regulation 79/10, 2007, s. 2. (1) physical abuse is defined as

the use of physical force by a resident that causes injury to another resident.

A. CI reports submitted to the MOHLTC in September 2017, November 2017 and February 2018, were reviewed. The health records of residents #033 and #034 were reviewed.

i. It was noted on an identified date in September 2017, staff observed resident #033 in a physical altercation with resident #034. Before staff were able to separate the residents, resident #034 had sustained injuries to a specified body area.

ii. It was noted on an identified date in November 2017, staff observed resident #033 in a physical altercation with resident #034. Resident #034 sustained an injury to a specified body area. The residents were separated. The residents had a history of violence and aggression toward each other.

iii. It was noted on an identified date in November 2017, staff observed resident #033 in a physical altercation with resident #034 causing injury to a specified body area of resident #034.

iv. It was noted on an identified date in February 2018, staff observed resident #033 involved in a physical altercation with resident #034 causing injury to a specified body area of resident #033. Resident #034 also sustained injury to an identified body area.

The review of the health records of residents #033 and #034 also outlined several altercations which did not result in injury. However, on the above noted dates, the licensee failed to ensure that resident #034 was protected from physical abuse by resident #033 when resident #034 was injured as a result of altercations with resident #033. The licensee also failed to ensure that resident #033 was protected from physical abuse when resident #033 sustained injury following an altercation with resident #034.

RCS #103 was interviewed and indicated staff were aware that resident #033 posed a risk to and had previous altercations with resident #034. They confirmed the residents were not protected from physical abuse.

Please note this area of non-compliance was identified during CI inspection, #004138-18, conducted during this inspection.

B. CI report submitted to the MOHLTC on an identified date in March 2017, was reviewed and indicated that on that date resident #503 was involved in a physical altercation with resident #502. The residents were separated. However, as a result of the incident, resident #502 sustained injuries to identified body areas.
The health records of residents #502 and #503 were reviewed and confirmed information as noted in the CI report.
RCS #103 was interviewed and confirmed the accuracy of the information in the CI report and in the residents' records. They also confirmed resident #502 was not protected from physical abuse by resident #503.

Please note this area of non-compliance was identified during CI inspection, #006660-17, conducted during this inspection. [s. 19. (1)]

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 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 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.

A. The health records including progress notes and assessments of residents #504 and #502 were reviewed. It was noted that on an identified date in March 2018, resident #504 was involved in an altercation with resident #502. Resident #502 sustained injuries to identified body areas. The residents were separated.

Approximately 25 minutes later, resident #502 was found by staff on the floor with their mobility device tipped over and resident #504 was being verbally abusive. The post-fall assessment indicated that a resident-to-resident altercation had contributed to the fall sustained by resident #502.

Registered staff #123 was interviewed and reported that although the residents were separated following the first incident, no further steps were taken to minimize the risk of altercation and potentially harmful interactions between the residents.

Please note this area of non-compliance was identified during complaint inspection, #009945-17, conducted during this inspection.

B. The health records including progress notes of residents #033 and #034, were reviewed. The residents had a documented history of violence and aggression toward each other. It was noted that on an identified date in September 2017, staff observed resident #033 involved in an altercation with resident #034. Before staff were able to separate the residents, resident #034 sustained injuries to specified body areas.

Following the incident, an identified intervention was initiated for resident #033, Dementia Observation System (DOS) charting was started and a referral was made to Behavioural Support Ontario (BSO). The DOS charting was discontinued on an identified date in September 2017. The specified intervention was discontinued on an identified date in October 2017.

Three days later, staff observed resident #033 and resident #034 in an altercation. There were no new interventions put into place at this time as confirmed by health record review.

Resident #033 had two other altercations with other residents that did not result in injury on identified dates in October 2017. There were no new interventions put into place on these dates as confirmed by health record review.

On an identified date in October 2017, resident #033 had another altercation with

resident #034, staff intervened and separated the residents. Steps were not taken to minimize the risk of altercations between resident #033 and #034 as confirmed by health record review.

Three days later, on an identified date in November 2017, resident #033 had another altercation with resident #034 and resident #034 sustained an injury to a specified body area. The residents were separated. An identified intervention was implemented for both residents the following day. However, before that occurred, resident #034 was involved in an altercation with a resident and staff were able to intervene and separate the residents.

RCS #138 confirmed steps were not taken to minimize the risk of altercations and potentially harmful interactions between and among residents #033 and #034 including: Identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation that potentially could trigger such altercations and identifying and implementing interventions.

Please note this area of non-compliance was identified during CI inspection, #0027028-17, conducted during this inspection. [s. 54.]

Additional Required Actions:

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

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).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out, clear directions to staff and others who provided direct care to the resident.

The health record including the care plan of resident #006 was reviewed. The care plan, revised on an identified date in February 2018, indicated the resident required the use of a specified device and an identified function of their mobility equipment as personal assistance services devices (PASDs). The care plan directed staff to engage the specified device and the identified function whenever the resident was using the mobility equipment.

On identified dates in March 2018, resident #006 was observed using the identified function of their mobility equipment, without the specified device. On an identified date in March 2018, resident #006 was observed using the mobility equipment and the specified

device was not in use. A tag was attached to their mobility equipment, which included a check mark to use the identified function. It did not include a check mark for the use of the specified device.

PSWs #111 and #112 were interviewed and reported they did not use the specified device when the resident was using the mobility equipment. Registered staff #110 was interviewed and reported the resident's plan of care directed staff to use the identified function and the specified device as PASDs. The tag attached to the resident's mobility equipment was used to direct staff on the use of the PASDs and confirmed the tag did not direct staff to apply the device. Registered staff #110 confirmed resident #006's written plan of care did not provide clear directions to staff and others who provided direct care to resident #006 in relation to the use of the PASDs. [s. 6. (1) (c)]

2. The licensee failed to ensure that the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

The home's incident record including a CI report was reviewed and indicated that on an identified date in June 2017, staff witnessed resident #022 exhibit a responsive behaviour with resident #023. Resident #022 was noted to have a history of responsive behaviours towards vulnerable residents and staff and had previously received treatment for the behaviours. It was also noted that one week prior to the incident, resident #022 was observed wandering and getting close to resident #023. The registered staff removed resident #023 from area and other staff were alerted to monitor the whereabouts of resident #022 at all times. The CI report also indicated resident #022 would remain under close observation and was not to be left unattended with vulnerable co-residents.
RCS #103 was interviewed and confirmed the accuracy of the information in the CI reports and the residents' records. They reported the resident was not to be placed next to vulnerable residents unattended in the common areas.

The health record of resident #022 was reviewed and the Behavioural Risk Management progress note of an identified date in June 2017, indicated information as contained in the CI report noted above. The plan of care was reviewed and did not include information that the resident was not to be placed next to vulnerable residents in the common area and the resident's whereabouts were to be monitored.
The plan of care was reviewed with RCS #103 who confirmed the care set out in the plan of care was not based on an assessment of the resident as noted above and they revised the resident's plan of care.

Please note this area of non-compliance was identified during CI inspections, #011359-17, #024572-17 and #0063360-18 conducted during this inspection. [s. 6. (2)]

3. The licensee failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

A. The plan of care for resident #502 was reviewed and indicated they were to be provided with an identified intervention at meals. The diet list located in the servery on the home area also indicated that the resident was to be provided the identified intervention.
The lunch meal was observed on an identified date in June 2018 and the resident did not receive the identified intervention.
Dietary Aide (DA) #115 was interviewed and confirmed that the identified intervention was not provided to the resident as specified in the plan.

Please note this area of non-compliance was identified during complaint inspection, #009945-17, conducted during this inspection.

B. The health record of resident #500 was reviewed and indicated on an identified date in June 2017, resident #500 fell. The resident was assessed as being at risk for falls on the Fall Risk Assessment form dated on the same date and was to have an identified device implemented as an intervention.

i. On an identified date in June 2017, resident #500 fell. The resident was transferred to bed. The identified device was not in place at the time of the fall.
RCS #103 was interviewed and confirmed the falls prevention intervention of the identified device was not in place as per the plan of care.

ii. On an identified date in August 2017, resident #500 fell. The identified device was not in place at the time of the fall.
Registered staff #103 was interviewed and confirmed the falls prevention intervention of the identified device was not in place as per the plan of care.

iii. On an identified date in November 2017, resident #500 fell. The resident was transferred to hospital where an identified medical procedure was performed for a specified injury. The identified device was not in place at the time of the fall.

RCS #103 was interviewed and confirmed the falls prevention intervention of the identified device was not in place as per the plan of care. Upon return from hospital on an identified date in November 2017, the identified device was put in place.

Please note this area of non-compliance was identified during CI inspection, #027513-17, conducted during this inspection.

C. The health record of resident #500 was reviewed and indicated the resident was at risk for falls. On an identified date in January 2018, the resident was assessed and it was noted they were to have a specified equipment installed as a falls prevention intervention. The specified equipment had not been installed as confirmed with PSW #129 and the Maintenance Supervisor on identified dates in May 2018. The planned care for the resident was not provided as specified in the plan.

Please note that this area of non-compliance was identified during CI inspection, #0027510-17, conducted during this inspection. [s. 6. (7)]

4. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

The health record of resident #031 including the progress notes and the care plan, revised on an identified date in November 2017, was reviewed. It indicated the resident had an identified device as a falls prevention intervention but it was discontinued on an identified date in August 2016. The care plan, indicated they were at risk for falls. In an identified three month period in 2017, resident #031 fell a specified number of times.

i. On an identified date in November 2017, it was noted resident #031 had a fall resulting in injury.

ii. On an identified date in November 2017, it was noted resident #031 had a fall without injury. After the fall, registered staff noted the resident had multiple unwitnessed falls over the previous two days and they went to nursing storage room to look for an identified device and none was available at that time.

iii. On an identified date in November 2017, it was noted resident #031 had an unwitnessed fall. The post-fall assessment was reviewed. Staff documented 'no' to the

question related to a specified device in use. The fall did not result in injury. Later the same day, the resident fell and was transferred to hospital. The resident remained in hospital for several days due to a specified injury and had a identified medical intervention. The resident returned to the home on an identified date in November 2017. The review of the resident's care plan did not show that any changes had been made to the care plan when they had an increase in falls beginning on an identified date in November 2017.
Registered staff #123 reviewed resident #031's fall documentation and care plan from November 2017, with LTCH Inspector #585 and confirmed no changes had been made to the plan over the identified period in November 2017.

The Occupational Therapist (OT) was interviewed and confirmed there was a change in the resident's care needs related to falls in November 2017, when they had an increase in falls. They reported the home's expectations would be for staff to initiate interventions. They also confirmed no changes were made to the resident's care plan regarding falls prevention interventions.

The licensee failed to ensure that resident #031 was reassessed and the plan of care reviewed and revised when their care needs changed in relation to falls prevention and management. [s. 6. (10) (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 that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A. In accordance with Ontario Regulation 79/10, 2007 s. 114. (1) and (2) every licensee of a long-term care home is required to develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. The licensee is required to ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage administration, and destruction and disposal of all drugs used in the home.
Ontario Regulation 79/10, 2007 s. 136. (2) indicates: The drug destruction and disposal policy must also provide for the following:
3. That drugs are destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The home's iPharm/S.M.A.R.T. record dated March 2018, was reviewed and indicated the procedure for wasting narcotics include: Two nurses acting together, documenting (two signatures) narcotic waste on the Narcotic Count Sheet; the medication goes into the bio-hazard container and the medication must be denatured and not visible as a dose.

On an identified date in May 2018, during the noon-hour medication administration observation with staff #152 and registered staff #108, the inspector observed an open ampule of an identified narcotic medication which was missing some of its contents in the top draw of the medication cart. Registered staff #108 and staff #152 were questioned

and confirmed the medication ampule contained narcotic medication waste. They reported resident #028 was administered the narcotic medication that morning approximately four hours earlier and the waste left in the ampule was placed in the top drawer of the medication cart. They reported the home's expectation, based on the narcotic waste policy was that the narcotic waste was to be placed in the sharps container and double singed by registered staff. They confirmed the medication was not disposed of as per the home's medication policy and procedure. They also reported another registered staff was not available that morning to dispose of the medication as per the home's policy and procedure.
RCS #103 was interviewed and confirmed home's policy and procedure of wasting narcotic medications as above and that the staff did not dispose of the narcotic medication waste as per the home's policy and procedure.

The home did not ensure that it's medication policy and procedure was complied with in relation to the narcotic medication waste. 123

B. In accordance with Ontario Regulation 79/10, 2007 r. 48. (1) every licensee of a long term care home is required to ensure that the following interdisciplinary programs are developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
Ontario Regulation 79/10, 2007 r. 30. (1) requires that each of the interdisciplinary programs required under section 48 of the Regulation have a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

The home's "Falls Prevention and Post Fall Management Program", number 9-1, last revised August 2017, was reviewed and identified that if a fall was unwitnessed or a resident hit their head a Head Injury Routine/Neuro-vital assessment was to be initiated. It directed staff to see the Head Injury Routine policy.
The "Head Injury Routine", policy last revised February 2017, identified that all residents were to be monitored for 30 hours following any incident, where a head injury was suspected or an actual head injury occurred unless indicated otherwise by the physician.

The health record of resident #501 was reviewed and it was noted that on an identified date in February 2018, resident #501 had an unwitnessed fall. The Director of Care

(DOC) confirmed a Head Injury Routine was not started in relation to resident #501's fall on the date noted above.
The home did not follow its Fall Prevention and Management Program policy and procedure related to head injury.

Please note that this area of non-compliance was identified during CI inspection, #008325-18, conducted during this inspection. [s. 8. (1) (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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the registered dietitian who was a member of the staff of the home completed a nutritional assessment for all residents on admission and whenever there was a significant change in a resident's health condition.

The health record of resident #502 including assessments, progress notes and plan of care was reviewed. It was noted the resident's diagnoses included a specified condition. The resident was sent to hospital and returned with an identified diagnosis on an identified number of occasions since October 2017.

The DOC and the Registered Dietitian (RD) were interviewed and they confirmed the RD did not complete a nutritional assessment to determine if these incidents may have been due to a specified health condition for resident #502 in: October 2017; November 2017; December 2017; February 2018 and May 2018. On all of these occasions, resident #502 was diagnosed with an identified condition and their health condition had changed. The DOC reported that on a go-forward basis, the home would ensure that all incidents of the identified health condition would be referred to the RD for assessment.
The home did not ensure the RD completed a nutritional assessment for resident #502 when there was a significant change in the resident's health condition related to a specified condition.

Please note that this area of non-compliance was identified during complaint inspection, #009945-17, conducted during this inspection. [s. 26. (4) (a)]

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 a registered dietitian who is a member of the staff of the home, completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

The health records of residents #033 and #034 were reviewed. It was noted that:

i. On an identified date in September 2017, resident #033 had an altercation with resident #034 where resident #034 sustained injuries to the skin on identified body areas. Interview with the Wound Care Nurse confirmed that there was no initial assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment completed by a member of the registered nursing staff for any of these injuries.

ii. On an identified date in November 2017, resident #033 had an altercation with resident #034 where resident #034 sustained an injury to the skin on an identified body area. Interview with the Wound Care Nurse confirmed that there was no initial assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment completed by a member of the registered nursing staff for the injury.

iii. On an identified date in November 2017, resident #033 had an altercation with resident #034 where resident #034 sustained an injury to the skin on an identified body area. Interview with the Wound Care Nurse confirmed that there was no initial assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment completed by a member of the registered nursing staff for the injury.

iv. On an identified date in February 2018, resident #033 had an altercation with resident #034 causing injuries to the skin on an identified body area of resident #033. Resident #034 also sustained an injury to the skin on a specified body area.

The Wound Care Nurse was interviewed and confirmed that there were no initial assessments using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment completed by a member of the registered nursing staff for the areas of altered skin integrity of residents #034 and #033 as noted above. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who was a member of the staff of the home, and that any changes made to the plan of care related to nutrition and hydration were implemented.

The health record of resident #018 was reviewed and indicated they had a new area of altered skin integrity noted on an identified date in June 2017. There was no documentation in the health record of a referral to the RD until an identified date in November 2017. The RD completed a triggered resident assessment protocol (RAP) on an identified date in August 2017, which stated the resident's skin was intact.
RCS #103 was interviewed and confirmed, a referral to the RD was not completed until an identified date in November 2017, when the area of altered skin integrity had worsened, and this should have been completed at the time the resident's area of altered skin integrity was identified. [s. 50. (2) (b) (iii)]

3. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A. The health record of resident #001 was reviewed and it was noted that the resident had several areas of altered skin integrity. The health record did not include documentation of a reassessment of all areas of altered skin integrity on a weekly basis.

i. It was noted that resident #001 had an area of altered skin integrity on an identified body area which was identified on an specified date in October 2017. The documentation indicated that a weekly wound assessment was completed once in November 2017, December 2017 and February 2018.

ii. It was noted that resident #001 had an area of altered skin integrity on an identified body area which was identified on an specified date in November 2017. Clinical record review confirmed that a weekly wound assessment was not completed until an identified date in February 2018.

RCS #103 was interviewed and confirmed, weekly reassessments of resident #001's areas of altered skin integrity were not completed by a member of the registered nursing staff as noted above.

B. The health record of resident #018 was reviewed and it was noted that the resident had an area of altered skin integrity which was identified on a specified date in June 2017. The review of the health record did not include a reassessment of all areas of altered skin integrity on a weekly basis. A wound assessment was completed on an identified date in August 2017; on two identified dates in December 2017; on an identified date in January 2018; on an identified date in February 2018 and on two identified dates in March 2018.
RCS #103 was interviewed and confirmed, weekly reassessments of resident #018's areas of altered skin integrity were not completed by a member of the registered nursing staff as noted above. (506)

C. The health records of residents #033 and #034 were reviewed and it was noted the resident #034 had several identified areas of altered skin integrity.

i. The review of the residents' record indicated that on an identified date in September 2017, resident #034 sustained injuries to the skin on an identified body area. Interview with the Wound Care Nurse confirmed that the Treatment Administration

Records (TARS) indicated that the one area of altered skin integrity (TARS did not indicate which one) had healed as of an identified date in September 2017. However, the other area of altered skin integrity did not heal until an identified date in September 2018. No weekly skin assessment was completed on an identified date in September 2018, although the treatment was changed.
Weekly reassessments of resident #034's areas of altered skin integrity were not completed by a member of the registered nursing staff.

ii) On an identified date in November 2017, resident #034 sustained an injury resulting in an identified area of altered skin integrity. The Wound Care Nurse was interviewed and confirmed that the TARS indicated that resident #034 had the area of altered skin integrity. The TARS indicated that the area had healed on an identified date in November 2017. However, there was no weekly skin assessment completed on an identified date in November 2017, although the treatment was changed several times until healed.

Weekly reassessments of resident #034's areas of altered skin integrity were not completed by a member of the registered nursing staff as noted above. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment; is assessed by a registered dietitian who is a member of the staff of the home and any changes made to the resident's plan of care related to nutrition are implemented and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A. The health record of resident #025 including the Physician's Orders and the Medication Administration Record (MAR) was reviewed. The home's medication Incident Report was reviewed. It was noted that on an identified date in February 2018, the nurse practitioner (NP) assessed the resident and ordered an additional medication to be added to their treatment.
The medication order was not appropriately transcribed and co-noted by a second registered staff and one of the medications was discontinued in error. As a result, the resident was not administered the medication as ordered by several staff until the error was discovered.
Registered staff #150 and the DOC were interviewed and confirmed the drug was not administered to resident #025 in accordance with the directions for use specified by the prescriber.

Please note this area of non-compliance was identified during complaint inspection, #002746-18, conducted during this inspection.

B. The home's medication Incident Report was reviewed. It was noted that on an identified date in March 2018, resident #009 did not receive a scheduled dose of an identified medication.
Registered staff #151 and the DOC were interviewed and confirmed the drug was not administered to resident #009 in accordance with the directions for use specified by the prescriber.

C. The home's medication Incident Report and the Physician's Orders for resident #026 were reviewed and it was noted on an identified date in January 2018, resident #026 was administered a specified amount of an identified medication instead of another identified medication.
Registered staff #149 and the DOC were interviewed and confirmed the drug was not administered to resident #026 in accordance with the directions for use specified by the prescriber. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

The home's records including the medication Incident Reports for the first quarter of 2018 were reviewed and the following was noted:

A. On an identified date in February 2018, it was noted a medication order was not appropriately transcribed and co-noted by a second registered staff. As a result, the medication was not administered to resident #025 as ordered. The incident was reported to the supervisor, the resident's substitute decision-maker (SDM) and the NP. The report did not indicate the Medical Director was informed.
The DOC confirmed the Medical Director was not informed.

Please note this area of non-compliance was identified during complaint inspection, #002746-18, conducted during this inspection.

B. On an identified date in January 2018, it was noted that resident #026 was ordered an identified medication and the staff administered a different medication. The incident report indicated the incident was reported to the supervisor, the SDM and the NP. It did not indicate the Medical Director was informed.
The DOC confirmed the Medical Director was not informed.

C. On an identified date in March 2018, it was noted that resident #009 did not receive a scheduled dose of an identified medication as ordered.
The Incident Report indicated the incident was reported to the supervisor, the resident and the Medical Director. The incident report did not indicate the resident's SDM was notified.
Registered staff #151 and the DOC were interviewed and confirmed the accuracy of the information in the medication Incident Report. The DOC confirmed the resident's SDM was not notified. [s. 135. (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 every medication incident involving a resident and every adverse drug reaction is, reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

The health record including the plan of care and the progress notes of resident #031 was reviewed.
Resident #031's plan of care, revised on an identified date in November 2017, indicated they were at risk for falls. The progress notes indicated on an identified date in November 2017, the resident had an unwitnessed fall and did not sustain injuries. No post-fall assessment was found in the health record.
Registered staff #123 was interviewed and reported any time a resident falls, registered staff were expected to complete a post-fall assessment and document in the resident's health record. Registered staff #123 reviewed resident #031's health record and confirmed no post-fall assessment was conducted when the resident fell on the identified date in November 2017.
The home did not ensure that a post-fall assessment using a clinically appropriate assessment instrument, was completed when resident #031 fell on the above date.

This non-compliance was identified in CI inspection, #027513-17, conducted during this inspection. [s. 49. (2)]

Issued on this 4th day of December, 2018

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

Original report signed by the inspector.

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

Ministère 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) :	MELODY GRAY (123), CAROL POLCZ (156), LEAH CURLE (585), LESLEY EDWARDS (506)
Inspection No. / No de l'inspection :	2018_558123_0011
Log No. / No de registre :	004797-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 2, 2018
Licensee / Titulaire de permis :	St. Peter's Care Centres 125 Redfern Avenue, HAMILTON, ON, L9C-7W9
LTC Home / Foyer de SLD :	St. Peter's Residence at Chedoke 125 Redfern Avenue, HAMILTON, ON, L9C-7W9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Renee Guder

To St. Peter's Care Centres, 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) (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 must be compliant with s. 19. (1) of the LTCHA.

Specifically, the licensee must:

1) Conduct a multidisciplinary assessment of the sexually responsive behaviours of resident #022 and implement interventions to ensure that residents #020, #023 and #024 and all other residents are protected from sexual abuse by resident #022.

2) Ensure residents #033, #034, #502 and all other residents are protected from resident-to-resident physical abuse.

Grounds / Motifs :

1. 1. The licensee failed to ensure that residents were protected from abuse by anyone.

In accordance with Ontario Regulation 79/10, 2007, s. 2. (1) sexual abuse is defined as any non-consensual touching, behaviour or remarks of a sexual nature or exploitation directed towards a resident by a person other than the licensee or staff member.

A. Critical Incident (CI) reports submitted to the MOHLTC on identified dates in March 2018, October 2017 and June 2017, were reviewed.

i. The home's incident record was reviewed. It was noted that on an identified date in March 2018, an incidence of sexual abuse occurred involving residents #020 and #022. Resident #022 demonstrated a responsive behaviour with

resident #020. The staff redirected resident #020 to their room. The staff followed-up with resident #020 about the incident and the police and the residents' substitute decision-makers (SDMs) were notified of the incident.

The health record of resident #022 was reviewed and it was noted that they had a history of cognitive impairment with responsive behaviours towards residents and staff. The resident's documented history indicated multiple incidences of alleged abuse including prior to and after being admitted to the home.

The health record of resident #020 was reviewed. It was noted that they were cognitively impaired and had a history of responsive behaviours.

Behavioural Support Ontario (BSO) staff #141 and #142 were interviewed and confirmed resident #022 had a history of responsive behaviours.

Resident Care Supervisor (RCS) #103 was interviewed and confirmed the accuracy of the information in the home's record and the residents' records. They also confirmed resdent #020 was abused by resident #022.
The home did not protect resident #020 from sexual abuse by resident #022.

Please note this area of non-compliance was identified during CI inspection, #006336-18, conducted during this inspection.

ii. The home's incident record was reviewed. It was noted on an identified date in October 2017, an incidence of sexual abuse occurred involving residents #022 and #024. Staff observed resident #022 demonstrate a responsive behaviour with resident #024. The staff removed resident #022 from the area. The police and the residents' SDMs were notified of the incident.

The health record of residents #024 and #022 were reviewed. It was noted that resident #024 had a history of impaired decision making. Resident #022 had a history of responsive behaviours towards residents and staff.

RCS #103 was interviewed and confirmed the accuracy of the information in the home's and the residents' records including resident #024 was cognitively impaired. They also confirmed resident #024 was abused by resident #022.

The home did not protect resident #024 from sexual abuse by resident #022.

Please note this area of non-compliance was identified during CI inspection, #024572-17, conducted during this inspection.

iii. The home's incident record was reviewed. It was noted that on an identified date in June 2017, an incidence of sexual abuse occurred involving residents #022 and #023. Staff witnessed resident #022 demonstrating a responsive behaviour with resident #023. Resident #023 did not react. The previous week staff observed resident #022 wandering the home area and getting close to specified vulnerable residents and the staff intervened. The police and the residents' SDMs were informed of the incident.

The health records of resident #022 and #023 were reviewed and included information as noted above. Resident #023 was noted to have a history of cognitive impairment. Resident #023 also had a history of responsive behaviours.

RCS #103 was interviewed and confirmed accuracy of the information as noted in the home's record including the CI report and the residents' records. They reported resident #023 was cognitively impaired. They confirmed resident #023 was abused by resident #022.
The home did not protect resident #023 from sexual abuse by resident #022.

Please note this area of non-compliance was identified during CI inspection, #011359-17, conducted during this inspection. [s. 19. (1)]

2. The Licensee failed to ensure that residents were protected from abuse by anyone.

In accordance with Ontario Regulation 79/10, 2007, s. 2. (1) physical abuse is defined as the use of physical force by a resident that causes injury to another resident.

A. CI reports submitted to the MOHLTC in September 2017, November 2017 and February 2018, were reviewed. The health records of residents #033 and #034 were reviewed.

i. It was noted on an identified date in September 2017, staff observed resident #033 in a physical altercation with resident #034. Before staff were able to separate the residents, resident #034 had sustained injuries to a specified body area.

ii. It was noted on an identified date in November 2017, staff observed resident #033 in a physical altercation with resident #034. Resident #034 sustained an injury to a specified body area. The residents were separated. The residents had a history of violence and aggression toward each other.

iii. It was noted on an identified date in November 2017, staff observed resident #033 in a physical altercation with resident #034 causing injury to a specified body area of resident #034.

iv. It was noted on an identified date in February 2018, staff observed resident #033 involved in a physical altercation with resident #034 causing injury to a specified body area of resident #033. Resident #034 also sustained injury to an identified body area.

The review of the health records of residents #033 and #034 also outlined several altercations which did not result in injury. However, on the above noted dates, the licensee failed to ensure that resident #034 was protected from physical abuse by resident #033 when resident #034 was injured as a result of altercations with resident #033. The licensee also failed to ensure that resident #033 was protected from physical abuse when resident #033 sustained injury following an altercation with resident #034.

RCS #103 was interviewed and indicated staff were aware that resident #033 posed a risk to and had previous altercations with resident #034. They confirmed the residents were not protected from physical abuse.

Please note this area of non-compliance was identified during CI inspection, #004138-18, conducted during this inspection.

B. CI report submitted to the MOHLTC on an identified date in March 2017, was

reviewed and indicated that on that date resident #503 was involved in a physical altercation with resident #502. The residents were separated. However, as a result of the incident, resident #502 sustained injuries to identified body areas.
The health records of residents #502 and #503 were reviewed and confirmed information as noted in the CI report.
RCS #103 was interviewed and confirmed the accuracy of the information in the CI report and in the residents' records. They also confirmed resident #502 was not protected from physical abuse by resident #503.

Please note this area of non-compliance was identified during CI inspection, #006660-17, conducted during this inspection. [s. 19. (1)]

(123)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 19, 2018

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2017_322156_0009, CO #001;

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 must be compliant with Ontario Regulation 79/10, s. 54.

Specifically, the licensee must:

Conduct multidisciplinary assessments and implement interventions to minimize the risk of altercations and potentially harmful interactions between and among residents #033 and #034; residents #502 and #504 and any other residents.

Grounds / Motifs :

1. The licensee failed to ensure that steps were 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.

A. The health records including progress notes and assessments of residents #504 and #502 were reviewed. It was noted that on an identified date in March 2018, resident #504 was involved in an altercation with resident #502. Resident #502 sustained injuries to identified body areas. The residents were separated.

Approximately 25 minutes later, resident #502 was found by staff on the floor with their mobility device tipped over and resident #504 was being verbally abusive. The post-fall assessment indicated that a resident-to-resident altercation had contributed to the fall sustained by resident #502.

Registered staff #123 was interviewed and reported that although the residents were separated following the first incident, no further steps were taken to minimize the risk of altercations and potentially harmful interactions between the residents.

Please note this area of non-compliance was identified during complaint inspection, #009945-17, conducted during this inspection.

B. The health records including progress notes of residents #033 and #034, were reviewed. The residents had a documented history of violence and aggression toward each other. It was noted that on an identified date in September 2017, staff observed resident #033 involved in an altercation with resident #034. Before staff were able to separate the residents, resident #034 sustained injuries to specified body areas.

Following the incident, an identified intervention was initiated for resident #033, Dementia Observation System (DOS) charting was started and a referral was made to Behavioural Support Ontario (BSO). The DOS charting was discontinued on an identified date in September 2017. The specified intervention was discontinued on an identified date in October 2017.

Three days later, staff observed resident #033 and resident #034 in an altercation. There were no new interventions put into place at this time as confirmed by health record review.

Resident #033 had two other altercations with other residents that did not result in injury on identified dates in October 2017. There were no new interventions put into place on these dates as confirmed by health record review.

On an identified date in October 2017, resident #033 had another altercation with resident #034, staff intervened and separated the residents. Steps were

not taken to minimize the risk of altercations between resident #033 and #034 as confirmed by health record review.

Three days later, on an identified date in November 2017, resident #033 had another altercation with resident #034 and resident #034 sustained an injury to a specified body area. The residents were separated. An identified intervention was implemented for both residents the following day. However, before that occurred, resident #034 was involved in an altercation with a resident and staff were able to intervene and separate the residents.

RCS #138 confirmed steps were not taken to minimize the risk of altercations and potentially harmful interactions between and among residents #033 and #034 including: Identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation that potentially could trigger such altercations and identifying and implementing interventions.

Please note this area of non-compliance was identified during CI inspection, #0027028-17, conducted during this inspection. (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 19, 2018

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 2nd day of November, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MELODY GRAY

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