Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Oct 4, 2019	2019_793743_0014	015084-19, 017250-19	Critical Incident System

Licensee/Titulaire de permis

Holland Christian Homes Inc.
7900 McLaughlin Road South BRAMPTON ON L6Y 5A7

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

Grace Manor
45 Kingknoll Drive BRAMPTON ON L6Y 5P2

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

KIYOMI KORNETSKY (743)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 6, 9-13, and 16, 2019.

**Log #017250-19/2942-000017-19 related to an incident of alleged sexual abuse.
Log # 015084-19/2942-000014-19 related to a fall that resulted in a significant change of status.**

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Behavior Support Ontario (BSO), Resident Assessment Instrument (RAI) Coordinator (RAI-C), Activation Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN) and Personal Support Workers (PSW).

The inspector also observed resident care and interactions with residents and other staff; reviewed clinical records, pertinent polices and procedures and the licensee's documentation related to relevant investigations.

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

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

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others who provided direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

Resident #001 had a history of responsive behaviours towards other residents.

The resident's plan of care included multiple interventions to address their responsive behaviours, including specified monitoring.

According to Assistant Director of Care (ADOC) #113, agency Personal Support Workers (PSW) were expected to follow the residents' plans of care and interventions; and agency PSWs were expected to follow the responsive behaviour interventions for resident #001.

ADOC #113 said agency PSWs were provided access codes for Point of Care (POC) and a binder with additional information about the residents' plans of care.

On a specific date, agency PSW #110 was providing the specified monitoring for resident #001. When asked what interventions were in place to address the resident's responsive behaviours, they outlined one specific intervention; but were unaware of any other interventions that were to be implemented to address the resident's responsive behaviours. When asked where they would find information about resident #001's plan of care and interventions, agency PSW #110 replied that staff were to provide them information about the resident.

The following day, agency PSW #111 was providing the specified monitoring for resident #001; and reported that they were not provided a binder with information about the resident, nor did they have access to the resident's kardex, care plan or POC. When asked if resident #001 had any responsive behaviours or interventions in place, PSW #111 replied that staff had informed them about one of the resident's behaviors and noted they had received conflicting information around resident #001's interventions.

The licensee failed to ensure that staff and others who provided direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it; when PSW #110 and #111, did not have convenient or immediate access to resident #001's plan of care; nor were they kept aware of the contents of resident #001's plan of care. [s. 6. (8)]

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 staff, including agency staff, are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect residents from abuse by anyone.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" means any non-consensual touching, behavior or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

The following is further evidence to support compliance order (CO) #001, issued on July 31, 2019, during Critical Incident System inspection 2019_723606_0015; to be complied September 29, 2019.

A Critical Incident was submitted to the Ministry of Long-Term Care (MLTC) related to the alleged abuse of resident #002 by resident #001.

Resident #001 had a history of responsive behaviours towards other residents. Documentation by Registered Nurse (RN) #112 in Point Click Care (PCC), noted that on a specific date at a specific time, a family member observed resident #001 exhibiting inappropriate behaviours towards resident #002. RN #112 noted that resident #002 was crying during the incident and the residents were subsequently separated.

Resident #001's plan of care included multiple interventions to address their responsive behaviours, including specified monitoring.

According to the Director of Care (DOC) #105, prior to the incident, the resident's responsive behaviors towards other residents had improved and the licensee was attempting to reduce their monitoring. DOC #105 and the Behaviour Support Ontario (BSO) #108, said resident #001 was kept in areas of the home with increased supervision and staff were aware to monitor the resident.

RN #112, who was the charge nurse on the date of the incident, reported they did not witness the altercation between resident #001 and resident #002, however, they were informed by another family member about where and when the incident had occurred.

The licensee failed to protect resident #002 from abuse by anyone, when resident #001 exhibited responsive behaviors towards resident #002. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance , to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The licensee's policy titled "Zero Tolerance of Resident Abuse and Neglect" last revised July 2018, instructed staff that all suspected, alleged, witnessed or actual incidents of abuse were to be reported immediately to the Director of Resident Care.

Resident #001 had a history of responsive behaviours towards other residents. Documentation by RN #112 in PCC noted that on a specific day, a family member observed resident #001 exhibiting responsive behaviours towards resident #002.

The following day, ADOC #113 informed RN #112 that the incident could be considered abuse and the MLTC was informed later that same day. DOC #105 acknowledged that staff did not immediately report the incident to the Director of Resident Care.

The licensee failed to ensure the licensee's "Zero Tolerance of Resident Abuse and Neglect" policy was complied with, when staff failed to immediately report the suspected abuse of resident #002 to the Director of Resident Care. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance , to be implemented voluntarily.

Issued on this 7th day of October, 2019

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

Original report signed by the inspector.