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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 27, 2016	2015_250511_0014	033659-15	Critical Incident System

Licensee/Titulaire de permis

GRACE VILLA LIMITED
284 CENTRAL AVENUE LONDON ON N6B 2C8

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

GRACE VILLA NURSING HOME
45 LOCKTON CRESCENT HAMILTON ON L8V 4V5

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

ROBIN MACKIE (511)

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): December 1, 9 and 22, 2015.

This is an inspection on alleged abuse.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, registered staff including Registered Nurses (RN's) and Registered Practical Nurses (RPN'S), Personal Support Workers (PSW's), Behavioural Supports Ontario staff member, Police Officers and residents. During this inspection the Inspector observed resident care, and reviewed clinical records and applicable policies.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with 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 has failed to ensure that the long-term care home protected residents from abuse by anyone and failed to ensure that residents were not neglected by the

licensee or staff.

Resident #002 was documented by the home to have full capacity for all aspects of decision making related to their care. They were admitted to the home in 2015 and required personal assistance with transfers.

A review of the clinical record contained a progress note in 2015 that indicated resident #002 was found crying by PSW #20. The staff member stated the resident indicated they wanted to speak with the RN on duty. PSW #20 immediately notified the Registered Nurse on nights. The RN documented that when they spoke to resident #002, they had stated they had been touched without consent by co-resident #001. Resident #002 stated to the RN that resident #001 had come into their room while they were sleeping and inappropriate touched them. Resident #002 was crying and stated to the RN that they did not feel safe in the home. The Social Worker met with resident #002 and confirmed the resident was teary, anxious, looked drowsy and stated that they continued to not feel safe in the home. The resident was documented to have told another staff member about the incident. The Administrator documented that resident #002 was able to recall the incident of inappropriate touching that had occurred earlier that morning and a Critical Incident report was submitted to the Ministry of Health and Long Term Care (MOHLTC).

In 2015, resident #002 was observed to become visibly upset when they talked about the allegation they had reported. Resident #002 told the Inspector that resident #001 had frequently went into other residents' rooms and into their room a number of times prior to this incident. On previous occasions the resident had told resident #001 to get out and they had left. The resident stated they had been touched without consent and was fearful it may happen again.

Interview with PSW #20 confirmed they had worked the evening of the allegation. PSW #20 stated resident #001 often went in and out of residents’ rooms and they had redirected the resident. PSW #20 stated on the night of the allegation the resident had been awake most of the night and had wandered into other residents' rooms. The PSW stated they had reported two incidents that occurred that evening. During the first incident, resident #001 had entered another resident’s room and was found laying on resident #006. The staff member further stated a second incident when they went into assist resident # 007’s in their room. Resident #007 was identified as cognitively impaired and had minimal ability to vocalize or move about in bed. PSW #20 stated the resident normally had slept through the night but on this occasion, resident #007 was awake with

their eyes open and was described as having looked "distressed", like they were upset. Their bed clothing was lifted, exposing the right side of their body closest to the door. The PSW stated they felt this was odd because they had left the resident covered up in bed with their bed clothing pulled down and blankets pulled up. Documentation, provided by the RN to the doctor, indicated resident #001 was in the room of resident #007 unsupervised during the time that their body was exposed. PSW #20 stated they asked the resident if someone had been in their room and they had nodded. PSW #20 further confirmed that they observed resident #001 leaving the hallway, where resident #002's room was located, around the time resident #002 was found crying.
PSW #20 stated they reported the above mentioned incidents involving resident #006 and #007 to the RPN on duty. The PSW indicated that after reporting the incidences, the RPN had not provided any direction for increased monitoring or interventions to reduce resident #001's wandering behaviours prior to the allegation of abuse of resident #002.

Interview with the DOC confirmed resident #001 was admitted to the long term care home in 2014 with cognitive impairment and a risk of wandering. The DOC stated the resident had a history of behaviours in the home. The DOC confirmed the licensee had prior knowledge the resident wandered into other resident rooms, unsupervised, in the late evening and early morning when co-residents were sleeping. The DOC confirmed the licensee had knowledge of the risks that resident #001 posed to residents of the home, including residents #002, #006, and #007. The DOC confirmed the licensee had not implemented any interventions or strategies to protect other residents, including resident #002, when they became aware of the incidents involving residents' #006 and #007. The licensee failed to ensure that the long-term care home protected resident #002 from abuse.

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. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

On a date in 2015 resident #001 was alleged to have wandered into resident #002's room in the early morning. PSW #20 confirmed they had observed the resident wander into two other resident rooms that evening and was noted to have wandered down the same hall as resident #002 on the date of the allegation. A review of resident #001's clinical record indicated the resident was admitted to the long term care home with cognitive impairment and a risk of wandering. The most recent plan of care indicated the resident had a progressive decline in intellectual functioning characterized by a deficit in their memory and judgment related to dementia. A review of the Behaviours-Wandering progress notes indicated for a 16 months period the resident wandered on 32 separate occasions. 25 of the 32 incidents occurred in the late evening and early morning in which the resident was documented to have wandered into other residents' rooms including resident #003, #004 and #005's. During an interview with PSW #20, they confirmed resident #001 had often been observed to be awake in the late evenings and early mornings and wandered frequently in and out of other resident's rooms. The staff would then redirect the resident to their own room. The staff member did not identify any potential triggers to this behaviour nor interventions that prevented resident #001 from entering other residents' rooms. A review of the resident's most recent Resident Assessment Protocol (RAP) did not identify the above specific wandering behaviour. There were no triggers for the behaviours nor were there interventions identified to mitigate the behaviours to protect the safety and privacy of other residents. Interview with a member from the Behavioural Supports Ontario (BSO), who was working at the home at the time of the incident, indicated resident #001 had not been referred to them for interventions to address any of the responsive behaviours. An Interview with the DOC confirmed they had not completed a referral to the BSO nor had they completed a Behavioural assessment to identify triggers and interventions to manage the identified behaviours of resident #001. [s. 26. (3) 5.]

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 plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

Issued on this 9th day of March, 2016

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

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

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) :	ROBIN MACKIE (511)
Inspection No. / No de l'inspection :	2015_250511_0014
Log No. / Registre no:	033659-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 27, 2016
Licensee / Titulaire de permis :	GRACE VILLA LIMITED 284 CENTRAL AVENUE, LONDON, ON, N6B-2C8
LTC Home / Foyer de SLD :	GRACE VILLA NURSING HOME 45 LOCKTON CRESCENT, HAMILTON, ON, L8V-4V5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Annette Spretnall

To GRACE VILLA LIMITED, 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 shall do the following for achieving compliance with LTCHA, 2007 S.O. 2007, c.8, s. 19 (1).
(a) Undertake an analysis and evaluation of the application of the licensee's plan for addressing responsive behaviours of resident #001 and identify what changes and improvements are required to prevent further incidents of wandering/disrobing to resident's bedrooms and inappropriate altercations between residents; and
(b) Develop and implement comprehensive policies and procedures to address residents with wandering behaviours taking into consideration the changes and improvements identified through the evaluation outlined in (a) above. These policies and procedures should include all aspects of interventions and strategies to mitigate responsive behaviours including wandering and inappropriate resident interactions, access to supports – both internal and external (ex. description of the role of internal and external BSO teams, timing and triggers for external specialist consults, access to High Intensity Needs Fund (HINF) for 1:1 staffing and preferred accommodation support) to protect resident's #002, #006 and #007.

Grounds / Motifs :

1. The licensee has failed to ensure that the long-term care home protected residents from abuse by anyone and failed to ensure that residents were not neglected by the licensee or staff.

The Order is made based upon the application of the factors of severity, scope and compliance history, in keeping with s.299(1) of the Regulation, in respect of the actual harm that resident #002 experienced, the numbers of other residents identified below who were affected by the responsive behaviours of resident

#001

Resident #002 was documented by the home to have full capacity for all aspects of decision making related to their care. They were admitted to the home in 2015, and required personal assistance with transfers.

A review of the clinical record contained a progress note in 2015 that indicated resident #002 was found crying by PSW #20. The staff member stated the resident indicated they wanted to speak with the RN on duty. PSW #20 immediately notified the Registered Nurse on nights. The RN documented that when they spoke to resident #002 , they had stated they had been touched without their consent by co-resident #001. Resident #002 stated to the RN that resident #001 had come into their room while they were sleeping. Resident #002 was crying and stated to the RN that they did not feel safe in the home. The Social Worker met with resident #002 and confirmed the resident was teary, anxious, looked drowsy and stated that they continued to not feel safe in the home. The resident was documented to have told another staff member about the incident. The Administrator documented that resident #002 was able to recall the incident of inappropriate touching that had occurred earlier that morning and a Critical Incident report was submitted to the Ministry of Health and Long Term Care.

In 2015, resident #002 was observed to become visibly upset when they talked about the allegation of a non-consensual touch that was reported. Resident #002 told the Inspector that resident #001 had frequently went into other residents' rooms and into their room a number of times prior to this incident. On previous occasions the resident had told resident #001 to get out and they would leave. The resident stated they had been been touched without consent and was fearful it may happen again.

Interview with PSW #20 confirmed they had worked the evening of the allegation. PSW #20 stated resident #001 often went in and out of residents' rooms and they redirected the resident. PSW #20 stated on the night of the allegation the resident had been awake most of the night and had wandered in and out of residents' rooms. The PSW stated they had reported two incidents. During the first incident resident #001 had entered another resident's room and was found clothed, laying on resident #006. The staff member further stated that during the second incident they went into resident # 007's room. Resident #007 was identified as cognitively impaired and had minimal ability to vocalize or

move about in bed. PSW #20 stated the resident normally had slept through the night but on this occasion, resident #007 was awake with their eyes open and was described as having looked "distressed" like they were upset. Their bed clothing was lifted, exposing the right side of their body closest to the door. The PSW stated they felt this was odd because they had left the resident covered up in bed with their bed clothing pulled down and blankets pulled up.
Documentation provided, by the RN to the doctor, indicated resident #001 was in the room of resident #007 unsupervised during the time that their body was exposed. PSW #20 stated they asked the resident if someone had been in their room and they had nodded. PSW #20 further confirmed that they observed resident #001 leaving the hallway, where resident #002's room was located, around the time resident #002 was found crying.
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Interview with the DOC confirmed resident # 001 was admitted to the long term care home in 2014 with cognitive impairment and a risk of wandering. The DOC stated the resident had a history of behaviours in the home. The DOC confirmed the licensee had prior knowledge the resident wandered into other resident rooms, unsupervised, in the late evening and early morning when co-residents were sleeping. The DOC confirmed the licensee had knowledge of the risks that resident #001 posed to residents of the home, including residents #002, #006, and #007. The DOC confirmed the licensee had not implemented any interventions or strategies to protect other residents, including resident #002, when they became aware of the incidents involving residents' #006 and #007.
The licensee failed to ensure that the long-term care home protected resident #002 from abuse. (511)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 29, 2016

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

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.

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 27th day of January, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Robin Mackie

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