Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 23, 2018	2018_587129_0004	005912-17, 009123-17, 011218-17, 011521-17, 011618-17, 012762-17, 017547-17, 021290-17, 022840-17, 003845-18	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

PHYLLIS HILTZ-BONTJE (129), KELLY CHUCKRY (611)

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): February 21, 22, 23, 26, 27, 28, March 2, 6, 7, 8, 12, 13 and 14, 2018.

The following Critical Incident System (CIS) intakes were inspected during this Critical Incident Inspection related to falls: Log #005912-17 (CIS 2741-000006-17),

#022840-17 (CIS 2741-000035-17) and #003845-18 (CIS 2741-000003-18).

The following CIS intakes were inspected during this Critical Incident Inspection related to alleged abuse: Log #011218-17 (CIS 2741-000016-17) and #011521-17 (CIS 2741-000017-17).

The following CIS intakes were inspected during this Critical Incident Inspection related to alleged abuse/management of responsive behaviour: Log #021290-17 (CIS 2741-000032-17), #009123-17 (CIS 2741-000014-17), #017547-17 (CIS 2741-000028-17), #012762-17 (CIS 2741-000020-17), and #011618-17 (CIS 2741-000018-17).

The following on-site Inquiries were completed during this Critical Incident Inspection:
Log #012302-17, related to provision of basic care.
Log #025105-17 and #021718-17, related to staff/resident interactions.
Log #020597-17, #220407-17 and #028300-17, related to medication administration and resident death.
Log #014863-17, #027537-17, #020931-17, #028495-17 and #021668-17, related to falls.
Log #024523-17, related to resident care and staffing.
Log #013138-17, #026438-17 and #028296-17, related to resident records and visitation.

Follow-up Inspection #015187-17 related to a previously issued Compliance Order under The Long-Term Care Homes Act 2007, c, 8, s. 19(1) was conducted concurrently with this Critical Incident Inspection and non-compliance related to the identified requirement has been issued on this Critical Incident Inspection report.

During the course of the inspection, the inspector(s) spoke with residents, resident's family members, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Physiotherapist, Social Worker, Director of Resident Care, Assistant Administrator, Administrator, Maintenance Manager and Housekeeping staff.

During the course of this inspection resident care was observed, resident clinical records were reviewed, incident investigative notes maintained by the home were reviewed, education/training records were reviewed, licensee's policies related to

Falls, Prevention of Abuse and Neglect as well as Responsive Behaviours were reviewed and a tour of the home was completed.

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

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

- **4 WN(s)**
- **3 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 failed to protect resident #022 from abuse by resident #026.

In accordance with O. Reg. 79/10, s. 2(1) abuse means, "the use of physical force by a resident that causes physical injury to another resident".

Resident #022 was abused by resident #026.
The Director of Care (DOC), a Critical Incident Report (CIR) submitted to the Director and a review of clinical documentation confirmed that on an identified date in 2017, resident #022 was noted to demonstrate a responsive behaviour in the vicinity of resident #026. Resident #026 became upset and in response, demonstrated a responsive behaviour that resulted in resident #022 sustaining and injury. Resident #022 was transferred to hospital for further assessment and then returned to the home.

The licensee failed to protect resident #022 from abuse, when:
a) Staff did not assess the potential risks to resident #022, when; on an identified date in 2017 they documented in resident #022's plan of care that the resident demonstrated a type of responsive behaviour that may result in altercations between residents. The DOC, Registered Practical Nurse (RPN) #115 and a review of clinical documentation confirmed that no assessment of the risks posed to resident #022 while demonstrating the identified responsive behaviour had been completed.

b) Staff did not identify and implement interventions to manage a risk posed by resident #026 that had been identified and documented in the resident's plan of care on an identified date in 2016. The DOC and a review of resident #026's plan of care indicated that on an identified date in 2016, staff documented that a behaviour demonstrated by co-residents may trigger resident #026 to demonstrate responsive behaviours. Resident #026's plan of care also indicated the resident had experienced a change in cognitive status that may result in altercations between co-residents. The DOC, RPN #115 and a review of clinical documentation confirmed that no interventions had been identified or implemented to manage the risk of altercations between residents, when co-residents demonstrated a responsive behaviour that may trigger resident #026 to demonstrate responsive behaviours in return.

c) Staff failed to comply with the licensee's policy, "Responsive Behaviour Policy", identified as section R.5, with an effective date of May 2017. The policy directed "to meet the needs of residents with responsive behaviours, there will be written approaches to care whether they address cognitive, physical, emotional, social, environmental factors which will include screening protocols, assessments, reassessments and identification of behavioural triggers" and "the prevention, minimizing of responsive behaviours will have written strategies including techniques and interventions that are integrated into the care

delivery to the resident".
Staff failed to comply with the above noted direction when they did not assess the potential risk to resident #022 when the resident demonstrated a responsive behaviour and they failed to implement interventions when they identified that resident #026 may be triggered to demonstrate responsive behaviours in response to co-residents who demonstrated the identified responsive behaviour. The DOC, RPN #115 and a review of clinical documentation confirmed that no interventions had been identified or implemented, either prior to or following, the incident between resident #022 and resident #025 on the identified date in 2017.

2. The licensee failed to protect resident #031 from abuse by resident #032.

In accordance with O. Reg. 79/10, s. 2 (1), abuse means, “any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member”.

Resident #031 was abused by resident #032.

The DOC, the Physiotherapist (PT), a CIR submitted to the Director and a review of clinical documentation indicated that on an identified date in 2017, resident #031 and resident #032 were sitting in the hallway of the home area. The PT became concerned that something was not right and approached the residents. The PT confirmed that when they approached the residents, resident #032 was seen demonstrate two responsive behaviours towards resident #031. The residents were separated and staff were contacted.
During an interview, the PT said that based on their knowledge of resident #031 and their interaction with this resident, it was their opinion that resident #031 would not have been able to consent to the actions taken by resident #032. During the same interview, the PT said that when the residents were separated resident #031 made a comment that lead them to believe that resident #031 had not consented to the actions taken by resident #032.
During an interview, Personal Support Worker (PSW) #119 and PSW #118 said that based on their knowledge and interactions with resident #031, they believed that resident #031 would not have been able to make a decision regarding how to respond to the actions of resident #032.
During an interview, PSW #119 confirmed that they were in attendance at the time of the above noted incident and immediately following the incident took resident #031 to their room, where the resident made a comment that indicated the resident did not know what

to do about the situation.
Staff #118 and staff #119 confirmed that the responsive behaviour demonstrated by resident #032 were known by staff and they noted that the behaviour had escalated. Resident #032's clinical record confirmed there were documented incidents of these behaviours.

The licensee failed to protect resident #031 from abuse, when:
a) Staff did not ensure that behavioural triggers were identified or strategies were developed and implemented to manage the responsive behaviours demonstrated by resident #032. The DOC and a review of clinical documentation confirmed that the identified behaviours demonstrated by resident #032 were first added to the resident's plan of care in early 2017; however, staff had not attempted an assessment of the behaviour in order to identify possible triggers or implemented care interventions to manage the behaviours. Staff did not assess the potential risk to co-residents when resident #032 demonstrated the identified behaviours.

b) Staff failed to comply with the licensee's policy, "Responsive Behaviour Policy", identified as section R.5, with an effective date of May 2017. The policy directed "to meet the needs of residents with responsive behaviours, there will be written approaches to care whether they address cognitive, physical, emotional, social, environmental factors which will include screening protocols, assessments, reassessments and identification of behavioural triggers" and "the prevention, minimizing of responsive behaviours will have written strategies including techniques and interventions that are integrated into the care delivery to the resident".

Staff failed to comply with the above noted direction when they did not assess the identified responsive behaviours demonstrated by resident #032, they did not assess the risk to co-resident related to those behaviours and they did not identify interventions to manage the responsive behaviours demonstrated by this resident. The DOC confirmed that the licensee's policy had not been complied with related to the management of responsive behaviours demonstrated by resident #032.

3. The licensee failed to protect resident #033 from abuse by resident #034.

In accordance with O. Reg. 79/10, s. 2 (1), abuse means, "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member".

Resident #033 was abused by resident #034.
The DOC, a CIR submitted to the Director and a review of clinical documentation confirmed that on an identified date in 2017, a PSW noted resident #033's room door closed. The PSW entered the room and they observed resident #034 to demonstrate a responsive behaviour towards resident #033. The PSW separated the residents and called for assistance. When the PSW re-entered they noted the appearance of the residents and that resident #033 appeared to have sustained an injury.
During an interview Registered Nurse (RN) #122 said that they responded immediately to the PSW's call for assistance and verified the appearance of the residents and the injury observed to resident #033.
During interviews both RPN #105 and PSW #121 who were familiar with, and provided care to resident #033, confirmed that based on their knowledge of the resident and the resident's plan of care resident #033 would not have been able to understand, consent to or respond to the actions of resident #034.

The licensee failed to protect resident #033 from abuse, when:
a) Staff did not ensure that behavioural triggers were identified or strategies were developed and implemented to manage the responsive behaviours demonstrated by resident #034. The DOC and a review of clinical documentation indicated that the identified behaviours were demonstrated by the resident and documented in the resident's clinical record.
Over the course of two days, staff documented in resident #034's clinical record that the resident demonstrated nine related responsive behaviours.
Clinical documentation indicated that staff from Behavioural Support Ontario (BSO) were involved in the ongoing assessment of resident #034 but had not been informed by staff of the identified related responsive behaviours demonstrated by the resident. As a result clinical notes made by BSO staff did not consider triggers for the identified behaviours or interventions to manage those behaviours.
RN #122 confirmed that they were in attendance at the time of the incident on the identified date in 2017, acknowledged they were aware resident #034 had demonstrated the identified responsive behaviour and was unable to explain why the identified responsive behaviours had not been assessed or interventions put in place to manage the behaviour prior to the incident involving resident #033.
The DOC and clinical documentation confirmed that the above noted behaviours had not been assessed and interventions for care had not been included in resident #034's plan of care until after the incident involving resident #033.

b) Staff failed to comply with the licensee's policy, "Responsive Behaviour Policy", identified as section R.5, with an effective date of May 2017. The policy directed "to meet the needs of residents with responsive behaviours, there will be written approaches to care whether they address cognitive, physical, emotional, social, environmental factors which will include screening protocols, assessments, reassessments and identification of behavioural triggers" and "the prevention, minimizing of responsive behaviours will have written strategies including techniques and interventions that are integrated into the care delivery to the resident".

Staff failed to comply with the above noted direction when they did not assess the responsive behaviours demonstrated by resident #034, they did not assess the risk to co-resident related to those behaviours and they did not identify interventions to manage the responsive behaviours demonstrated by this resident. The DOC confirmed that the licensee's policy had not been complied with related to the management of responsive behaviours demonstrated by resident #034.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Staff failed to comply with the licensee's "Abuse-Prevention, Elimination and Reporting Policy", located in the Administration and Nursing Manual, with an effective date of May 2017.

The Director of Care (DOC) provided the above noted policy from the computerized policy manual and verified that it was the policy in place in the home related to the promotion of zero tolerance of abuse and neglect of residents.

a) The above noted policy directed that "a staff member receiving the initial report shall initiate the Investigation of Allegations of Abuse form".

i) During an interview the DOC confirmed that following an incident of abuse of resident #022 by resident #026, that resulted in resident #022 sustaining an injury on an identified date in 2017, staff had not initiated the Investigation of Allegations of Abuse form.
ii) During an interview the DOC confirmed that following an allegation that resident #031 had been abused by resident #032 on an identified date in 2017, staff had not initiated the Investigation of Allegations of Abuse form.

b) The above noted policy directed that "The Administrator/Director of Care or Nursing/delegate will ensure that the resident's representative/POA/Substitute Decision Maker is informed of the incident immediately and of the status of the investigation. Ideally, a Family Conference will be scheduled as soon as possible following the incident. Time and date of the contact will be noted in the resident chart(s)".

During an interview the DOC confirmed that resident #031's family was not contacted regarding a Family Conference and there was no documentation of the time and date to indicate the resident's Substitute Decision Maker (SDM) was notified of the incident of abuse that occurred on an identified date in 2017. The DOC, staff who provided cared to resident #031 and the resident's computerized record confirmed that the resident had a designated SDM.

The DOC and records maintained by the home confirmed that staff did not comply with the licensee's policy identified as "Abuse-Prevention, Elimination and Reporting Policy". [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 and ensure that 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, where possible and strategies are developed and implemented to respond to those behaviours, where possible.

a) Staff did not attempt to identify possible triggers for identified responsive behaviours demonstrated by resident #034 or implement interventions to manage the behaviour.

A review of clinical documentation indicated:

Registered staff made clinical notes over a two day period in 2017, that indicated

resident #034 demonstrated the identified behaviours nine times.

A review of resident #034's plan of care confirmed that there were no care interventions put in place to monitor the resident, no action had been taken to identify potential triggers for the behaviours and no strategies had been developed or implemented to respond to the demonstrated behaviours.

During an interview registered staff #122 said that staff were aware of resident #034's behaviours. They confirmed that there had not been an attempt to identify potential triggers for the behaviours or to develop or implement strategies to respond to the behaviour.

Staff failed to identify potential triggers for the responsive behaviour demonstrated by resident #034 and did not develop or implement strategies to respond to the demonstrated behaviour. [s. 53. (4)]

2. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, the behavioural triggers for the resident were identified, where possible.

Staff did not to attempt to identify possible behavioural triggers when resident #032 demonstrated identified responsive behaviours.

A review of resident #032's clinical record indicated:

Over a ten month period of time in 2017, staff had made clinical notes that indicated resident #032 demonstrated identified responsive behaviours seven times. Following initial documented of the identified responsive behaviours staff initiated a care focus in the resident's plan of care that identified the responsive behaviours and a care intervention that directed that staff to "determine what triggered/lead up to the behaviour".

A review of resident #032's plan of care, at the time of this inspection, indicated that there continued to be a care focus related to the identified responsive behaviours and a direction to "determine what triggered/lead up to the behaviour"; however, there were no potential behavioural triggers identified in the resident's plan of care.

During interviews, staff #118 and staff #119 said that resident #032 was known by staff to demonstrate the identified behaviours.

During an interview the DOC acknowledged that the home did not have a process in place for attempting to determine behavioural triggers for residents and that there had not been an attempt to identify potential behavioural triggers for behaviours demonstrated by resident #032.

Staff failed to attempt to identify behavioural triggers for the responsive behaviours demonstrated by resident #032. [s. 53. (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 and ensure that, for each resident demonstrating responsive behaviours, the behavioural triggers for the resident were identified, where possible and strategies were developed and implemented to respond to those behaviours, where possible, to be implemented voluntarily.

WN #4: 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: identifying factors based on an interdisciplinary assessment as well as identifying and implementing interventions to minimize the risk of altercations.

On an identified date in 2017 resident #026 engaged in an altercation with resident #022 which resulted in resident #022 sustaining an injury, for which they were transferred to hospital for further assessment.

The DOC, a Critical Incident Report (CIR) submitted to the Director and a review of clinical documentation confirmed that on the identified date in 2017, resident #022 was noted to demonstrate an identified responsive behaviour in the vicinity of resident #026. Resident #026 became upset when they noted resident #022 to demonstrate this behaviour and demonstrated an identified responsive behaviour in return, which resulting in resident #022 sustaining an injury.

a) Resident #022's plan of care indicated that the resident demonstrated the identified responsive behaviour. The DOC, RPN #115 and a review of clinical documentation confirmed that no assessment of the risks posed to resident #022 while demonstrating the responsive behaviour had been completed.

b) Resident #026's plan of care indicated that the resident demonstrated a responsive behaviour that could be triggered by the behaviour of co-residents and may pose a risk to those residents. The DOC, RPN #115 and a review of clinical documentation confirmed that no interventions had been identified or implemented when staff became aware resident #026 was a risk to other residents who demonstrated an identified responsive behaviour.

Staff in the home failed to take steps to minimize the risk of an altercation between resident #022 who demonstrated an identified responsive behaviour and resident #026 whose responsive behaviours could be triggered by the responsive behaviour demonstrated by resident #022.

Following the altercation between resident #022 and resident #026 on the identified date in 2017, staff in the home failed to take steps to minimize the risk to other residents who were also were known to demonstrate the identified responsive behaviour that may trigger resident #026 to demonstrate a responsive behaviour in return. [s. 54.]

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 and ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including: identifying factors based on an interdisciplinary assessment as well as identifying and implementing interventions to minimize the risk of altercations, to be implemented voluntarily.

Issued on this 16th day of May, 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

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

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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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PHYLLIS HILTZ-BONTJE (129), KELLY CHUCKRY (611)
Inspection No. / No de l'inspection :	2018_587129_0004
Log No. / No de registre :	005912-17, 009123-17, 011218-17, 011521-17, 011618-17, 012762-17, 017547-17, 021290-17, 022840-17, 003845-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 23, 2018
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 :	Janet West

To Grace Villa Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

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

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 shall ensure that:

A written plan for achieving compliance and ensuring that resident #022, resident #031, resident #033, and all other residents, are protected from abuse by co-residents who demonstrate responsive behaviours; is prepared, submitted and implemented.

The plan is to include, but not limited to:

1. The develop and implement a responsive behaviour assess that includes the identification of possible triggers for the behaviours demonstrated and the identification of the potential risks posed to co-resident when resident #026, resident #032 and any other resident demonstrates responsive behaviours.

2. A schedule for the implementation of the above noted assessment and tools for resident #026, resident #032 and all other residents demonstrating responsive behaviours.

4. A schedule for the provision of face to face training for all staff who provide direct care to resident #026 and resident #032 that includes;
-What constitutes a responsive behaviour,
-How the above noted assessment and tools are to be utilized, and
-The expectations for the development and the evaluation of the effectiveness of plans of care related to the management of responsive behaviours.
Documentation of the above noted training is to be maintained by the home.

5. A schedule for the implementation of on-going quality monitoring activities related to the completion of the above noted assessment and tools, the development and evaluation of the plans of care to respond to the needs of residents who demonstrate responsive behaviours and staffs compliance with the licensee's policy related to the management of responsive behaviours.

Please submit the written plan for achieving compliance for inspection 2018_587129_0005 to Phyllis Hiltz-Bontje, LTC Homes Inspector, MOHLTC, by email to HamiltonSAO.moh@ontario.ca by May 7, 2018.
Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to comply with the following compliance order CO #001 from inspection #2017_569508_0007 (A2) served on July 12, 2017, with a compliance date of August 31, 2017.

The licensee was ordered to:
1) ensure that all residents are protected from abuse, including resident #034, #041 and #036,
2) ensure that all residents who exhibit responsive behaviours of physical aggression or who have potential to harm co-residents have interventions in place to minimize the risk of abuse towards co-residents,
3) develop and implement a plan to ensure that these interventions are reviewed at least quarterly and after any near miss or actual incident of resident to resident abuse to ensure the effectiveness of these interventions.

2. The licensee failed to protect resident #022 from abuse by resident #026.

In accordance with O. Reg. 79/10, s. 2(1) abuse means, "the use of physical force by a resident that causes physical injury to another resident".

Resident #022 was abused by resident #026.
The Director of Care (DOC), a Critical Incident Report (CIR) submitted to the Director and a review of clinical documentation confirmed that on an identified date in 2017, resident #022 was noted to demonstrate a responsive behaviour in the vicinity of resident #026. Resident #026 became upset and in response, demonstrated a responsive behaviour that resulted in resident #022 sustaining and injury. Resident #022 was transferred to hospital for further assessment and then returned to the home.

The licensee failed to protect resident #022 from abuse, when:
a) Staff did not assess the potential risks to resident #022, when; on an identified date in 2017 they documented in resident #022's plan of care that the resident demonstrated a type of responsive behaviour that may result in altercations between residents. The DOC, Registered Practical Nurse (RPN) #115 and a review of clinical documentation confirmed that no assessment of the risks posed to resident #022 while demonstrating the identified responsive behaviour had been completed.

b) Staff did not identify and implement interventions to manage a risk posed by resident #026 that had been identified and documented in the resident's plan of care on an identified date in 2016. The DOC and a review of resident #026's plan of care indicated that on an identified date in 2016, staff documented that a behaviour demonstrated by co-residents may trigger resident #026 to demonstrate responsive behaviours. Resident #026's plan of care also indicated the resident had experienced a change in cognitive status that may result in altercations between co-residents. The DOC, RPN #115 and a review of clinical documentation confirmed that no interventions had been identified or implemented to manage the risk of altercations between residents, when co-residents demonstrated a responsive behaviour that may trigger resident #026 to demonstrate responsive behaviours in return.

c) Staff failed to comply with the licensee's policy, "Responsive Behaviour Policy", identified as section R.5, with an effective date of May 2017. The policy directed "to meet the needs of residents with responsive behaviours, there will be written approaches to care whether they address cognitive, physical, emotional, social, environmental factors which will include screening protocols, assessments, reassessments and identification of behavioural triggers" and "the prevention, minimizing of responsive behaviours will have written strategies including techniques and interventions that are integrated into the care delivery to the resident".
Staff failed to comply with the above noted direction when they did not assess the potential risk to resident #022 when the resident demonstrated a responsive behaviour and they failed to implement interventions when they identified that resident #026 may be triggered to demonstrate responsive behaviours in response to co-residents who demonstrated the identified responsive behaviour. The DOC, RPN #115 and a review of clinical documentation confirmed that no interventions had been identified or implemented, either prior to or following, the incident between resident #022 and resident #025 on the identified date in 2017.

3. The licensee failed to protect resident #031 from abuse by resident #032.

In accordance with O. Reg. 79/10, s. 2 (1), abuse means, "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member".

Resident #031 was abused by resident #032.

The DOC, the Physiotherapist (PT), a CIR submitted to the Director and a review of clinical documentation indicated that on an identified date in 2017, resident #031 and resident #032 were sitting in the hallway of the home area. The PT became concerned that something was not right and approached the residents.The PT confirmed that when they approached the residents, resident #032 was seen demonstrate two responsive behaviours towards resident #031. The residents were separated and staff were contacted.
During an interview, the PT said that based on their knowledge of resident #031 and their interaction with this resident, it was their opinion that resident #031 would not have been able to consent to the actions taken by resident #032.
During the same interview, the PT said that when the residents were separated resident #031 made a comment that lead them to believe that resident #031 had not consented to the actions taken by resident #032.
During an interview, Personal Support Worker (PSW) #119 and PSW #118 said that based on their knowledge and interactions with resident #031, they believed that resident #031 would not have been able to make a decision regarding how to respond to the actions of resident #032.
During an interview, PSW #119 confirmed that they were in attendance at the time of the above noted incident and immediately following the incident took resident #031 to their room, where the resident made a comment that indicated the resident did not know what to do about the situation.
Staff #118 and staff #119 confirmed that the responsive behaviour demonstrated by resident #032 were known by staff and they noted that the behaviour had escalated. Resident #032's clinical record confirmed there were documented incidents of these behaviours.

The licensee failed to protect resident #031 from abuse, when:
a) Staff did not ensure that behavioural triggers were identified or strategies were developed and implemented to manage the responsive behaviours demonstrated by resident #032. The DOC and a review of clinical documentation confirmed that the identified behaviours demonstrated by resident #032 were first added to the resident's plan of care in early 2017; however, staff had not attempted an assessment of the behaviour in order to identify possible triggers or implemented care interventions to manage the behaviours. Staff did not assess the potential risk to co-residents when resident #032 demonstrated the identified behaviours.

b) Staff failed to comply with the licensee's policy, "Responsive Behaviour Policy", identified as section R.5, with an effective date of May 2017. The policy

directed "to meet the needs of residents with responsive behaviours, there will be written approaches to care whether they address cognitive, physical, emotional, social, environmental factors which will include screening protocols, assessments, reassessments and identification of behavioural triggers" and "the prevention, minimizing of responsive behaviours will have written strategies including techniques and interventions that are integrated into the care delivery to the resident".

Staff failed to comply with the above noted direction when they did not assess the identified responsive behaviours demonstrated by resident #032, they did not assess the risk to co-resident related to those behaviours and they did not identify interventions to manage the responsive behaviours demonstrated by this resident. The DOC confirmed that the licensee's policy had not been complied with related to the management of responsive behaviours demonstrated by resident #032.

4. The licensee failed to protect resident #033 from abuse by resident #034.

In accordance with O. Reg. 79/10, s. 2 (1), abuse means, "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member".

Resident #033 was abused by resident #034.
The DOC, a CIR submitted to the Director and a review of clinical documentation confirmed that on an identified date in 2017, a PSW noted resident #033's room door closed. The PSW entered the room and they observed resident #034 to demonstrate a responsive behaviour towards resident #033. The PSW separated the residents and called for assistance. When the PSW re-entered they noted the appearance of the residents and that resident #033 appeared to have sustained an injury.
During an interview Registered Nurse (RN) #122 said that they responded immediately to the PSW's call for assistance and verified the appearance of the residents and the injury observed to resident #033.
During interviews both RPN #105 and PSW #121 who were familiar with, and provided care to resident #033, confirmed that based on their knowledge of the resident and the resident's plan of care resident #033 would not have been able to understand, consent to or respond to the actions of resident #034.

The licensee failed to protect resident #033 from abuse, when:
a) Staff did not ensure that behavioural triggers were identified or strategies were developed and implemented to manage the responsive behaviours demonstrated by resident #034. The DOC and a review of clinical documentation indicated that the identified behaviours were demonstrated by the resident and documented in the resident's clinical record.
Over the course of two days, staff documented in resident #034's clinical record that the resident demonstrated nine related responsive behaviours.
Clinical documentation indicated that staff from Behavioural Support Ontario (BSO) were involved in the ongoing assessment of resident #034 but had not been informed by staff of the identified related responsive behaviours demonstrated by the resident. As a result clinical notes made by BSO staff did not consider triggers for the identified behaviours or interventions to manage those behaviours.
RN #122 confirmed that they were in attendance at the time of the incident on the identified date in 2017, acknowledged they were aware resident #034 had demonstrated the identified responsive behaviour and was unable to explain why the identified responsive behaviours had not been assessed or interventions put in place to manage the behaviour prior to the incident involving resident #033.
The DOC and clinical documentation confirmed that the above noted behaviours had not been assessed and interventions for care had not been included in resident #034's plan of care until after the incident involving resident #033.

b) Staff failed to comply with the licensee's policy, "Responsive Behaviour Policy", identified as section R.5, with an effective date of May 2017. The policy directed "to meet the needs of residents with responsive behaviours, there will be written approaches to care whether they address cognitive, physical, emotional, social, environmental factors which will include screening protocols, assessments, reassessments and identification of behavioural triggers" and "the prevention, minimizing of responsive behaviours will have written strategies including techniques and interventions that are integrated into the care delivery to the resident".

Staff failed to comply with the above noted direction when they did not assess the responsive behaviours demonstrated by resident #034, they did not assess the risk to co-resident related to those behaviours and they did not identify interventions to manage the responsive behaviours demonstrated by this resident. The DOC confirmed that the licensee's policy had not been complied

with related to the management of responsive behaviours demonstrated by resident #034.

5. The severity of this issue was determined to be a level 3 as there was actual harm to a resident. The scope of the issue was a level 2 as it related to three of seven residents reviewed. The home had a level 4 history of on-going non-compliance with this section of the Act that included:
- Compliance Order (CO) served January 27, 2016.
- Compliance Order (CO) served July 9, 2017.

(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 28, 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 23rd day of April, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE

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