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 # / Registre no	Type of Inspection / Genre d'inspection
Jun 9, 2016	2016_267528_0011	009198-16	Critical Incident System

Licensee/Titulaire de permis

CITY OF HAMILTON
77 James Street North, Suite 400 HAMILTON ON L8R 2K3

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

MACASSA LODGE
701 UPPER SHERMAN AVENUE HAMILTON ON L8V 3M7

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

CYNTHIA DITOMASSO (528)

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): June 7, 2016

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Director of Building Services, Nurse Managers, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), housekeeping staff, and residents.

During the course of the inspection, the inspector also observed the provision of care and reviewed documents including but not limited to, clinical health records, policies and procedures, staff schedules, investigation reports, and training records.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 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	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. 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 there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with.

The home's policy "Prevention of Abuse and Neglect - Policy to Promote Zero Tolerance", last revised December 2015, identified that "the MOHLTC will be notified immediately either via CIS report during regular business hours or by calling the after-hours pager"

On two identified days in March 2016, staff #101 and #105 overheard PSW #104 talking in a loud and hard tone to two residents. Staff did not report the allegations of mistreatment immediately as required in the home's policy. Review of the home's investigation notes confirmed that both staff did not report the allegations of resident mistreatment to the Director of Building Services until several days after the incidents. Interview with staff #101 and #105 confirmed they did not report the allegations of mistreatment immediately and instead waited until their direct manager returned to work. Interview with the DOC confirmed that the staff did not report the allegations immediately as required in the home's policy, and therefore, the Director was not notified immediately. [s. 20. (1)]

WN #2: 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 filed to ensure that for each resident demonstrating responsive behaviours strategies were developed and implemented to respond to these behaviours, where possible.

On an identified day in March 2016, PSW #104 assisted resident #001 with removing their shirt. When the resident refused, the PSW continued to remove the resident's shirt. During the altercation both the PSW and resident were overheard speaking to each other in a loud and harsh manner.
i. Review of the plan of care identified that in November 2015, the Minimum Data Set (MDS) for resident #001 coded the resident as having responsive behaviours. Interventions included medication as needed; and in November 2015, the Resident Assessment Protocol (RAPS) directed staff to learn the resident's preferences for care.
ii. Interview with PSW #104 RPN#103 and RN #100 confirmed that the resident was able to accept and refuse treatment or care and did so regularly. Interview with NM # 107 confirmed that staff are to leave a resident who is refusing care and in March 2016, PSW #104 did not implement strategies to respond to responsive behaviours for resident #001. [s. 53. (4) (b)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that staff received training on the home policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities.

Approximately one month after housekeeping staff #105 began working at the home they overheard PSW staff #104 talking in an inappropriate tone with resident #001. Review of the home's investigation notes confirmed that housekeeping staff #105 waited two days to report the incident to their direct manager. Interview with housekeeping staff #105 identified that at the time of the incident, they did not know what to do, as they had not received formal training on prevention of abuse. Interview with the Director of Building Services confirmed that housekeeping staff #105 was performing their responsibilities prior to receiving mandatory training in May 2016, including but not limited to, the home's policy to promote zero tolerance of abuse and neglect of residents. [s. 76. (2) 3.]

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Issued on this 13th day of June, 2016

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

Original report signed by the inspector.