Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 1, 2019	2019_803748_0004	011505-19, 012252-19, 013401-19	Critical Incident System

Licensee/Titulaire de permis

Maryban Holdings Ltd.
3700 Billings Court BURLINGTON ON L7N 3N6

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

Oakwood Park Lodge
6747 Oakwood Drive NIAGARA FALLS ON L2G 0J3

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

EMMY HARTMANN (748)

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): July 9, 10, 11, 12, 15, 16, 18, 19, 2019

This following intakes were completed in this Critical Incident Inspection:

Log #012252-19, CIS #2661-000011-19, was related to resident to resident physical abuse.
Log #011505-19, CIS #2661-000010-19, was related to resident to resident physical altercation.
Log #013401-19, CIS #2661-000012-19, was related to resident to resident responsive behaviour.

This inspection was completed concurrently with Complaint Inspection #2019_543561_0018, for which inspector #561 was also present.

Findings of non-compliance identified during this Critical Incident Inspection related to Ontario Regulation 79/10, s.30 (2) can be found in Complaint Inspection report #2019_543561_0018.

During the course of the inspection, the inspector(s) spoke with residents, the Administrator, Director of Care (DOC), Assistant Director of Care(ADOC), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), Nursing Administrative Assistant, and Housekeepers.

During the course of the inspection, the inspector also observed the provision of care and services, and reviewed records, audits, and 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.

5 WN(s)
2 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

During the course of this inspection, Administrative Monetary Penalties (AMP) were not issued.

0 AMP(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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

WN #1: 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 home failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could have potentially triggered such altercations.

A: Critical Incident System (CIS) #2661-000011-19, log #012252-19, submitted to the Director in June 2019, described an altercation between resident #001 and resident #002. The CIS indicated that resident #002 sustained an injury, as a result of the incident.

During an interview with PSW #107, it was identified that they witnessed the incident between the two residents, and that there were previous concerns related to resident #001, which had been reported to management.

During an interview with PSW #111, they identified triggers to resident #001's behaviours.

A review of resident #001's clinical records with RN #105, identified that the triggers were not included in the resident's plan of care, prior to, and after the incident.

During an interview with DOC #102, they identified that the home had a process for the monitoring of residents with responsive behaviours. They indicated that monitoring was done through the home's Responsive Behaviour team that met every two weeks, and

residents with responsive behaviours were reviewed at the meeting, including identification of triggers to their behaviours. DOC #102 identified that resident #001 had responsive behaviours, and that there were triggers to their behaviours. The responsive behaviour meeting notes were reviewed with DOC #102, and it was identified that resident #001 was not discussed at the meetings. DOC #102 acknowledged that an update to resident #001's care plan to include the potential triggers for altercations between resident #001 and other residents, should have been completed as a step to minimize the risk of altercations.

The home failed to ensure that steps were taken to minimize the risk of altercations for resident #001, by identifying factors based on an interdisciplinary assessment, that could potentially trigger an altercation with other residents.

B. CIS #2661-000010-19, log #011505-19, submitted to the Director in June 2019, described an altercation between resident #001 and resident #006, which resulted in an injury to resident #001.

A review of resident #001's progress notes, documented on an identified date and time, indicated that resident #001 and resident #006 were involved in an altercation, where resident #001 sustained an injury.

During an interview with RN #121, they indicated that they were the charge nurse on duty when the incident between residents #001 and #006 took place. They indicated that they separated the residents, talked to them, assessed them for injuries, and called the police and management. RN #121 identified that resident #001 acquired an injury, as a result of the incident, and identified a trigger to resident #006's behaviour related to the incident.

A review of resident #006's clinical records, identified that the trigger to the incident was not included in the resident's plan of care.

During an interview with DOC #102, they identified that the home had a process for the monitoring of residents with responsive behaviours. They indicated that monitoring was done through the home's Responsive Behaviour team that met every two weeks, and residents with responsive behaviours were reviewed at the meeting, including identification of triggers to their behaviours. They identified that, after the meeting, they were responsible for passing on interventions for residents to the appropriate people.

The responsive behaviour meeting notes were reviewed with DOC #102, for meetings that took place on identified dates, and it was verified that the trigger to the resident's behaviour related to the incident was not added to the resident's plan of care after the meetings.
DOC #102 acknowledged that an update to resident #006's care plan to include the potential triggers for altercations, should have been completed as a step to minimize the risk of altercations.

The home failed to ensure that steps were taken to minimize the risk of altercations for resident #006, by identifying factors based on an interdisciplinary assessment, that could potentially trigger an altercation with other residents.

C: CIS #2661-000012-19, log #013401-19, submitted to the Director in July 2019, described an altercation between resident #007 and resident #008, where resident #008 sustained an injury as a result of the incident.

During an interview with PSW #120, they identified potential triggers to resident #007's behaviour towards resident #008.

During an interview with RPN #123, they indicated that resident #007 had a history of responsive behaviours, and identified that potential triggers to altercations as per their observation of the resident. RPN #123 identified that they did not add this information to the resident's care plan.

During an interview with DOC #102, they identified that the home had a process for the monitoring of residents with responsive behaviours. They indicated that monitoring was done through the home's Responsive Behaviour team that met every two weeks, and residents with responsive behaviours were reviewed at the meeting, including identification of triggers to their behaviours. They identified that, after the meeting, they were responsible for passing on interventions for residents to the appropriate people.
DOC #102 identified that they were informed by PSW #120 of the potential trigger to resident #007's behaviour towards resident #008. The minutes of meeting for the responsive behaviour team was reviewed with DOC #102, and it was revealed that triggers to resident #007's behaviours related to the incident was not identified.
The DOC acknowledged that there was still a risk for altercations between resident #007 and other residents, as their plan of care was not updated to reflect the triggers to their behaviour.

A review of resident #007's clinical records, did not reflect interventions and instructions to staff on what to do to minimize altercations.

The home failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, by 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. [s. 54. (a)]

Additional Required Actions:

CO # - 002 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. 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 #002, #001, and #008 from abuse.

A: Critical Incident System (CIS) #2661-000011-19, log #012252-19, submitted to the Director in June 2019, described an incident between resident #001 and resident #002. The CIS indicated that resident #002 sustained an injury as a result of the incident.

During an interview with PSW #107, they confirmed that they witnessed the incident between resident #001 and resident #002, which resulted in an injury to resident #002.

During an interview with resident #002, they identified that they sustained an injury after the altercation.

During an interview with DOC #102, it was identified that they saw resident #002, the day after the incident, and they confirmed that the resident was injured as a result of the

incident.

The home failed to protect resident #002 from abuse by resident #001.

B. CIS #2661-000010-19, log #011505-19, submitted to the Director in June 2019, described an altercation between resident #001 and resident #006, which resulted in an injury to resident #001.

During an interview with RN #121, they indicated that they were the charge nurse on duty when the incident between resident #001 and resident #006 took place. They indicated that they separated the residents, talked to them, assessed them for injuries, and called the police and management. RN #121 identified that resident #001 acquired an injury, as a result of the incident.

The home failed to protect resident #001 from abuse by resident #006.

C: CIS #2661-000012-19, log #013401-19, submitted to the Director in July 2019, described an altercation between resident #007 and resident #008. The CIS indicated that resident #008 sustained an injury, as a result of the incident.

The progress notes for resident #008, documented on an identified date and time, indicated that the resident would be placed on special monitoring related to their injury, and that the resident had discomfort and an altered skin integrity.

During an interview with RPN #123, they indicated that they were called to respond to the incident and that they assessed resident #008 after the incident. They confirmed that resident #008 sustained an injury, as a result of the incident.

The home failed to protect resident #008 from abuse by resident #007. [s. 19. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the right of residents to have their personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with the Act, to be fully respected and promoted.

Personal health information (PHI) is defined in the Personal Health Information Protection Act, 2004, s.4(1), as identifying information about an individual in oral or recorded form, if the information,
(a) relates to the physical or mental health of the individual, including information that consists of the health history of the individual's family,
(b) relates to the providing of health care to the individual, including the identification of a person as a provider of health care to the individual,
(c) is a plan of service within the meaning of the Home Care and Community Services Act, 1994 for the individual,
(d) relates to payments or eligibility for health care, or eligibility for coverage for health

care, in respect of the individual,
(e) relates to the donation by the individual of any body part or bodily substance of the individual or is derived from the testing or examination of any such body part or bodily substance,
(f) is the individual's health number, or
(g) identifies an individual's substitute decision-maker.

During an interview with RPN #116, they indicated that an identified document, along with the care plan and Kardex were used to inform staff of a resident's care needs.

During an observation on an identified date, PSW #111 showed the inspector the identified document that was used by the home for resident #009, in their room. The identified document was affixed on the wall above the resident's bed and contained information related to the resident's disease diagnosis.

The inspector also observed the chart racks which were stored just outside of an identified Nursing Station, had a pull down cover and a locking mechanism. However, the rack cover was observed to be open for the chart rack on identified dates, with charts for four residents on top of the chart racks. During the observations, the chart racks were left unattended, when staff had left the area.

Additionally, the inspector observed the Kardex binders that PSWs used to obtain information related to a resident's health, and instructions on how to provide care to residents, were also observed to be left unattended at an identified dining room.

During an interview with RPN #122, they identified that the binders on top of the chart racks were resident's charts that needed to be thinned, and that they were stored on top of the chart racks because they did not fit inside. They indicated that anyone would be able to access the resident records on the binders, when the area was left unattended by staff.

During an interview with RPN #115, they confirmed that the overbed logo form contained PHI of resident #009, and they also acknowledged that anyone would be able to access the resident records on the chart racks, and Kardex binders, when the area was left unattended by staff. They had identified that the chart racks should have been secured, and that the Kardex binders should not have been left at the identified dining room.

The licensee failed to ensure the right of residents to have their personal health

information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with the Act, to be fully respected and promoted. [s. 3. (1) 11. iv.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

Critical Incident System (CIS) #2661-000011-19, log #012252-19, submitted to the Director in June 2019, described an altercation between resident #001 and resident #002.

A review of resident #002's progress notes, documented on an identified date and time, indicated that an altercation occurred between resident #002 and resident #001.

A review of resident #001's progress notes, documented on an identified date and time, revealed that resident #001 had received instructions from DOC #102, related to the activity that took place prior to the incident.

During an interview with PSW #107, it was identified that they witnessed the incident between the two residents, and that there were previous concerns related to resident #001, which had been reported to management. PSW #107 identified that an agreement was made between resident #001 and management, related to the concern.

During an interview with PSW #111, they indicated that they were familiar with resident #001's care needs. They indicated that resident #001 informed them of the incident that took place with resident #002. Resident #001 informed them that there was an agreement with DOC #102, related to the activity prior to the incident,, but that the PSW staff that was working that night did not know of the agreement.

During an interview with RN #116, they identified that staff knew of an agreement or arrangement regarding resident #001 and their activity; however, nothing was in writing.

A review of resident #001's clinical records, identified that there was no mention of the arrangement or agreement between resident #001 and management.

The home failed to ensure that there was a written plan of care for resident #001's activity. [s. 6. (1) (a)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to immediately report the suspicion and the information upon which it is based to the Director, when they had reasonable grounds to suspect that abuse of a resident by anyone, had occurred or may have occurred.
As per Ontario Regulation 79/10, s.2(1), physical abuse is defined as:
(a) the use of physical force by anyone other than a resident that causes physical injury or pain,
(b) administering or withholding a drug for an inappropriate purpose, or
(c) the use of physical force by a resident that causes physical injury to another resident;

Critical Incident System (CIS) #2661-000011-19, log #012252-19, submitted to the Director in June 2019, described an incident that took place on an identified date and

time, where resident #001 had an altercation with resident #002. The CIS indicated that resident #002 sustained an injury, as a result of the incident.

The CIS indicated that the critical incident occurred on an identified date and time, and that the after-hours pager was not contacted to report the incident immediately.

During an interview with PSW #107, they confirmed that they witnessed the incident between resident #001 and resident #002, which resulted in an injury to resident #002.

During an interview with RN #106, they confirmed that they were the charge nurse on duty when the incident between resident's #001 and #002 took place. They indicated that they responded to the incident including interviewing and assessing the residents, speaking with staff that witnessed the incident, and calling the police. They indicated that they did not immediately report the incident to the ministry, and did not call the after-hours pager to report the incident. They identified that they sent an email notification of the incident to DOC #102, and Administrator #101, and that management then completed the reporting of the incident.

During an interview with Administrator #101, they indicated that incidents are reported to the ministry by management, upon notification from staff in the home. They indicated that they were notified late in the evening regarding this incident of abuse, and may have missed reporting it to the ministry through the after-hours pager. They added that if the call was not noted in the CIS report that was submitted the following day, then the immediate reporting was missed.

The licensee failed to immediately report the suspicion and the information upon which it is based to the Director, when they had reasonable grounds to suspect that resident #001 had abused resident #002. [s. 24. (1)]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 30th day of August, 2019

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

Ministry of Health and Long-Term Care

Order(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 sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	EMMY HARTMANN (748)
Inspection No. / No de l'inspection :	2019_803748_0004
Log No. / Registre no:	011505-19, 012252-19, 013401-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 1, 2019
Licensee / Titulaire de permis :	Maryban Holdings Ltd. 3700 Billings Court, BURLINGTON, ON, L7N-3N6
LTC Home / Foyer de SLD :	Oakwood Park Lodge 6747 Oakwood Drive, NIAGARA FALLS, ON, L2G-0J3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Stephen Moran

To Maryban Holdings Ltd., you are hereby required to comply with the following order (s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCHA.

Specifically, the licensee shall ensure that:
1. Resident #001, #002 and all other residents are protected from abuse by anyone.

Grounds / Motifs :

1. The licensee failed to protect residents #002, #001, and #008 from abuse.

A: Critical Incident System (CIS) #2661-000011-19, log #012252-19, submitted to the Director in June 2019, described an incident between resident #001 and resident #002. The CIS indicated that resident #002 sustained an injury as a result of the incident.

During an interview with PSW #107, they confirmed that they witnessed the incident between resident #001 and resident #002, which resulted in an injury to resident #002.

During an interview with resident #002, they identified that they sustained an injury after the altercation.

During an interview with DOC #102, it was identified that they saw resident #002, the day after the incident, and they confirmed that the resident was injured as a result of the incident.

The home failed to protect resident #002 from abuse by resident #001.

B. CIS #2661-000010-19, log #011505-19, submitted to the Director in June 2019, described an altercation between resident #001 and resident #006, which resulted in an injury to resident #001.

During an interview with RN #121, they indicated that they were the charge nurse on duty when the incident between resident #001 and resident #006 took place. They indicated that they separated the residents, talked to them, assessed them for injuries, and called the police and management. RN #121 identified that resident #001 acquired an injury, as a result of the incident.

The home failed to protect resident #001 from abuse by resident #006.

C: CIS #2661-000012-19, log #013401-19, submitted to the Director in July 2019, described an altercation between resident #007 and resident #008. The CIS indicated that resident #008 sustained an injury, as a result of the incident.

The progress notes for resident #008, documented on an identified date and time, indicated that the resident would be placed on special monitoring related to their injury, and that the resident had discomfort and an altered skin integrity.

During an interview with RPN #123, they indicated that they were called to respond to the incident and that they assessed resident #008 after the incident. They confirmed that resident #008 sustained an injury, as a result of the incident.

The home failed to protect resident #008 from abuse by resident #007.

The severity of this issue was determined to be a level 2 as there was minimal harm or minimal risk to the residents. The scope of the issue was a level 3 as it was related to three residents. The scope of the issue was a level 3 as it was related to three residents. The home had a level 3 compliance history with previous non-compliance that included:
-Compliance Order (CO) issued on May 31, 2017 (2017_575214_0006)
-Written Notification (WN) issued on August 31, 2017 (2017_574586_0016)
-Voluntary Plan of Correction (VPN) issed on June 4, 2018

(2018_577611_0009)

(748)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 08, 2019

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee must be compliant with Ontario Regulation 79/10 s.54 (a) of the LTCHA.

Specifically, the licensee shall ensure that:
1. Resident #001, #006, #007, and all other residents exhibiting responsive behaviours have an interdisciplinary assessment completed, to identify potential triggers to altercations.
2. On-going audits are completed to ensure that factors that could potentially trigger altercations are identified for residents exhibiting responsive behaviours. Documentation of the audits, when they were completed, and who participated in the audits, are to be maintained by the home.

Grounds / Motifs :

1. The home failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could have potentially triggered such altercations.

A: Critical Incident System (CIS) #2661-000011-19, log #012252-19, submitted to the Director in June 2019, described an altercation between resident #001

and resident #002. The CIS indicated that resident #002 sustained an injury, as a result of the incident.

During an interview with PSW #107, it was identified that they witnessed the incident between the two residents, and that there were previous concerns related to resident #001, which had been reported to management.

During an interview with PSW #111, they identified triggers to resident #001's behaviours.

A review of resident #001's clinical records with RN #105, identified that the triggers were not included in the resident's plan of care, prior to, and after the incident.

During an interview with DOC #102, they identified that the home had a process for the monitoring of residents with responsive behaviours. They indicated that monitoring was done through the home's Responsive Behaviour team that met every two weeks, and residents with responsive behaviours were reviewed at the meeting, including identification of triggers to their behaviours. DOC #102 identified that resident #001 had responsive behaviours, and that there were triggers to their behaviours. The responsive behaviour meeting notes were reviewed with DOC #102, and it was identified that resident #001 was not discussed at the meetings. DOC #102 acknowledged that an update to resident #001's care plan to include the potential triggers for altercations between resident #001 and other residents, should have been completed as a step to minimize the risk of altercations.

The home failed to ensure that steps were taken to minimize the risk of altercations for resident #001, by identifying factors based on an interdisciplinary assessment, that could potentially trigger an altercation with other residents.

B. CIS #2661-000010-19, log #011505-19, submitted to the Director in June 2019, described an altercation between resident #001 and resident #006, which resulted in an injury to resident #001.

A review of resident #001's progress notes, documented on an identified date and time, indicated that resident #001 and resident #006 were involved in an altercation, where resident #001 sustained an injury.

During an interview with RN #121, they indicated that they were the charge nurse on duty when the incident between residents #001 and #006 took place. They indicated that they separated the residents, talked to them, assessed them for injuries, and called the police and management. RN #121 identified that resident #001 acquired an injury, as a result of the incident, and identified a trigger to resident #006's behaviour related to the incident.

A review of resident #006's clinical records, identified that the trigger to the incident was not included in the resident's plan of care.

During an interview with DOC #102, they identified that the home had a process for the monitoring of residents with responsive behaviours. They indicated that monitoring was done through the home's Responsive Behaviour team that met every two weeks, and residents with responsive behaviours were reviewed at the meeting, including identification of triggers to their behaviours. They identified that, after the meeting, they were responsible for passing on interventions for residents to the appropriate people. The responsive behaviour meeting notes were reviewed with DOC #102, for meetings that took place on identified dates, and it was verified that the trigger to the resident's behaviour related to the incident was not added to the resident's plan of care after the meetings.
DOC #102 acknowledged that an update to resident #006's care plan to include the potential triggers for altercations, should have been completed as a step to minimize the risk of altercations.

The home failed to ensure that steps were taken to minimize the risk of altercations for resident #006, by identifying factors based on an interdisciplinary assessment, that could potentially trigger an altercation with other residents.

C: CIS #2661-000012-19, log #013401-19, submitted to the Director in July 2019, described an altercation between resident #007 and resident #008, where resident #008 sustained an injury as a result of the incident.

During an interview with PSW #120, they identified potential triggers to resident #007's behaviour towards resident #008.

During an interview with RPN #123, they indicated that resident #007 had a

history of responsive behaviours, and identified that potential triggers to altercations as per their observation of the resident. RPN #123 identified that they did not add this information to the resident's care plan.

During an interview with DOC #102, they identified that the home had a process for the monitoring of residents with responsive behaviours. They indicated that monitoring was done through the home's Responsive Behaviour team that met every two weeks, and residents with responsive behaviours were reviewed at the meeting, including identification of triggers to their behaviours. They identified that, after the meeting, they were responsible for passing on interventions for residents to the appropriate people. DOC #102 identified that they were informed by PSW #120 of the potential trigger to resident #007's behaviour towards resident #008. The minutes of meeting for the responsive behaviour team was reviewed with DOC #102, and it was revealed that triggers to resident #007's behaviours related to the incident was not identified. The DOC acknowledged that there was still a risk for altercations between resident #007 and other residents, as their plan of care was not updated to reflect the triggers to their behaviour.

A review of resident #007's clinical records, did not reflect interventions and instructions to staff on what to do to minimize altercations.

The home failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, by 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. [s. 54. (a)]

The severity of this issue was determined to be a level 2 as there was minimal harm or minimal risk to the residents. The scope of the issue was a level 3 as it was related to three residents. The home had a level 2 compliance history with previous non-compliance that was issued to a different subsection.

(748)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 08, 2019

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
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 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 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 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

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 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

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 1st day of August, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Emmy Hartmann

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