Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

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


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
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| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Apr 30, 2014 | 2014_205129_0006 | H-000346-14 | Critical Incident System |

**Licensee/Titulaire de permis**

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

TELFER PLACE
245 GRAND RIVER STREET NORTH, PARIS, ON, N3L-3V8

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

PHYLLIS HILTZ-BONTJE (129)

**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): April 11, 14, and 15, 2014

During the course of the inspection, the inspector(s) spoke with residents, registered and unregulated nursing staff, the Assistant Director of Care, the Director of Care and the Executive Director in relation to Log #H-000346-14

During the course of the inspection, the inspector(s) observed residents, reviewed clinical documents, reviewed the home's Dementia Care Policy, the Dementia and Behavioural Care Guidelines Resource Binder, the Resident Non-Abuse policy and staff training records.

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

Findings of Non-Compliance were found during this inspection.

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 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:**
**2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee did not ensure that the right of resident #001 to be protected from abuse was fully respected and promoted, in relation to the following: [3(1)2]
-On an identified date in 2013 staff were alerted when they heard resident #001 calling out for help. Clinical records indicated that when staff responded they found resident #002 demonstrating a response behaviour to resident #001. Staff documented in progress notes that resident #001 sustained a minor injury as a result of this incident Approximately two months later staff were again alerted to a situation when they heard yelling from resident #001's room. When staff entered the room they found resident #002 demonstrating the same responsive behaviour towards resident #001. Resident #001 was very upset about the incident and would not immediately allow staff to complete an assessment. Within 30 minutes of the incident staff assessed resident #001 and documented that this resident sustained 11 minor injuries as a result of this incident. Staff identified a concern that resident #001 may have sustained a head injury and initiated a head injury routine for the resident.
Thirteen days later staff were again alerted to a situation between resident #001 and resident #002. When staff responded they found resident #002 standing over resident #001 who was on the floor. A witness to the incident reported that there were words between the two residents and resident #002 walked over to resident #001 and demonstrated the same responsive behaviour as the two previous incidents and pushed resident #001 backwards out of their wheelchair. Staff indicated that there were no cuts or bruises noted on resident #001.
Resident #001 described resident #002 as a large person who can overpower you with their height and weight. Resident #002's plan of care indicated the resident was independently ambulatory. Resident #001 was noted to be small in stature, slight of build, used a wheelchair for ambulation and would be unable to move quickly due to a muscular condition. Resident #001 indicated that they felt the actions of resident #002 represented abuse and repeatedly expresses feelings of relief and a sense of calmness after being told resident #002 would not be returning to the home.
Staff confirmed that no actions were taken to protect resident #001 from the responsive behaviour being repeatedly demonstrated by resident #002 until after the third incident when resident #002 was transferred to hospital. [s. 3. (1) 2.]

*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 ensuring that the right of residents to be protected from abuse is dully respected and promoted, to be implemented voluntarily.*

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**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).**

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**Findings/Faits saillants :**

1. The licensee did not fulfil their duty to protect resident #001 from abuse by a co-resident, in relation to the following: [19(1)]
Staff did not take action to prevent resident #002 from repeatedly demonstrating a responsive behaviour toward resident #001 and placing resident #001's health and safety at risk.
-On an identified date in 2014 staff went to resident #001's room and found resident #002 demonstrating a responsive behaviour towards resident #001. Five days after this incident external Behavioural Support Ontario (BSO) staff recommended that resident #002 was to avoid being placed in area with loud or aggressive residents and resident #002 was to be provided a quiet safe place. Staff did not take actions in relation to these recommendations and resident #002 remained in close proximity to resident #001. Staff confirmed the a plan of care did not contain behavioural interventions to manage this identified and actions were not taken to protect resident #001 from a reoccurrence of this incident.
-Approximately two months later staff were altered to a situation in resident #001's room and found resident #002 demonstrating the same responsive behaviour towards this resident. Staff did not take action to attempt to prevent a reoccurrence of this incident when resident #002 continued to be in close proximity to resident #001. Staff confirmed the a plan of care did not contain behavioural interventions to manage this identified behaviour of resident #002 and actions were not taken to protect resident #001 from a reoccurrence of this incident.
-Twelve days after the above noted incident staff were alerted to another situation and found resident #001 on the floor and resident #002 standing over the resident. A witness to the incident reported that there was a verbal conflict between resident #002 and resident #001 which resulted in resident #002 demonstrating the same responsive behaviour identified in this report towards resident #001. This incident resulted in resident #001 sustaining 11 minor injuries. Resident #002 remained in close proximity to resident for three days following this incident when resident #002 was transferred to hospital. [S. 19. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensure that the licensee of a long-term care home protects residents from abuse by anyone, to be implemented voluntarily.***

WN #3: 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 Executive Director and the Director of Care did not immediately report three witnessed incidents of resident abuse that posed a significant risk to the health and safety of resident #001, in relation to the following: [24(1) 2]
-On an identified date in 2014 resident #002 was found to be demonstrating a responsive behaviour towards resident #001 that placed this resident's health and safety at risk. A critical incident report, identified as abuse, was submitted to the Hamilton Services Area Office seven days after the incident. The Executive Director and the Director of Care were unable to provide a reason for the delay in reporting this incident at the time of this inspection.
-Approximately two months after the first incident resident #002 was again found to be demonstrating the same responsive behaviour towards resident #001. A critical incident report, identified as abuse, was submitted to the Hamilton Services Area Office three days after the incident. The Executive Director and the Director of Care were unable to provide a reason for the delay in reporting this incident at the time of this inspection.
-Thirteen days later resident #002 was again observed to be demonstrating the same responsive behaviour towards resident #001. A critical incident report, identified as abuse, was submitted to the Hamilton Area Services Office two days after this incident. The Executive Director and the Director of Care were unable to provide a reason for the delay in reporting this incident at the time of this inspection. [s. 24. (1) 2.]

***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 a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm has occurred or may occur that the suspicion and the grounds on which it is based is immediately reported to the Director, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee did not ensure that the plan of care was based on an interdisciplinary assessment of mood and behaviour patterns, including any identified responsive behaviours and any potential behavioural triggers, in relation to the following: [26(3) 5] Resident #002 demonstrated a responsive behaviour towards a co-resident. After the first incident of resident #002 demonstrated this behaviour the resident was assessed and recommendations were made to manage this behaviour. The document used in the home to provide specific care directions to staff did not contain the identification of this specific behaviour or care directions for staff identified in the above noted assessment. Resident #002 demonstrated this same behaviour towards the same resident approximately two months later. Staff confirmed that the identification of this specific behaviour was not included in the care plan, although staff interviewed at the time of this inspection indicated they were aware of conflict between these two residents, they confirmed that the care plan did not identify this conflict as a potential trigger for resident #002's behaviour. [s. 26. (3) 5.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensure that the plan of care is based on , at a minimum, interdisciplinary assessments of mood and behaviour patterns, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.***

**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

**s. 53. (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,**
**(a) integrated into the care that is provided to all residents; O. Reg. 79/10, s. 53 (2).**
**(b) based on the assessed needs of residents with responsive behaviours; and O. Reg. 79/10, s. 53 (2).**
**(c) co-ordinated and implemented on an interdisciplinary basis. O. Reg. 79/10, s. 53 (2).**

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**Findings/Faits saillants :**

1. The licensee did not ensure that the program and services related to the management of responsive behaviours were coordinated and implemented on an interdisciplinary basis, in relation to the following: [52(c)]
Staff in the home confirmed that there was not a person designated in the home or a process in place to co-ordinate the care for residents who were demonstrating responsive behaviours.
-Staff interviewed at the time of this inspection indicated that they were unaware of the directions for the management of residents who demonstrate responsive behaviours identified in the homes policy [Dementia Care-LTC-E-100, revised on August 2012] and were unaware of the resources identified in the Dementia and Behaviour Care Guidelines Resource Binder, referred to in the policy. Staff were not readily able to locate the Dementia and Behavioural Care Guidelines Resource Binder.
-Staff confirmed they do not complete assessments of residents demonstrating responsive behaviours as directed in the Dementia Care Policy and the Behavioural Care Guidelines Resource Binder and confirmed that it is the practice in the home to rely on external Behavioural Support Ontario staff to initiate and complete the assessments.
-The policy provided staff with an identified tool that may be used as a resource to manage disruptive and or aggressive behaviours; however staff confirmed that the identified tool was not used and there were no strategies developed or implemented to manage the responsive behaviour being demonstrated by resident #002.
-The policy provided staff with an identified tool that may be used as a resource to monitor responsive behaviours being demonstrated; however staff confirmed they do not use this tool. At the time of this inspection staff indicated that they use a form identified as [The Resident of the Week] to monitor responsive behaviours. Staff indicated that when a resident is demonstrating a responsive behaviour staff were to complete this form. A review of the clinical record for resident #002 indicated that this

form was completed once related to this resident demonstrating a different responsive behaviour and there were no forms completed related to the three incidents of the responsive behaviour identified in this report. Staff indicated that [Resident of the Week] forms completed would possible be reviewed during shift changes and at quarterly interdisciplinary meetings. Staff confirmed there is not a process for staff to analyze all the forms completed for a resident around a specific behaviour in order to establish possible triggers for the behaviours being demonstrated.
-Staff confirmed that resident #002 was placed on one to one monitoring program for two or three shifts after one of the incidents identified in this report and then this monitoring was removed even though staff had not completed an assessment to ensure the resident#002 was no longer a risk to the health and safety of resident #001.
-Staff confirmed that there is not a process implemented in the home to ensure that responsive behaviours being demonstrated by residents are included in the plan of care or that specific techniques and interventions are communicated to staff providing direct care to these residents. [s. 53. (2) (c)]

***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 the programs and services related to responsive behaviours are coordinated and implemented on an interdisciplinary basis, to be implemented voluntarily.***

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**Issued on this 1st day of May, 2014**

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

Phyllis Hiltz-Bontje