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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 11, 2016	2016_258519_0006	017274-16	Complaint

Licensee/Titulaire de permis

LUTHERAN HOMES KITCHENER-WATERLOO
2727 KINGSWAY DRIVE KITCHENER ON N2C 1A7

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

TRINITY VILLAGE CARE CENTRE
2727 KINGSWAY DRIVE KITCHENER ON N2C 1A7

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

SHERRI GROULX (519)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 15, 2016

This was a Complaint Inspection related to resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Nurse Managers, Registered Practical Nurses, the Social Worker, the Behavioural Support Ontario (BSO) Personal Support Worker, Personal Support Workers, and Recreation staff.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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

- **3 WN(s)**
- **0 VPC(s)**
- **2 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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

The licensee failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported was immediately investigated:
(i) Abuse of a resident by anyone.

According to the documentation noted in the progress notes of a resident's clinical records, it was noted that an identified resident exhibited a specific behaviour and was involved in several incidents of alleged abuse.

In an interview with the Administrator, on a specific date and time , a request was made for the investigation notes into all alleged incidents of abuse involving the identified resident. The notes were faxed to the Ministry of Health and Long Term Care (MOHLTC) on a specific date, but investigation notes were not included for all of the incidents.

In a telephone interview with the Administrator, on a specific date and time, a request was made for the investigation notes into all alleged incidents of abuse involving the identified resident. She stated that the Behavioural Support staff were looking for the investigation notes into these incidents.

A request was made, on a specific date and time, for the Director of Care (DOC) to fax these investigation notes to the Inspector but they were not received.

During a telephone interview with the Administrator and the Director of Care, on a specific date and time, it was stated that they did not conduct a formal investigation of the alleged incidents as they felt their interventions with the resident were proof that an investigation had occurred. They stated they could not provide the inspector with investigation notes.

The licensee failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that was reported was immediately investigated when a resident exhibited a specific behaviour and was involved in several incidents of alleged abuse.

The severity of this issue was actual harm and the scope of this issue was a pattern as there were five documented incidents. The home had a history of a previous written notification (WN) in a similar area. [s. 23. (1) (a)]

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. 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 :

The licensee failed to ensure that residents were protected from abuse by anyone and were free from neglect by the licensee or staff.

The definition of sexual abuse, in the Long-Term Care Homes Act (LTCH Act) 2007, under s.2(1)(a)(b) heading "sexual abuse" stated:
(a) subject to subsection (3), any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or
(b) 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

A resident was admitted to the home with a history of behaviours.

A review of the progress notes for one year revealed that a resident was involved in alleged abuse incidents on different occasions; which was witnessed and documented by staff.

These documented incidents were not formally investigated or reported to the Ministry of Health and Long Term Care (MOHLTC) after they occurred.

The inspector interviewed registered and direct care staff who all stated that the resident had a medical condition and would exhibit this behaviour. One staff member stated they

had witnessed one incident of alleged abuse and had reported it to the manager.

In a telephone interview with the Social Worker (SW), on a specific date and time, it was stated that the resident was admitted to the long-term care home (LTCH) several years ago. The resident had a history of behaviours so interventions were put into place on their arrival. Specific interventions continued to be in place to prevent further incidents.

In an interview with Behavioural Supports Ontario (BSO) PSW, at a specific date and time, it was stated that BSO knew of the resident and the interventions in place.

The initial plan of care, written on a specific date, addressed the resident's inappropriate behaviours.

After the documented incidents, on an earlier date, there were no revisions made to the written plan of care. After documented incidents, on a later date, there were some revisions made to the plan of care by BSO and the SW.

In an interview with the Director of Care (DOC), on a specific date and time, it was stated that the resident had a history of behaviours. He stated that interventions were in place for the resident. He stated that he was aware of the resident's behaviour and involvement in alleged abuse incidents.

In an interview with the Administrator, on a specific date and time, she stated she was aware of the resident's behaviour and involvement in alleged abuse incidents.

The licensee failed to ensure that residents of the home were protected from abuse when another resident was involved in alleged abuse incidents.

The severity of this issue was actual harm and the scope of this issue was a pattern as there were five documented incidents. The home had a history of ongoing non-compliance with a Voluntary Plan of Correction (VPC) or Compliance Order (CO). [s. 19. (1)]

Additional Required Actions:

CO # - 002 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. 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 :

The licensee failed to ensure that there was a written policy that promoted zero tolerance of abuse and neglect of residents and that it was complied with.

According to a resident's documentation in the progress notes there were alleged incidents of abuse.

In an interview with the Director of Care (DOC), on a specific date and time, the DOC stated that a Critical Incident Report was not submitted to the Ministry of Health and Long Term Care (MOHLTC) as he decided the incidents did not fit the criteria of the MOHLTC's Abuse decision tree for reporting.

In an interview with the Administrator, on a specific date and time, the Administrator agreed that the identified incidents had not been reported to the MOHLTC. She stated that the DOC completed the Critical Incident reports to the MOHLTC but that she usually had knowledge of them before they were submitted, as they would collaborate on whether to report.

The home's policy titled "Abuse" stated:

Physicial/Sexual Abuse (Residents Bill of Rights #2 "Every resident has the right to be protected from abuse"): Any physical assault, threatening behaviour or unnecessary use of force that inflicts physical harm. Examples:

-Shaking, pushing, slapping, beating, any rough handling
-Confinement, inappropriate use of restraint
-Force-feeding, placing in an unsafe condition or situation
-Unwanted sexual acts including kissing, fondling, intercourse

Responsibilities of the Licensee include the following:
1. Every alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that the licensee knows of, or that is reported to the licensee is immediately investigated.
2. Appropriate action is taken in response to every such incident.
3. Reporting the results of every investigation undertaken to the MOHLTC.

Reporting certain matters to the MOHLTC:
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 MOHLTC.
1. Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.
3. Unlawful conduct that resulted in harm or risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to the licensee.

The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with when alleged incidents of abuse were not reported to the MOHLTC. [s. 20. (1)]

Issued on this 19th day of August, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHERRI GROULX (519)
Inspection No. / No de l'inspection :	2016_258519_0006
Log No. / Registre no:	017274-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 11, 2016
Licensee / Titulaire de permis :	LUTHERAN HOMES KITCHENER-WATERLOO 2727 KINGSWAY DRIVE, KITCHENER, ON, N2C-1A7
LTC Home / Foyer de SLD :	TRINITY VILLAGE CARE CENTRE 2727 KINGSWAY DRIVE, KITCHENER, ON, N2C-1A7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Debby Riepert

To LUTHERAN HOMES KITCHENER-WATERLOO, 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. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Order / Ordre :

The licensee shall ensure that every alleged, suspected or witnessed incident of abuse of the resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated.

Grounds / Motifs :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported was immediately investigated:
(i) Abuse of a resident by anyone.

According to the documentation noted in the progress notes of a resident's clinical records, it was noted that an identified resident exhibited a specific behaviour and was involved in several incidents of alleged abuse.

In an interview with the Administrator, on a specific date and time , a request was made for the investigation notes into all alleged incidents of abuse involving the identified resident. The notes were faxed to the Ministry of Health and Long Term Care (MOHLTC) on a specific date, but investigation notes were not

included for all of the incidents.

In a telephone interview with the Administrator, on a specific date and time, a request was made for the investigation notes into all alleged incidents of abuse involving the identified resident. She stated that the Behavioural Support staff were looking for the investigation notes into these incidents.

A request was made, on a specific date and time, for the Director of Care (DOC) to fax these investigation notes to the Inspector but they were not received.

During a telephone interview with the Administrator and the Director of Care, on a specific date and time, it was stated that they did not conduct a formal investigation of the alleged incidents as they felt their interventions with the resident were proof that an investigation had occurred. They stated they could not provide the inspector with investigation notes.

The licensee failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that was reported was immediately investigated when a resident exhibited a specific behaviour and was involved in several incidents of alleged abuse.

The severity of this issue was actual harm and the scope of this issue was a pattern as there were five documented incidents. The home had a history of a previous written notification (WN) in a similar area. [s. 23. (1) (a)]

(519)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 06, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall protect all residents in the home, as well as residents # 002 and # 003, from abuse by resident # 001.

Grounds / Motifs :

1. The licensee failed to ensure that residents were protected from abuse by anyone and were free from neglect by the licensee or staff.

The definition of sexual abuse, in the Long-Term Care Homes Act (LTCH Act) 2007, under s.2(1)(a)(b) heading "sexual abuse" stated:
(a) subject to subsection (3), any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or
(b) 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

A resident was admitted to the home with a history of behaviours.

A review of the progress notes for one year revealed that a resident was involved in alleged abuse incidents on different occasions; which was witnessed and documented by staff.

These documented incidents were not formally investigated or reported to the Ministry of Health and Long Term Care (MOHLTC) after they occurred.

The inspector interviewed registered and direct care staff who all stated that the resident had a medical condition and would exhibit this behaviour. One staff

member stated they had witnessed one incident of alleged abuse and had reported it to the manager.

In a telephone interview with the Social Worker (SW), on a specific date and time, it was stated that the resident was admitted to the long-term care home (LTCH) several years ago. The resident had a history of behaviours so interventions were put into place on their arrival. Specific interventions continued to be in place to prevent further incidents.

In an interview with Behavioural Supports Ontario (BSO) PSW, at a specific date and time, it was stated that BSO knew of the resident and the interventions in place.

The initial plan of care, written on a specific date, addressed the resident's inappropriate behaviours.

After the documented incidents, on an earlier date, there were no revisions made to the written plan of care. After documented incidents, on a later date, there were some revisions made to the plan of care by BSO and the SW.

In an interview with the Director of Care (DOC), on a specific date and time, it was stated that the resident had a history of behaviours. He stated that interventions were in place for the resident. He stated that he was aware of the resident's behaviour and involvement in alleged abuse incidents.

In an interview with the Administrator, on a specific date and time, she stated she was aware of the resident's behaviour and involvement in alleged abuse incidents.

The licensee failed to ensure that residents of the home were protected from abuse when another resident was involved in alleged abuse incidents.

The severity of this issue was actual harm and the scope of this issue was a pattern as there were five documented incidents. The home had a history of ongoing non-compliance with a Voluntary Plan of Correction (VPC) or Compliance Order (CO). [s. 19. (1)]

(519)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 06, 2016

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 Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 11th day of August, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sherri Groulx

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