Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 9, 2019	2019_560632_0014	010474-19	Complaint

Licensee/Titulaire de permis

Barton Retirement Inc.
1430 Upper Wellington Street HAMILTON ON L9A 5H3

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

The Wellington Nursing Home
1430 Upper Wellington Street HAMILTON ON L9A 5H3

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

YULIYA FEDOTOVA (632)

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): May 28, 29, 30, 31, June 5, 6, 10, 11, 2019.

The following Complaint inspection was completed:
log #010474-19 - related to responsive behaviors, skin and wound care, personal support services.

This inspection was conducted concurrently with a complaint inspection number 2019_543561_0013, log #010838-19.

DARIA TRZOS (561) was also present for a Complaint Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Food Service Supervisor, Nurse Manager (NM), Unit Clerk, Social Worker, Behavioural Supports Ontario (BSO) Personal Support Worker, Housekeeper, health care aids (HCAs), personal support workers (PSWs), registered nurses (RNs), registered practical nurses (RPNs), residents and their families.

During the course of the inspection, the inspector reviewed clinical records, policies, procedures and practices within the home, reviewed meeting minutes, observed the provision of care and medication administration.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

8 WN(s)
3 VPC(s)
1 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 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 ensure that resident #002 was protected from abuse by anyone.

Complaint log #010474-19 (IL-67019-HA) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date in May 2019, regarding identified behaviour management for resident #020.

1. Based on clinical records review, it was suggested that resident #002 and resident #020 had identified impairments.

Progress notes review, as documented by RPN #108, RPN #119 and RPN #124 indicated that on an identified dates in May 2019, resident #020 performed identified activities towards co-resident #002.

The Social Worker was informed about the incident. On an identified date in June 2019, the Social Worker indicated to Inspector #632 that, in their opinion, resident #002 had specified ability to express themselves and was able to provide consent to identified activity.

Care plan review indicated that resident #002 had specified communication ability.

The ADOC indicated that they were inconclusive in their decision about resident #002's ability to provide a consent during the incident on an identified date in May 2019.

On an identified date in June 2019, resident #002's Substitute Decision Maker (SDM) indicated that the resident was not able to provide a consent to resident #020's identified activity.

On an identified date in June 2019, resident #002 was observed and interviewed by Inspector #632. During the interview resident #002 exhibited identified behaviour and was able to make specified choices.

The DOC acknowledged that resident #002 was not protected from abuse by resident #020 in the home.

The home did not ensure that resident #002 was protected from abuse by resident #020 in the home.

2. The licensee failed to ensure that resident #021 was protected from abuse by anyone.

Resident #020 had an identified impairment.

Progress notes review on identified dates in April 2019, indicated that resident #020 performed identified activities towards resident #021. On identified dates in June 2019, RPN #116 and RPN #121 indicated that resident #021 was not able to provide a consent to resident #020.

On identified date in June 2019, the Social Worker indicated that resident #021 expressed specified needs, which were misperceived by resident #020.

The DOC acknowledged that resident #021 was not protected from abuse by resident #020 in the home.

The home did not ensure that resident #021 was protected from abuse by resident #020 in the home. [s. 19. (1)]

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Complaint log #010474-19 (IL-67019-HA) was submitted to the MOHLTC on an identified date in May 2019, regarding identified behaviour management of resident #020.

Progress notes review indicated that on identified dates in April 2019, resident #020 performed identified activities towards resident #021. Care plan review indicated that resident #021 had identified activities and requests.

On an identified date in June 2019, the Social Worker indicated that resident #021 expressed specified needs, which were misperceived by resident #020. The Social Worker also indicated that on an identified date in April 2019, they spoke with the care team about resident #021's needs and suggested specified routines and interventions.

On an identified date in June 2019, the DOC indicated that all interdisciplinary team members, who had an access to resident #021's written plan of care, were expected to update the written plan of care based on resident #021's assessments and needs.

The home failed to ensure that the care set out in the plan of care for resident #021 was based on an assessment of the resident and the needs and preferences of that resident. [s. 6. (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 care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

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 :

1. The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A review of the home's Abuse Policy Number ADM-VI-06 NUR-II-02 (date February 2018), indicated that "any staff member witnessing an alleged and/or actual; act of abuse or becoming aware of one" would "immediately report it to their immediate supervisor and/or to the NM on duty". After resident's safety was ensured the NM would contact the Director of Care or designate and would relay all information with respect to the incident. The NM would call MOHLTC after hours contact number and report suspected and/or alleged abuse.

1. i. Resident #002 and resident #020 had identified impairments.

Progress notes review indicated that on an identified date in May 2019, resident #020 performed identified activity towards co-resident #002. On an identified date in June 2019, RPN #119 indicated that they were not able to recall, who reported the incident of alleged abuse to the NM. RN #123 indicated that they were not informed about the incident on an identified date in May 2019.

On an identified date in June 2019, the ADOC indicated that, once registered staff became aware about an incident of alleged abuse, they were to investigate and inform the DOC or the ADOC, which was to be reported immediately to the MOHLTC.

The home failed to ensure that the Abuse policy to promote zero tolerance of abuse and neglect of residents was complied with.

ii. Resident #002 and resident #020 had identified impairments.

Progress note review indicated that on an identified date in May 2019, resident #020

performed identified activity towards resident #002. On an identified date in June 2019, RPN #124, who worked at the time of the incident in the home, indicated that they did not inform the NM about the incident of alleged abuse.

On an identified date in June 2019, the ADOC indicated that, once registered staff became aware about the incident of alleged abuse, they were to investigate and inform the DOC or the ADOC, which was to be reported immediately to the MOHLTC.

The home failed to ensure that the Abuse policy to promote zero tolerance of abuse and neglect of residents was complied with.

iii. Resident #002 and resident #020 had identified impairments.

Progress note review indicated that resident #020 performed identified activity towards resident #002 on an identified date in May 2019. On an identified date in June 2019, RPN #108 indicated that they reported to the NM and to the ADOC on an identified date in May 2019, about the incident of alleged abuse.

On an identified date in June 2019, the ADOC indicated that they were not informed by staff about the incident on an identified date in May 2019. The home's expectations were once the registered staff became aware about the incidence of alleged abuse, they were to investigate and inform the DOC or the ADOC, which was to be reported immediately to the MOHLTC.

The home failed to ensure that the Abuse policy to promote zero tolerance of abuse and neglect of residents was complied with.

2. i. Resident #021 and resident #020 had identified impairments.

Progress notes review indicated that resident #020 performed identified activity towards resident #021.

On an identified date in June 2019, RPN #116 indicated that the NM was informed about the incident on an identified date in April 2019. On an identified date in June 2019, RN # 123 did not recall that they were informed about the incident of alleged abuse on an identified date in April 2019.

On an identified date in June 2019, the ADOC indicated that, once registered staff

became aware about the incident of alleged abuse, they were to investigate and inform the DOC or the ADOC, which was to be reported immediately to the MOHLTC.

The home failed to ensure that the Abuse policy to promote zero tolerance of abuse and neglect of residents was complied with.

ii. Resident #021 and resident #020 had identified impairments.

Progress notes review indicated that resident #020 performed identified activity towards resident #021. On an identified date in June 2019, RN #121 indicated that resident #021 had specified verbal expressions, which was confirmed to the RN by staff was normal for resident #021. RN #121 also indicated that the SDM and the home's management were not informed about the incident.

On an identified date in June 2019, the ADOC indicated that once registered staff became aware about the incident of alleged abuse, they were to investigate and inform the DOC or the ADOC, which was to be reported immediately to the MOHLTC.

The home failed to ensure that the Abuse policy to promote zero tolerance of abuse and neglect of residents was complied with. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Progress notes review indicated that on an identified date in April 2019, resident #020 performed identified activity towards resident #021.

On an identified date in June 2019, the ADOC indicated that the SDM was to be informed about the incident of alleged abuse and it was to be recorded in the resident's progress note.

Review of progress notes did not contain documentation about contacting resident #021's SDM within 12 hours upon becoming aware of the incident.

On an identified date in June 2019, RN #121, who witnessed the incident, confirmed that the SDM for resident #021 was not contacted.

The home failed to ensure that resident #021's SDM was notified within 12 hours upon becoming aware of alleged incident of abuse on an identified date in April 2019.

2. i. Progress notes review indicated that on an identified date in May 2019, resident #020 performed identified activity towards co-resident #002.

On an identified date in June 2019, the ADOC indicated that the SDM was to be informed about the incident of alleged abuse and it was to be recorded in the resident's progress note.

Review of progress notes did not contain documentation about contacting resident #002's SDM within 12 hours upon becoming aware of the incident.

On an identified date in June 2019, RN #123 did not recall about the details of the incident on an identified date in May 2019, including SDM notification.

The home failed to ensure that resident #002's SDM was notified within 12 hours upon becoming aware of an alleged incident of abuse on an identified date in May 2019.

ii. Progress notes review indicated that on an identified date in May 2019, resident #020 performed identified activity towards resident #002.

On an identified date in June 2019, the ADOC indicated that the SDM was to be informed about the incident of alleged abuse and it was to be recorded in the resident's progress note.

Review of progress notes did not contain documentation about contacting resident #002's SDM within 12 hours upon becoming aware of the incident.

On an identified date in June 2019, RPN #124 indicated that the SDM was informed about the incident on an identified date in May 2019.

The home failed to ensure that resident #002's SDM was notified within 12 hours upon becoming aware of alleged incident of abuse on an identified date in May 2019.

iii. Progress notes review indicated that on an identified date in May 2019 resident #020 performed identified activity towards resident #002.

On an identified date in June 2019, the ADOC indicated that the SDM was to be informed about the incident of alleged abuse and it was to be recorded in the resident's progress note.

Review of progress notes contained documentation about initial contact of resident

#002's SDM on an identified date in May 2019, which was more than 29 hours after the incident of alleged abuse occurred.

The home failed to ensure that resident #002's SDM was notified within 12 hours upon becoming aware of alleged incident of abuse on an identified date in May 2019.

3. i. Progress notes review indicated that on an identified date in April 2019, resident #020 performed identified activity towards resident #021.

On an identified date in June 2019, the ADOC indicated that the SDM was to be informed about the incident of alleged abuse and it was to be recorded in the resident's progress note.

Review of progress notes did not contain documentation about contacting resident #020's SDM within 12 hours upon becoming aware of the incident of alleged abuse.

On an identified date in June 2019, RN #121, who witnessed the incident, confirmed that the SDM for resident #020 was not contacted.

The home failed to ensure that resident #020's SDM was notified within 12 hours upon becoming aware of alleged incident of abuse on an identified date in April 2019.

ii. Progress notes review indicated that on an identified date in May 2019, resident #020 performed identified activity towards co-resident #002.

On an identified date in June 2019, the ADOC indicated that the SDM was to be informed about the incidents of alleged abuse and it was to be recorded in the resident's progress note.

Review of progress notes did not contain documentation about contacting resident #020's SDM within 12 hours upon becoming aware of the incident.

On an identified date in June 2019, RN #123 did not recall about the details of the incident on an identified date in May, 2019, including the SDM notification.

The home failed to ensure that resident #020's SDM was notified within 12 hours upon becoming aware of alleged incident of sexual abuse on an identified date in May 2019.

iii. Progress notes review indicated that on an identified date in May 2019, resident #020 performed identified activity towards resident #002.

On an identified date in June 2019, the ADOC indicated that the SDM was to be informed about the incident of alleged abuse and it was to be recorded in the resident's progress note.

Review of progress notes did not contain documentation about contacting resident #020's SDM within 12 hours upon becoming aware of the incident.

On an identified date in June 2019, RPN #124 indicated that the SDM was not informed about the incident on an identified date in May 2019.

The home failed to ensure that resident #020's SDM was notified within 12 hours upon becoming aware of alleged incident of abuse on an identified date in May 2019.

iv. Progress notes review indicated that on an identified date in May 2019, resident #020 performed identified activity towards resident #002.

On an identified date in June 2019, the ADOC indicated that the SDM was to be informed about the incident of alleged abuse and it was to be recorded in the resident's progress note.

Review of progress notes contained documentation about initial contact of resident #020's SDM on an identified date in May 2019, which was more than 28 hours after the incident of alleged abuse occurred.

The home failed to ensure that resident #020's SDM was notified within 12 hours upon becoming aware of alleged incident of abuse on an identified date in May 2019. [s. 97. (1) (b)]

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 resident's SDM and any other person specified by the resident are notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments and interventions and the resident's responses to interventions were documented.

Resident #002 and resident #020 had identified impairments.

Progress notes review for resident #020 indicated that on identified dates in May 2019, resident #020 performed identified activities towards co-resident #002. There was no documentation identified in resident #002's clinical records about the incident, as assessment, interventions or the resident's response.

Based on the procedure in the home's Abuse Policy Number ADM-VI-06 NUR-II-02, the NM would document in resident's electronic chart in Point Click Care (PCC) a detailed description of the incident, findings, resident's assessment and what care was provided as a result of an incident. The ADOC indicated that resident #002's assessments and interventions were not documented in resident #002's electronic chart.

The home failed to ensure that assessments and interventions and resident #002's responses to interventions were documented in relation to incidents of alleged abuse occurred on identified dates in May 2019. [s. 30. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that at least annually, the matters referred to in subsection (1) (a) were evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

On an identified date in June 2019, the DOC indicated to Inspector #632 that no annual evaluation in 2018 was completed for Responsive Behaviour Program, which included, written approaches to care, written strategies, residents monitoring and internal reporting protocols and protocols for the referral of residents to specialized resources, where required.

The home failed to ensure that at least annually, the matters referred to in subsection (1) (a) were evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices. [s. 53. (3) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The Licensee failed to comply with O.Reg 79/10, s. 54 that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations:

Complaint log #010474-19 (IL-67019-HA) was submitted to the MOHLTC on an identified date in May 2019, identifying specified behaviour management for resident #020.

Resident #020 and resident #002 had identified impairments.

According to the clinical records on identified dates in May 2019, resident #020's performed identified activities towards co-resident #002.

Review of written plan of care provided interventions for staff if witnessed that resident #020 exhibited identified activity towards co-residents.

Review of specified meeting minutes indicated some interventions for resident #020's identified behaviour management. No factors based on interdisciplinary assessment were identified in the home for resident #020 that could potentially trigger resident #020's identified behaviour.

On an identified date in June 2019, the ADOC indicated that specified interventions could be used in resident #020's identified behaviour management.

The home failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #020 and other residents including identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations. [s. 54. (a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure that (b) at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

On an identified date in June 2019, the DOC indicated to Inspector #632 that no evaluation was made in 2018 to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents.

The home failed to ensure that an evaluation was made in 2018 to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences. [s. 99. (b)]

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 16th day of July, 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) :	YULIYA FEDOTOVA (632)
Inspection No. / No de l'inspection :	2019_560632_0014
Log No. / Registre no:	010474-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 9, 2019
Licensee / Titulaire de permis :	Barton Retirement Inc. 1430 Upper Wellington Street, HAMILTON, ON, L9A-5H3
LTC Home / Foyer de SLD :	The Wellington Nursing Home 1430 Upper Wellington Street, HAMILTON, ON, L9A-5H3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lisa Brentnall

To Barton Retirement Inc., 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 LTCHA, 2007 s. 19 (1).
Specifically the licensee shall ensure:
a) Residents #002 and #021 and all other residents, that can not provide consent to identified activities, be protected from abuse by anyone.
b) Resident #020, and all other residents, that are known to staff to demonstrate identified behaviours, have interventions in place to monitor the resident(s) for their behaviours and interventions implemented to protect other residents from abuse.

Grounds / Motifs :

1. 1. The licensee failed to ensure that resident #002 was protected from abuse by anyone.

Complaint log #010474-19 (IL-67019-HA) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date in May 2019, regarding identified behaviour management for resident #020.

1. Based on clinical records review, it was suggested that resident #002 and resident #020 had identified impairments.

Progress notes review, as documented by RPN #108, RPN #119 and RPN #124 indicated that on an identified dates in May 2019, resident #020 performed identified activities towards co-resident #002.

The Social Worker was informed about the incident. On an identified date in June 2019, the Social Worker indicated to Inspector #632 that, in their opinion,

resident #002 had specified ability to express themselves and was able to provide consent to identified activity.

Care plan review indicated that resident #002 had specified communication ability.

The ADOC indicated that they were inconclusive in their decision about resident #002's ability to provide a consent during the incident on an identified date in May 2019.

On an identified date in June 2019, resident #002's SDM indicated that the resident was not able to provide a consent to resident #020's identified activity.

On an identified date in June 2019, resident #002 was observed and interviewed by Inspector #632. During the interview resident #002 exhibited identified behaviour and was able to make specified choices.

The DOC acknowledged that resident #002 was not protected from abuse by resident #020 in the home.

The home did not ensure that resident #002 was protected from abuse by resident #020 in the home.

2. The licensee failed to ensure that resident #021 was protected from abuse by anyone.

Resident #020 had an identified impairment.

Progress notes review on identified dates in April 2019, indicated that resident #020 performed identified activities towards resident #021. On identified dates in June 2019, RPN #116 and RPN #121 indicated that resident #021 was not able to provide a consent to resident #020.

On identified date in June 2019, the Social Worker indicated that resident #021 expressed specified needs, which were misperceived by resident #020.

The DOC acknowledged that resident #021 was not protected from abuse by resident #020 in the home.

The home did not ensure that resident #021 was protected from abuse by resident #020 in the home.

This order is made up on the application of the factors of severity (2), scope (2), and compliance history (3). This is in respect to the severity of minimal harm or minimal risk that identified residents experienced, the scope of this being pattern incident. The home had a level 3 history as they had previous noncompliance to the same subsection of the LTCHA that included:
- voluntary plan of correction (VPC) issued August 22, 2016 (2016_341583_0012).
(632)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 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 9th day of July, 2019

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Yuliya Fedotova

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