Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
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Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 25, 2020	2020_577611_0003	020377-19, 022816-19, 023701-19	Critical Incident System

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

KELLY CHUCKRY (611)

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): January 20, 2020 offsite, January 21, 22, 23, and 27, 2020 onsite, and February 4, 2020 offsite.

During the course of this inspection, the inspector(s) reviewed relevant clinical health records, investigation notes, relevant policies and procedures, education documentation, and annual evaluations.

During the course of the inspection, the inspector(s) spoke with the Director of Care(DOC), the Registered Dietitian (RD), registered staff, Personal Support Workers (PSWs), residents, and the police department.

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.
- **2 WN(s)**
- **1 VPC(s)**
- **1 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	Légende 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 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 ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #001 and other residents by not identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observations, that could potentially trigger such an altercation, and identifying and implementing interventions.

The home submitted a Critical Incident Report on an identified date, pertaining to the prevention of abuse and neglect.

The progress notes for resident #001 from an identified date, identified that resident #001 was physically aggressive towards resident #002, which resulted in injury to resident #002.

A Behavioural Support Ontario (BSO) referral was completed the day of the incident, and they were in the home in response to the referral on the same day. In a progress note on the same date, BSO recommended specific interventions for resident #001.

According to the progress notes, resident #001 had one of the specific interventions in place for 72 hours post incident, then it was discontinued. The home also had another monitoring intervention in place for a specified time period that had been discontinued prior to this inspection. At the time of the inspection, an intervention recommended by BSO had not been explored by the home.

A telephone interview was conducted with PSW staff #105, who regularly worked with resident #001, and acknowledged that there was a possibility that a similar situation could happen again with resident #001.

An interview was conducted with registered staff #106, who worked part-time with on the same area where resident #001 resided, and it was confirmed that "definitely there was a possibility another similar incident could happen" with resident #001. Registered staff #104 confirmed that resident #001 was capable of having another similar event. Staff #104 further confirmed that an interdisciplinary meeting had not taken place to discuss potential triggers to this incident, and feasibility of implementation of the intervention recommended by BSO. The triggers associated with this incident had not been fully

reviewed and identified in resident #001's plan of care.

In an interview conducted with the DOC, it was confirmed that the recommended intervention made by BSO was not fully explored and an interdisciplinary assessment had not been completed. Specifically, it was confirmed that the home did not fully explore all identified triggers to decrease the risk of subsequent altercations, including the identification and implementation of interventions. [s. 54.]

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 :

1. The licensee failed to ensure that resident resident #002 was protected from abuse by resident #001.

The home submitted a Critical Incident Report on an identified date, pertaining to the prevention of abuse and neglect

For the purposes of the definition of "physical abuse" in subsection 2 (1) of the Act, physical abuse means (2), (c) the use of physical force by a resident that causes physical injury to another resident.

The progress notes for resident #001 identified that resident #001 was physically aggressive towards resident #002, which resulted in injury to resident #002.

In a telephone interview with staff #105 it was confirmed that they witnessed part of this incident of physical responsive behaviour.

In an interview conducted with resident #002, it was confirmed that this resident was afraid of resident #001.

A review of progress notes for resident #001 from an identified period of time revealed there was only one (1) minor physical altercation between resident #001 and another resident.

In an interview conducted with the Director of Care, it was confirmed that resident #001 abused resident #002 in the above noted incident. [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 to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

Issued on this 4th day of March, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY CHUCKRY (611)
Inspection No. / No de l'inspection :	2020_577611_0003
Log No. / No de registre :	020377-19, 022816-19, 023701-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 25, 2020
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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

To Barton Retirement Inc., you are hereby required to comply with the following order (s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 001

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 O. Reg. 79/10, s. 54.

Specifically, the licensee must:
a) ensure that an interdisciplinary assessment takes place for resident #001.
b) ensure that potential triggers are identified for resident #001 with respect to physical responsive behaviours.
c) ensure interventions are identified and implemented for resident #001 to minimize the risk of harm to any other residents in the home.

Grounds / Motifs :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #001 and other residents by not identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observations, that could potentially trigger such an altercation, and identifying and implementing interventions.

The home submitted a Critical Incident Report on an identified date, pertaining to the prevention of abuse and neglect.

The progress notes for resident #001 from an identified date, identified that resident #001 was physically aggressive towards resident #002, which resulted

in injury to resident #002.

A Behavioural Support Ontario (BSO) referral was completed the day of the incident, and they were in the home in response to the referral on the same day. In a progress note on the same date, BSO recommended specific interventions for resident #001.

According to the progress notes, resident #001 had one of the specific interventions in place for 72 hours post incident, then it was discontinued. The home also had another monitoring intervention in place for a specified time period that had been discontinued prior to this inspection. At the time of the inspection, an intervention recommended by BSO had not been explored by the home.

A telephone interview was conducted with PSW staff #105, who regularly worked with resident #001, and acknowledged that there was a possibility that a similar situation could happen again with resident #001.

An interview was conducted with registered staff #106, who worked part-time with on the same area where resident #001 resided, and it was confirmed that "definitely there was a possibility another similar incident could happen" with resident #001. Registered staff #104 confirmed that resident #001 was capable of having another similar event. Staff #104 further confirmed that an interdisciplinary meeting had not taken place to discuss potential triggers to this incident, and feasibility of implementation of the intervention recommended by BSO. The triggers associated with this incident had not been fully reviewed and identified in resident #001's plan of care.

In an interview conducted with the DOC, it was confirmed that the recommended intervention made by BSO was not fully explored and an interdisciplinary assessment had not been completed. Specifically, it was confirmed that the home did not fully explore all identified triggers to decrease the risk of subsequent altercations, including the identification and implementation of interventions. [s. 54.]

The severity of this issue was determined to be a level three (3), as there was actual harm, and there is actual risk. The scope of this issue was a level one

(1), as this was an isolated incident. The home had a level three (3) compliance history as there was previous non compliance to the same subsection that included:

-a Written Notification (WN) issued July 9, 2019 (2019_560632_0014)

Additionally, the LTC home has a history of six (6) other compliance orders in the last 36 months. (611)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 06, 2020

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 25th day of February, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kelly Chuckry

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