Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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
Jan 29, 2019	2019_570528_0002	009701-18, 030900-18, 031965-18, 031966-18	Critical Incident System

Licensee/Titulaire de permis

St. Peter's Care Centres
125 Redfern Avenue HAMILTON ON L9C 7W9

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

St. Peter's Residence at Chedoke
125 Redfern Avenue HAMILTON ON L9C 7W9

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

CYNTHIA DITOMASSO (528)

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 15, 16 and 17, 2019

This Critical Incident Inspection includes:
i. Critical Incident Log #009701-18, related to safe lift and transfer
ii. Critical Incident Log #030900-18, related to allegations of sexual abuse
iii. Follow up Inspection Log # 031965-18, related to CO #001 from inspection #2018_558123_0011 regarding s. 19(1) of the LTCHA
iv. Follow up Inspection Log #031966-18, related to CO #002 from inspection #2018_558123_0011 regarding s. 54(b) of Ontario Regulation 79/10

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Care Supervisor (RCS), Environmental Services Manager (ESM), Physiotherapist (PT), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), residents and families.

During the course of the inspection, the inspector(s) also observed the provision of care and reviewed documents including but not limited to: medical records, resident lists, investigation notes, work orders, maintenance records, operating manuals, policies and procedures.

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

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

6 WN(s)
3 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

0 AMP(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2018_558123_0011	528
O.Reg 79/10 s. 54.	CO #002	2018_558123_0011	528

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. 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 there was a written policy that promoted zero tolerance of abuse and neglect of the residents and that it was complied with.

The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Critical Incident System #2927-000046-18 and log #030900-18, submitted in November 2018, identified an altercation between resident #022 and #023.

The home's policy "Non-Abuse of Residents", revised May 2017, directed any staff member to report all allegations, suspected, or witnessed resident abuse to the nurse in charge. The nurse in charge will then follow an outlined procedure, including but not limited to, initiate the CIS report or MOHLTC emergency on call pager.

Review of the CIS report #2927000046-18, submitted in November 2018, revealed that on an identified day in November 2018, resident #022 was observed by PSW #111 to be demonstrating responsive behaviours towards resident #023. Review of the medical record for resident #022 identified that they had a history of responsive behaviours with coresidents. Interview with RPN #104 confirmed that the incident occurred on an identified day in November 2018, and was reported to them by the PSW after the incident. Interview with RPN #104 confirmed that they did not notify the RN in charge of the incident, but documented in the health record. Interview with ADOC #102 confirmed they were the Resident Care Supervisor (RCS) at the time of the incident. In the interview ADOC #102 revealed that they had reviewed the documentation during a Risk Management Meeting several days later, at which time, they reported the incident to the Director. Interview with ADOC #102 confirmed that the incident on an identified day in November 2018, was not reported immediately, as required in the home's "Non-Abuse of Residents" policy. [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 to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of the residents and that it is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that actions taken to meet the needs of the resident with responsive behaviours included documentation of the resident's responses to the interventions.

A. Critical Incident System #2927-000046-18, was submitted in November 2018, which described an incident in November 2018, where resident #022 was displaying responsive behaviours towards resident #023.

i. Follow up log #031965-18, from Resident Quality Inspection #2018_558123_0011, regarding Compliance Order (CO) #001 for s. 19(1) of the LTCHA had a compliance date of November 19, 2018, and required the licensee to protect resident #023 from sexual abuse by resident #022.

ii. Review of progress notes from November 2018, documented a plan to prevent further incidents of altercation including dementia observational system (DOS) charting.

iii. Review of the DOS charting from November 2018 to January 2019, revealed the several days when there was no documentation identifying the residents behaviours. In addition, review of the DOS record identified several occasions where the resident was coded as displaying responsive behaviours, but there was no further documentation in the 'Summary Section' of the DOS or in the progress notes to describe behavioural incidents.

iv. Interview with the ADOC and DOC, confirmed that DOS was in place for resident #022, which required staff to observe and document the residents behaviour every 30 minutes; and if there was a demonstrated behaviour it was to be reported to registered staff so that the assessments and interventions could be documented.

v. Review of DOS documentation with the ADOC and DOCconfirmed that from the identified time period, the 30 minute observations were not consistently documented; and actions taken to respond to the resident displaying sexually inappropriate behaviours were not documented.

B. Review of the medical record for resident #003 identified that the resident had a history of responsive behaviours. In October 2018, documentation included DOS charting.

i. Review of DOS charting from an identified time period, did not include documented behaviour monitoring every 30 minutes as required on 19 occasions.
ii. Interview with ADOC #102 and DOC #101, confirmed that the resident required documentation related to 30 minute behavioural monitoring at all times, so that the home could identify any patterns or changes in the resident's behaviours. Interview with the ADOC #102 and DOC #101 confirmed that the DOS monitoring for resident #003 at the identified time period was not consistently documented every 30 minutes, as required.

Actions taken to meet the needs of the resident with responsive behaviours including documentation of the resident's responses to the interventions were not documented. [s. 53. (4) (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 to ensure that actions taken to meet the needs of the resident with responsive behaviours include documentation of the resident's responses to the interventions, to be implemented voluntarily.

WN #3: 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, reassessments, interventions and the resident's responses to interventions were documented.

A. Critical Incident System #2927000018-18, submitted in May 2018, identified that resident #001 had a change in health status.

Review of the incident report revealed that on an identified day in May 2018, resident #001 had a change in health status while staff were using a device to assist them with activities of daily living resulting in a fall and injury. Review of the progress notes and post fall assessment revealed that the resident was assessed by RPN #105 and RN #106; however, the post fall assessment and progress notes did not identify any details related to range of motion (ROM) and pain. Interview with RPN #105, identified that they assessed resident #001 immediately after the incident, which included range of motion and pain. Interview with ADOC/RCS #102 confirmed that documentation of the post fall assessment should include all of the assessment completed by the registered staff including ROM and pain related to any injuries. [s. 30. (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 to ensure that any actions taken within respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident-staff communication and response system could be easily seen, accessed and used by residents, staff and visitors at all times.

Critical Incident System #2927-000018-18, submitted in May 2018, described an incident where resident #001 had a change in condition.

Review of the progress notes and CIS reports indicated that on and identified day in May 2018,RPN #105 was called to assess resident #001, who had a change in condition. Interview with PSW #107 identified that they had assisted PSW #108 to use a device to assist resident #001 when the resident had a change in condition. As a result of the incident, PSW #107 stated that they needed a third PSW to help. PSW #107 stated that the communication response system did not work at that time. Interview with PSW #108, confirmed that they had activated the communication response system but staff were not coming, and as a result, they had to go out to the hallway and yell for help. PSW #108 stated that they did not know the communication and response system was not working until they needed assistance. In the interview PSW #108 identified that the system was not working after the home had completed routine testing that morning. Interview with ESM, confirmed that on the identified day in May 2018, the home did complete routine testing around the time of the incident. In addition, ESM confirmed that on two unidentified occasions around the time of the CIS, the communication response system was not working properly on resident #001's home area, and required a reset of the system. The exact dates of the reset were not documented and could not be recalled. Interview with the Administrator revealed that they were unaware of the home area communication response system issue on the date of the incident, but it would be the expectation that the system could be used by resident, staff and visitors at all times. [s. 17. (1) (a)]

WN #5: 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 residents were protected from abuse by anyone.

i. On November 2, 2018, the home was issued CO #001 from RQI Inspection #2018_558123_0011, related to s. 19(1) of the LTCHA with a compliance date of November 19, 2018, directed the home to protect #023 from sexual abuse by resident #022. This non-compliance will be issued as a Written Notification (WN) as the incident occurred on prior to the compliance date.

ii. Critical Incident System (CIS) #2927-000046-18 and log #030900-18, submitted in November 2018, identified an altercation between resident #22 to resident #023.

iii. For the purposes of the definition of "abuse" in subsection 2 (1) of the act "sexual abuse" means any consensual or non-consensual touching, behaviour, or remarks of a sexual nature that is directed towards a resident by a person other than a licensee or staff member.

iv. Review of the health record for resident #022, identified that the resident had a history of responsive behaviours towards residents and staff.

v. Review of the CIS report identified that on an identified day in November 2018, resident #022 was displaying responsive behaviours towards resident #023. Interview with RPN #104 confirmed that the incident was reported to them by PSW staff and their assessment of resident #023 did not indicate that the resident recalled the incident or that there was harm to resident #023. Interview with the ADOC confirmed that resident #023 would not be able to consent to the sexually responsive behaviour.

The home failed to protect resident #023 from sexual abuse in November 2018. Interview with the ADOC and DOC and review of health records for resident #022 and #023 revealed that after the identified incident, no further incidents of sexual abuse have occurred between resident #022 and any other resident. [s. 19. (1)]

WN #6: 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 and among residents including identifying and implementing interventions.

i. On November 2, 2018, the home was issued RQI Order Report #2018_558123_0011, including the following compliance orders:
a. CO #001 related to s. 19(1) of the LTCHA with a compliance date of November 19, 2018, directed the home to conduct a multidisciplinary assessment of the sexually responsive behaviours of resident #022 and implement interventions to ensure that resident #020, #023, and #024 and all other residents were protected from sexual abuse by resident #022.
b. CO #002 related to s. 54(b) of Ontario Regulation 79/10 with a compliance date of November 19, 2018, directed the home to conduct a multidisciplinary assessment and implement interventions to minimize the risk of altercations and potentially harmful interactions between and among any residents.
This non-compliance will be issued as a Written Notification (WN) as the incident occurred prior to the compliance date.

ii. Critical Incident System (CIS) #2927-000046-18 and log #030900-18, submitted in November 2018, identified an incident of sexual abuse by resident #022 to resident #023.

iii. Review of the health record for resident #022, identified that the resident had a history

of responsive behaviours towards residents and staff.

iv. Review of the CIS reported revealed that on an identified day in November 2018, resident #022 was found displaying responsive behaviours towards resident #023. Review of the medical records for resident #022 identified a progress note several days prior to the incident, where the resident was required to have a device in place; and a Risk Management Meeting note, documented the same day, identified that the device was part of the safety plan for resident #022 and required regular checks. Review of investigation notes and interview with ADOC #102 confirmed that on the date of the incident, the device was not implemented according to the plan of care.

The device, which was part of resident #022's plan, was not implemented on the identified day in November 2018 . Noting that the date of the critical incident was prior to the compliance date for CO #002, related to r. 54(b), non compliance will be issued as a Written Notification. [s. 54. (b)]

Issued on this 5th day of February, 2019

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

Original report signed by the inspector.