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

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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
Sep 23, 2019	2019_715672_0010	003816-18, 004364-18, 007606-18, 015348-18, 017421-18, 017700-18, 027057-18, 028750-18, 002341-19, 007301-19	Complaint

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Bay Ridges
900 Sandy Beach Road PICKERING ON L1W 1Z4

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

JENNIFER BATTEN (672), KARYN WOOD (601), SAMI JAROUR (570)

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): August 8, 9, 12-16, 19-23, 26, 27, 2019

The following intakes were inspected during this inspection:

Logs #017700-18 and #015348-18 - related to complaints regarding withholding of admission to the Long Term Care Home

Log #007301-19 - related to environmental and staffing concerns

Log #004364-18 - related to a Critical Incident Report regarding an allegation of resident to resident abuse

Log #003816-18 - related to a Critical Incident Report regarding an allegation of resident to resident abuse

Log #007606-18 - related to a complaint regarding resident exhibited responsive behaviours, the complaints process in the home and personal support services

Log #002341-19 - related to a complaint regarding environmental support services specific to air temperatures

PLEASE NOTE: A Written Notification related to LTCHA, 2007, s. 20. (1), identified during a concurrent Critical Incident System Inspection (#2019_598570_0017) (Log #016181-18) was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), RAI Coordinator, Resident Services Coordinator (RSC), Office Manager, Environmental Services Manager (ESM), Dietary Services Manager (DSM), Physiotherapists (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), ward clerks, dietary aides, Physicians, housekeeping staff, residents, volunteers, family members and visitors to the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Admission and Discharge
Continence Care and Bowel Management
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

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

- **7 WN(s)**
- **3 VPC(s)**
- **0 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 LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times unless there is an allowable exception to this requirement.

According to O. Reg. 79/10, s. 45 (1) (2) ii, The following are the exceptions to the requirement that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, as required under subsection 8 (3) of the Act:

For homes with a licensed bed capacity of more than 64 beds and fewer than 129 beds,

ii. in the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this Regulation fails to ensure that the requirement under subsection 8 (3) of the Act is met, a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if,

(a)the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone, and

(b) a registered practical nurse who is both an employee of the licensee and a member of the regular nursing staff is on duty and present in the home. O. Reg. 79/10, s. 45 (1).

Ontario Regulation 79/10 section 45. (2) indicates that "emergency" means an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home.

Related to complaint log(s) #028750-18; 027057-18; 017421-18:

Bay Ridges is a one hundred and twenty-four bed home.

Inspector #601 reviewed the licensee's staffing schedule for registered nurses for an approximate six month period of time and from another specified two month period of time.

During review of the approximate six month period of time, Inspector #601 observed there was no Registered Nurse (RN) who was an employee of the licensee and a member of the regular nursing staff or pursuant to a contract or an agreement between

the nurse and the licensee present in the home during 125 shifts.

During the review of the two month period of time, Inspector #601 observed there was no Registered Nurse (RN) who was an employee of the licensee and a member of the regular nursing staff or pursuant to a contract or an agreement between the nurse and the licensee present in the home during 25 shifts.

During an interview, RPN #107 and RPN #153 both indicated that they had worked some shifts, especially on the weekend when there was not an RN working in the home.

During separate interviews, Ward Clerk #111 indicated to Inspector #601 that when an RN was not able to work due to illness or vacation an RPN would replace the RN's scheduled shift. Ward Clerk #111 confirmed that during the reviewed approximate six month time period, the licensee did not have an RN on duty on the identified 125 shifts.

During separate interviews, the Executive Director (ED) indicated to Inspector #601 there had been days when RN hours were not covered due to illness and vacation. The ED further indicated that RPN's had replaced RN's when they were not available to work and the Director of Care and the ED had been available in the home for some of the identified shifts, after they began working in the home. The ED confirmed that during the identified two month time period. the licensee did not have an RN on duty on the identified 25 shifts. The ED confirmed that during the identified two month time period, the registered nurses were not available to work due to illness or vacation time and the home did not have at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty.

The licensee has failed to comply with r. 45 (1) (2) ii of O. Reg. 79/10, whereby the licensee did not meet the exceptions to the requirement that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times as required under subsection 8 (3) of the Act. [s. 8. (3)]

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 at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff is on duty and present at all times unless there is an allowable exception, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents were locked when they were not being supervised by staff.

Related to Complaint Log #017421-18:

A complaint was received by the Director indicating resident #004 was missing from the home for a ten minute time period and no one knew the resident was missing until the resident was returned to the home by a neighbor.

Inspector #601 reviewed the Critical Incident Report (CIR) submitted to the Director for the incident involving resident #004 missing from the home for nine minutes on a specified date. The CIR indicated that PSW #128 had placed the courtyard door on bypass to allow a co-resident who was outside the ability to return to the inside. The camera was viewed and resident #004 was observed leaving the property through the

gate as the pad lock on the gate had malfunctioned. Resident #004 was returned to the home by a neighbor with no injury.

A review of resident #004's clinical health record by Inspector #601 identified that resident #004 resided in the secured unit.

A review of resident #004's care plan in place at the time of the incident identified that resident #004 had interventions related to responsive behaviours in place.

A review of resident #004's progress notes by Inspector #601 identified that on a specified date, the ADOC documented that a person in the neighborhood had brought resident #004 back to the home as they were found walking on the sidewalk alone. No injuries observed upon head to toe assessment by the ADOC. Two days later, RPN #152 documented that following the incident, it was noted that the court yard door had been left open and the gate latch was bent. Documentation from the Executive Director (ED) who was no longer working in the home stated that resident #004 had eloped from the home through the door in the lounge area which opened onto the outdoor patio and was able to exit through the gate and crossed the street before being returned to the home by the neighbor. Staff working in resident #004's home area at the time of the incident were not aware that the resident was missing until the resident was returned to the home. A new latch was placed on the outdoor fence, the door to the lounge area was checked for safety and was to remain locked. An identified intervention was put in place for resident #004 in an attempt to prevent them from going through the front door should they exit the secured unit through its main entrance.

During separate interviews, PSW #128, RPN #107 and RPN #153 indicated that resident #004 exhibited responsive behaviours. They all indicated being aware that resident #004 had eloped from the home but could not recall the details. They further indicated that the courtyard door was always to be locked when residents were not being supervised.

During an interview, the Executive Director (ED) indicated to Inspector #601 they were not aware of the details involving resident #004 eloping from the home as this occurred prior to the Director of Care and the ED working in the home. The ED further indicated that the courtyard door was always to be locked when residents were not being supervised.

The licensee failed to ensure that all doors leading to non-residential areas that were equipped with locks to restrict unsupervised access to those areas by residents were

locked when they were not being supervised by staff.

The following finding of non-compliance was identified by Inspector #601 during Critical Incident Report (CIR) Inspection #2019_598570_0017 conducted concurrently with this Complaint Inspection #2019_715672_0010 and issued under this report.

Related to Log #012261-19:

Record review of a Critical Incident Report by Inspector #601 identified that on a specified date and time, resident #009 was returned to the home by the police after being found walking near Highway 401, with no injuries observed. According to the CIR, resident #009 had exited the home into the yard from the door located in the television room and then exited the gate in the yard due to the latch being broken. Following the incident, the Environmental Service Manager (ESM) immediately repaired the latch on the outside gate and checked to ensure the courtyard door was locked.

Review of resident #009's clinical health record by Inspector #601 identified resident #009 resided in the secured unit.

A review of resident #009's plan of care identified that resident #009 exhibited identified responsive behaviours and had planned interventions in place.

A review of resident #009's progress notes by Inspector #601 identified that RPN #107 documented that resident #009 was discovered missing on the specified date when staff went to find the resident for a meal. According to the progress note, staff proceeded to complete room checks and were then notified that resident #009 had been returned to the home by the police and was in the front lobby.

During separate interviews, PSWs #128 and #139 indicated to Inspector #601 that resident #009 had been exit seeking and was frequently refusing one of the interventions. They further indicated that the courtyard door was always to be locked when residents were not being supervised.

During an interview, RPN #107 indicated to Inspector #601 that resident #009 exhibited identified responsive behaviours and would frequently refuse one of the planned interventions. RPN #107 indicated they recalled that it was determined that resident #009 had exited the home by the courtyard doors but were not sure how the resident was able to exit the gate from the yard to the street. RPN #107 indicated they did not recall a

power failure occurring on the date of resident #009's elopement and that the courtyard door was always to be locked when residents were not being supervised.

During separate interviews, the Environmental Service Manger (ESM) and the Executive Director (ED) indicated to Inspector #601 that on the date of resident #009's elopement there had been a power failure, which could have caused the courtyard door lock to disengage. They both indicated not being aware of the gate lock being broken and that a second lock was installed on the gate following resident #009's elopement to the courtyard onto the street. The ESM and ED both indicated that the courtyard door was always to be locked when residents were not being supervised.

The licensee failed to ensure that all doors leading to non-residential areas that were equipped with locks to restrict unsupervised access to those areas by residents were locked when they were not being supervised by staff. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas that are equipped with locks to restrict unsupervised access to those areas by residents are kept locked at all times when not being supervised by staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. Under the LTCHA, 2007, s. 44(7) the appropriate placement coordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43(6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless, (a) the home lacks the physical facilities necessary to meet the applicant's care requirements; (b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or (c) circumstances exist which are provided for in the regulations as being a ground for withholding approval.

Related to Log #017700-18:

A complaint was received by the Ministry of Long Term Care, submitted by the Central East Local Health Integration Network (CELHIN) indicating an applicant had been refused admission to the Long-Term Care Home.

Review of the applicant's refusal letter for admission from the licensee indicated the applicant was refused admission because the home lacked the nursing expertise necessary to meet the applicant's care requirements while ensuring the safety of the other residents in the home.

The explanation provided by the licensee in the refusal letter indicated the home lacked the nursing expertise necessary to meet the applicant's care requirements while ensuring the safety of the other residents in the home due to the applicant's behaviours. The letter was signed by the Resident Services Coordinator.

During an interview, the Resident Services Coordinator indicated that the home had a secured specialized dementia care unit, there was a Behavioural Supports Ontario (BSO) team in the home and the nursing staff had received education and training related to exhibited responsive behaviours and Gentle Persuasive Approach (GPA trained). The Resident Services Coordinator further indicated the licensee had a previous history of noncompliance under the legislation related to responsive behaviours, therefore would often decline applications where the applicants exhibited responsive behaviours, especially responsive behaviours which could be directed towards other residents.

The documented evidence provided by the licensee did not support how the home lacked the nursing expertise to meet the applicant's care requirements, or how the licensee did not have the necessary resources to meet the applicant's care requirements. [s. 44. (7)]

2. Under the LTCHA, 2007, s. 44(7) the appropriate placement coordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43(6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless, (a) the home lacks the physical facilities necessary to meet the applicant's care requirements; (b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or (c) circumstances exist which are provided for in the regulations as being a ground for withholding approval.

Related to Log #015348-18:

A complaint was received by the Director from a case manager at the Central East Local Health Integration Network (CELHIN) indicating an applicant had been refused admission to the Long-Term Care Home.

Review of the applicant's refusal letter for admission from the licensee indicated the applicant was refused admission because the home lacked the number of staff and nursing expertise necessary to meet the applicant's care requirements.

During a telephone interview, the case manager from the CELHIN indicated that the applicant had been refused admission to the home based on concerns the licensee indicated they had related to responsive behaviours exhibited by the applicant. The case manager from CELHIN further indicated the licensee based their decision to refuse the application on an outdated assessment of the applicant, and had sent an updated assessment to the licensee and requested the licensee conduct a home visit with the applicant.

The explanation provided by the licensee in the refusal letter was that the home lacked the nursing expertise necessary to meet the applicant's care requirements when the applicant exhibited responsive behaviours and required the secured unit.

Following the licensee's rejection of the application, the CELHIN sent an updated Personal Health Profile and Assessment of the applicant, and requested the licensee review the updated assessment, view the applicant in their current home setting and reconsider the application. A notation observed by Inspector #672 in the applicant's package in the home indicated that the updated assessment was reviewed by the Resident Services Coordinator, and the rejection of the application remained in place.

Review of the Personal Health Profile and Assessment indicated that the applicant did not exhibit any responsive behaviours.

During an interview, the Resident Services Coordinator indicated that they did not go to assess the applicant in their current home setting, as per the request of the CELHIN and was aware that the updated assessment indicated the applicant had stabilized and no longer exhibited responsive behaviours. The Resident Services Coordinator further indicated they had refused the application based on the applicant's previous history of responsive behaviours, the current behaviours which were occurring in the home within the licensee's resident population, the applicant's age, and not being convinced that the information listed within the assessment provided by the CELHIN was truly reflective of

the applicant's care needs. The Resident Services Coordinator indicated they did not ask any further questions or attempt to verify the information listed within the applicant's updated Personal Health Profile and Assessment prior to refusing the application.

The documented evidence provided by the licensee did not fully explain how the home lacked the number of staff and/or nursing expertise required to support the applicant's care requirements. [s. 44. (7)]

3. The licensee has failed to ensure that when withholding approval for admission, the licensee shall provide to persons described in subsection (10) a written notice setting out, the ground or grounds on which the licensee was withholding approval; a detailed explanation of the supporting facts, as they related both to the home and to the applicant's condition and requirements for care; an explanation of how the supporting facts justified the decision to withhold approval; and contact information for the Director.

Related to Log #017700-18:

This inspection was initiated related to a complaint received by the Ministry of Long Term Care, submitted by the CELHIN, related to applicant #005. The complaint pertained to withholding approval for admission to Bay Ridges LTC Home.

An application for admission was made to the LTC home by applicant #005. A letter from the Resident Services Coordinator on behalf of Bay Ridges LTC home addressed to the applicant stated approval for admission to the home was being withheld due to the applicant's responsive behaviours, as the home lacked the nursing expertise necessary to meet the applicant's care requirements while ensuring the safety of the other (vulnerable) residents in the home.

During an interview, the Resident Services Coordinator indicated awareness that when withholding approval for admission, the legislation in subsection (10) required a written notice setting out, the ground or grounds on which the licensee was withholding approval; a detailed explanation of the supporting facts as they related both to the home and to the applicant's condition and requirements for care; an explanation of how the supporting facts justified the decision to withhold approval; and contact information for the Director. Following review of the refusal letter, the Resident Services Coordinator indicated the letter did not meet the requirements, as it did not provide for a detailed explanation of the supporting facts related both to the home and to the applicant's condition and requirements for care, how the supporting facts justified the decision to

withhold approval, or contact information for the Director. [s. 44. (9)]

4. The licensee has failed to ensure that when withholding approval for admission, the licensee shall provide to persons described in subsection (10) a written notice setting out, the ground or grounds on which the licensee was withholding approval; a detailed explanation of the supporting facts, as they related both to the home and to the applicant's condition and requirements for care; an explanation of how the supporting facts justified the decision to withhold approval; and contact information for the Director.

Related to Log #015348-18:

This inspection was initiated related to a complaint received by the Ministry of Long Term Care, submitted by the CELHIN, related to applicant #006. The complaint pertained to withholding approval for admission to Bay Ridges LTC Home.

An application for admission was made to the LTC home. A letter from the Resident Services Coordinator on behalf of Bay Ridges LTC home addressed to the applicant stated approval for admission to the home was being withheld due to the applicant's responsive behaviours, as the home lacked the number of staff and nursing expertise necessary to meet the applicant's care requirements.

During an interview, the Resident Services Coordinator indicated awareness that when withholding approval for admission, the legislation in subsection (10) required a written notice setting out, the ground or grounds on which the licensee was withholding approval; a detailed explanation of the supporting facts as they related both to the home and to the applicant's condition and requirements for care; an explanation of how the supporting facts justified the decision to withhold approval; and contact information for the Director. Following review of the refusal letter, the Resident Services Coordinator indicated the letter did not meet the requirements, as it did not provide for a detailed explanation of the supporting facts related both to the home and to the applicant's condition and requirements for care, how the supporting facts justified the decision to withhold approval, or contact information for the Director. [s. 44. (9)]

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 applications to the home are approved unless there is an allowable exception, and if admission is being denied, the refusal letter must contain all of the information required under the legislation, to be implemented voluntarily.

WN #4: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the written plan of care for resident #004 set out clear directions to staff and others who provided direct care to the resident regarding a specified intervention.

Related to Complaint Log #017421-18:

A complaint was received by the Director related to resident #004 eloping from the home for ten minutes and no staff noticed the resident was missing until the resident was returned to the home by a neighbor.

During an interview, resident #004's SDM indicated to Inspector #601 that resident #004 was at risk for eloping and a specified intervention was supposed to be in place at all times. Resident #004's SDM further indicated to Inspector #601 that the specified intervention was not in place when they had visited the resident earlier in the day.

During a review of resident #004's clinical health record, Inspector #601 identified that resident #004 resided in the secured unit.

Inspector #601 observed that resident #004 did not have a specified intervention in place during three separate resident observations.

A review of resident #004's care plan interventions following the incident of elopement from the home identified that resident #004's written interventions included the specified intervention, which was put into place after the incident.

During separate interviews, PSW #100, PSW #139 and PSW #128 indicated to Inspector #601 that resident #004 had not recently been exhibiting the responsive behaviour. They further indicated that resident #004 used to wander and they were not sure the reason resident #004 no longer had the specified intervention in place.

During an interview, RPN #107 reviewed resident #004's current plan of care for the behaviours. The care plan indicated that resident #004 continued to have the specified intervention in place. RPN #107 and RPN #153 indicated that they were not aware of the reason resident #004 no longer had the specified intervention in place. RPN #107 and RPN #153 further indicated that resident #004 had not recently been exhibiting the responsive behaviour and were not clear who determined that resident #004 no longer required the specified intervention to be in place or if resident #004's SDM had been made aware that the resident no longer had the specified intervention.

The licensee failed to ensure that there was a written plan of care for resident #004 that set out clear directions to staff and others who provided direct care to the resident regarding a specified intervention. [s. 6. (1) (c)]

WN #5: 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 has failed to ensure that the internal policy entitled "Mandatory Reporting of Resident Abuse or Neglect" was complied with.

Related to Log #004364-18:

A Critical Incident Report was submitted to the Director regarding an alleged incident of resident to resident abuse between residents #002 and #008. According to the CIR, PSW #117 intervened and separated the residents.

During record review, Inspector #672 observed the CIR stated the previous DOC, who had filed the report, had become aware of the incident on a specified date, following review of the 24 hour shift documentation from the previous day, which mentioned the incident which had occurred one week prior.

Inspector #672 reviewed an internal policy related to incidents of resident to resident abuse which indicated staff members were expected to immediately report any incident of resident abuse immediately.

PSW #117 was not available for interview during this inspection.

During an interview, the current DOC indicated they could not speak to the incident, as it occurred prior to their working in the home. The DOC further indicated the expectation in the home was that any staff member who had a suspicion or knowledge of an incident of resident abuse or neglect was to immediately report the suspicion and the information upon which it was based to someone from the management team during business hours, and to the charge nurse after business hours.

The licensee failed to ensure that an allegation of resident to resident abuse was immediately reported to the Director. The incident was not reported to the Director until

six days after the incident occurred.

The following finding of non-compliance was identified by Inspector #570 during a Critical Incident System Inspection (#2019_598570_0017) conducted concurrently with this Complaint Inspection (#2019_715672_0010) and issued under this report.

2) The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

A review of an internal policy related to incidents of resident to resident abuse indicated staff members were expected to immediately report any incident of resident abuse immediately.

Related to Log #016181-18

The former Director of Care (DOC) at the LTC home submitted a Critical Incident Report specific to an alleged incident of staff to resident abuse. The CIR indicated that PSW #135 reported to RPN #129 that while PSW #136 and another unidentified PSW were providing care to resident #014 one year prior, PSW #136 abused the resident causing harm.

A review of progress notes for resident #014 during the month of the alleged incident indicated that RPN #101 documented on a specified date and time that resident #014 had an identified injury to the specified body part.

A review of the survey documentation report on Point Click Care (PCC) for the month indicated that PSW #136 was working during the shift the injury was observed and provided care to resident #014.

During an interview, RPN #129 acknowledged that PSW #135 reported the allegation of resident abuse to them on a specified date at the end of the shift. The RPN indicated that they reported the allegation to the ADOC at the beginning of their shift the next day. The RPN indicated they were aware of the reporting requirements and that the allegation should have been immediately reported to the manager on call.

During an interview, the DOC indicated to Inspector #672 that any allegation of resident abuse or neglect was expected to be immediately reported to a member of the management team. The manager would submit a CIR if the allegation was made during

business hours, or would use the after hours pager and complete the CIR the next business day, if the allegation was made after business hours.

The licensee's internal policy related to resident abuse was not complied with, when RPN #129 and PSW #135 failed to immediately report an allegation of staff to resident abuse involving resident #014. [s. 20. (1)]

2. Related to Log #004364-18:

A Critical Incident Report was submitted to the Director regarding an alleged incident of resident to resident abuse which occurred between residents #002 and #008. According to the CIR, PSW #117 intervened and separated the residents.

Related to Log #003816-18:

A Critical Incident Report was submitted to the Director related to an alleged incident of resident to resident abuse which occurred between residents #002 and #007.

During an interview, PSW #113 indicated they observed the alleged incident between residents #002 and #007. PSW #113 further indicated they immediately reported the incident to RPN #156, who happened to be standing in the area administering medications. RPN #156 separated the residents and reported the incident to the management team in the home.

Inspector #672 reviewed the internal policy entitled resident abuse which indicated witnesses and the accused were to be identified, advised of the allegation(s) and interviewed within 24 hours; the resident(s) involved in the allegation and residents who were in the area of the incident, along with family members and/or visitors if they were present at the time of the alleged incident were also to be interviewed, which included residents with cognitive impairment and were to be documented and include the resident's non-verbal signs.
All statements and interviews were expected to be dated, timed, signed and documented in the actual words of the person interviewed. Documentation of the investigation was to be kept in a specified investigation file and include specified documentation.

Inspector #672 reviewed the internal investigation package related to the critical incident report. The investigative package did not include written statements from either of the residents involved or the staff members who witnessed and/or intervened during the

incident, documentation to support that further witnesses of the incident other than PSW #113 and RPN #156 were sought out to ascertain what they may have observed, an analysis of the alleged incident, the final conclusion of what occurred or whether the allegation was substantiated or not. The interviews of PSW #113 and RPN #156 were not documented in their own words and were not dated, timed and signed. Documentation from one of the investigations which was to be kept in a specified investigation file did not include the specified documentation as outlined in the internal policy, and there was no internal investigation package related to the alleged incident between residents #002 and #007.

During separate interviews, PSW #113 and RPN #156 indicated they had spoken to the previous DOC regarding their observation of the incident which occurred between residents #002 and #007, but had not provided a written statement or received a formal interview regarding their observations.

PSW #117 was not available for interview during this inspection.

During an interview, the current DOC indicated they could not speak to either incident, as both incidents occurred prior to their working in the home. The DOC further indicated they could not locate any internal investigation documentation or notes related to the incident which occurred between residents #002 and #007, and was only able to locate one personal notation written by the previous DOC which outlined the actions taken as a result of the incident. The DOC indicated the expectation in the home was for the internal policies to be followed.

The licensee failed to ensure that the internal policy related to resident abuse was complied with, specific to the alleged incidents of resident to resident abuse between residents #002 and #007, and residents #002 and #008, related to the completion of the internal investigations. [s. 20. (1)]

WN #6: 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. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of every abuse or neglect investigation was reported to the Director.

Related to Log #004364-18:

A Critical Incident Report was submitted to the Director regarding an alleged incident of resident to resident abuse which occurred between residents #002 and #008. According to the CIR, PSW #117 intervened and separated the residents.

During record review, Inspector #672 observed the CIR stated resident #002 was being assessed by the internal Behavioural Support Ontario (BSO) team lead, an external community outreach team and physician #155, who was considering a specified intervention, if resident #002 and their POA consented. The last amendment to the critical incident report did not include the outcome of the assessments, whether the specified intervention was implemented for the resident or what the effects of the specified intervention was assessed to be.

During an interview, the current DOC indicated they could not speak to the incident, as it occurred prior to their working in the home. The DOC further indicated they could not locate any internal investigation documentation or notes related to the incident within the home. The DOC stated the expectation in the home was for each critical incident report submitted to the Director was to include the outcome of every abuse or neglect investigation.

The licensee failed to ensure that the report to the Director included the outcome of the assessments of resident #002 by the internal BSO team lead, the external community outreach assessment, whether a specified intervention was prescribed for the resident or what the effects of the specified intervention on resident #002 was assessed to be. [s. 23. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the name of every staff member who responded to an incident of alleged resident to resident abuse.

Related to Log #004364-18:

A Critical Incident Report was submitted to the Director regarding an alleged incident of resident to resident abuse which occurred between residents #002 and #008. According to the CIR, PSW #117 intervened and separated the residents.

During record review, Inspector #672 observed the CIR stated the registered staff member was placed on administrative leave pending the outcome of the investigation. Further review of the CIR did not reveal the name or designation of the registered staff member.

During an interview, the current DOC indicated they could not speak to the incident, as it occurred prior to their working in the home. The DOC further indicated they could not locate any internal investigation documentation or notes related to the incident within the home, therefore could not provide the name or designation of the registered staff member mentioned in the critical incident report. The DOC stated the expectation in the home was for each critical incident report submitted to the Director to include the name and designation of every staff member who were either present at, discovered or responded to an incident or allegation of resident abuse or neglect.

The previous DOC, who filed the critical incident report was not available for interview during this inspection, as they no longer worked in the home.

The licensee failed to ensure that the critical incident report submitted to the Director related to an allegation of resident to resident abuse included the name of the registered staff member who was placed on administrative leave pending the outcome of the internal investigation into the incident, as stated in the report. [s. 104. (1) 2.]

Issued on this 25th day of September, 2019

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

Original report signed by the inspector.