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

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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 30, 2018	2018_601532_0022	023271-18, 025512-18, 025814-18	Complaint

Licensee/Titulaire de permis

Bennett Health Care Centre
1 Princess Anne Drive Georgetown ON L7G 2B8

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

Bennett Health Care Centre
1 Princess Anne Drive Georgetown ON L7G 2B8

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

NUZHAT UDDIN (532), JANET GROUX (606)

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): September 24, 25, 26, 27, 28, 2018 and October 1, 2, 3, 4, 5, 2018.

The following Critical Incidents (CI) were conducted in conjunction with this inspection.
Log #023271-18, CI# 2816-000006-18 related to resident to resident abuse.
Log #025512-18, CI # 2816-000008-18 related to fall with injury.
Log #025814-18, complaint related to a fall.

A Written Notification and Compliance Order related to LTCHA, 2007, s. 19 (1) and identified in Critical Incident System Inspection (CIS) 2018_723606_0021 (Log # 023987-17, CI #2816-000006-17, Log #005347-18, CI # 2816-000004-18 and Log # 026051-18, CI #2816-000009-18) were issued in this report.

During the course of the inspection, the inspector(s) spoke with the acting Administrator, Director of Care (DOC), Physicians, Nurse Practitioners (NP), Pharmacist, Detective, Physiotherapist, Dietitian, Resident Assessment Instrument (RAI) Coordinator, Behaviour Support Ontario (BSO) staff, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents and Family members.

Inspectors also toured the resident home areas, observed resident care provision; resident/staff interaction, reviewed relevant resident's clinical records, video surveillance, relevant policies and procedures, as well as notes pertaining to the inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

- **7 WN(s)**
- **3 VPC(s)**
- **3 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. 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 has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

a) This inspection was completed related to a complaint and Critical Incident (CI), submitted to the Ministry Of Health and Long Term Care (MOHLTC) which reported an allegation of resident to resident physical abuse.

Record review stated that an identified resident was found on the floor with injury and another identified resident was present in the room at the time of the incident.

An identified Registered Nurse (RN) stated that a staff approached them and informed them that an identified resident was on the floor. They noted that the resident was lying on the floor and appeared injured. They also observed another resident in the room at the time of the incident.

The Director of Care (DOC) stated that the identified resident sustained a significant injury.

b) Review of another CI submitted to the MOHLTC reported an allegation of staff to resident physical and verbal abuse.

Record review indicated that two identified residents had responsive behaviours.

Further review of the critical incident stated that identified staff members were providing care to the residents at which time the residents displayed responsive behaviours.

An identified staff was witnessed verbally abusing and rough handling the residents

during care.

The DOC acknowledged that the home completed an investigation and concluded that the staff had provided care to the residents in an abusive manner.

c) A CI submitted to the MOHLTC reported an allegation of resident to resident physical abuse that resulted in an injury.

Record review stated that the identified resident reported to an RN an altercation with another resident that resulted in an injury.

The RN and the DOC acknowledged that the resident sustained an injury related to the altercation with another resident.

The licensee has failed to ensure that residents were protected from abuse by anyone. [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. 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 there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with.

Specifically, staff did not comply with the licensee's policy section: "1. Resident Rights,

subsection: 1.3 Non Abuse Program."

This inspection was completed related to a complaint and CI related to an allegation of resident to resident physical abuse.

a) Record review stated that an identified resident was found on the floor with injury and another resident was present in the room at the time of the incident.

Record review stated that the identified resident sustained an injury and was assessed by the Nurse Practitioner (NP).

The RN said that the resident present in the room at the time of the incident was not assessed by the physician or the NP as stated in the policy.

b) A CI submitted to the MOHLTC reported an allegation of resident to resident physical abuse that resulted in an injury.

Record review stated that the identified resident reported an altercation with another resident that resulted in an injury.

A progress note stated that there was no assessment documented for the identified residents.

The DOC stated that the registered staff were to notify the physician in relation to the incidents, but the physician would not come immediately to do an assessment on the residents. The DOC shared that there was no immediate medical assessment done on either of the identified residents involved in the altercation.

c) Review of a CI submitted to the MOHLTC reported an allegation of staff to resident physical and verbal abuse.

An identified staff was witnessed by another staff verbally abusing and rough handling the identified residents during care.

The identified staff stated that they witnessed the abuse during care, but did not report the incident immediately. (606)

The licensee failed to ensure that the home's policy to promote zero tolerance of abuse

and neglect of residents was complied with. [s. 20. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with 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).

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 has failed to ensure that the responsive behaviour program was being evaluated annually and updated in accordance with evidence-based practices or prevailing practices.

The DOC was asked for the responsive behaviour program evaluation and they confirmed that there was no responsive behaviour program evaluation completed for the last two years.

The licensee has failed to ensure that the responsive behaviour program was evaluated annually and updated in accordance with evidence-based practices or prevailing practices. [s. 53. (3) (b)]

2. The licensee has failed to ensure that strategies were developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

a) A CI was submitted to the MOHLTC which reported an allegation of resident to resident physical abuse that resulted in an injury.

The CI report indicated that the identified resident exhibited a behaviour.

Record review stated that as a consequence of the behaviour there was an altercation with another resident that caused an injury.

Review of progress notes for the identified resident indicated that there were a number of behavioural occurrences.

The plan of care for the resident did not identify strategies to address the behaviour for the identified resident.

The RN reviewed the plan of care and acknowledged that the identified behaviour was not part of the plan of care and there were no strategies developed and implemented to respond to the behaviour.

The DOC stated that the behaviours should have been identified in the plan of care and strategies developed and implemented to respond to and manage the behaviour.

b) This inspection was completed related to a complaint and CI submitted to the MOHLTC in relation to an allegation of resident to resident physical abuse.

Record review stated that an identified resident was found on the floor with injury and another resident was present in the room at the time of the incident.

The plan of care did not identify any strategies to respond to the resident demonstrating responsive behaviours.

Review of progress notes stated that there were number of incidents where the identified resident exhibited the specified responsive behaviour.

A number of staff reported that the resident exhibited the specified responsive behaviours.

BSO RN/Lead reported that the identified resident had responsive behaviours. The BSO/RN indicated that they had not tried other interventions or strategies.

The DOC indicated that there were no strategies or interventions in place to address the specified responsive behaviour.

The licensee has failed to ensure that strategies were developed and implemented to respond to the resident demonstrating responsive behaviours. [s. 53. (4) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

In accordance with O.reg.79/10, r. 52. (1), the licensee was required to ensure that the pain management program provided for the monitoring of residents' responses to, and the effectiveness of the pain management strategies was developed and implemented.

Specifically, staff did not comply with the licensee's policy regarding "Pain Management Program".

Record review of the identified resident's progress notes showed that the resident often complained of pain and asked for pain medication. The resident was on analgesics on as needed (PRN) basis.

The RN shared that the resident was being managed on the PRN medication. The policy was reviewed with the RN and they acknowledged that the policy was not complied with as the pain was managed with the PRN medication.

The DOC stated that the policy related to pain was not followed and round the clock dosing of the current PRN medication was not considered.

The licensee has failed to ensure that any policy related to pain was not complied with for resident #001. [s. 8. (1) (a),s. 8. (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 The licensee must ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, 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, reassessments, interventions and the resident's responses to interventions were documented.

This inspection was completed related to a complaint and a CI submitted to the MOHLTC which reported an allegation of resident to resident physical abuse.

Record review of the identified resident's progress notes stated that the resident had an altered skin integrity.

It was noted through record review that there was no evidence of any weekly wound assessments being completed.

The RPN stated that the identified resident had no further skin assessments completed.

The DOC stated that it was the home's practice to complete weekly skin assessments using the Weekly Wound Assessment - Bates Jensen V2 for any resident who had altered skin integrity.

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.

b) This inspection was completed related to a complaint and CI submitted to the MOHLTC which reported an allegation of resident to resident physical abuse.

Record review of the identified resident's progress notes stated that the identified resident had an area of altered skin integrity.

Review of the resident's "Weekly Wound Assessment - Bates Jensen V2" and written care plan identified that the resident was on a specified intervention.

The identified RPN and the DOC stated that the resident did not have a documented intervention in place.

b) Review of an identified resident's progress notes stated that the resident was admitted to the home with altered skin integrity.

Record review for the resident, stated an intervention to manage the resident's altered skin integrity.

During interviews with RPNs and the DOC, they stated the identified resident did not have a documented intervention in place.

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. [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 The licensee must ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #6: 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 has failed to ensure that 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 are required to prevent further occurrences.

The home's 2017 annual evaluation of their abuse and neglect policy was not available for review.

The DOC stated that the home did not complete an annual evaluation of the home's abuse and neglect policy for 2017.

The licensee has failed to ensure that 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 are required to prevent further occurrences. [s. 99. (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 The licensee must ensure 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, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff were provided training in pain management, including recognition of specific and non-specific signs of pain.

Record review of the program evaluation completed for an identified period of time indicated that the home did not reach the goal of 100 per cent surge learning and it was documented as ongoing.

Review of surge learning course completion regarding pain assessment and management; module for registered staff, showed that 63.6 per cent of registered staff completed the pain assessment and management training and 36.4 per cent did not complete the education.

The DOC acknowledged that the surge learning for pain assessment and management was not completed by all the resgistered staff.

The licensee has failed to ensure that direct care staff were provided training in pain management. [s. 221. (1) 4.]

Issued on this 8th day of January, 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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NUZHAT UDDIN (532), JANET GROUX (606)
Inspection No. / No de l'inspection :	2018_601532_0022
Log No. / No de registre :	023271-18, 025512-18, 025814-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 30, 2018
Licensee / Titulaire de permis :	Bennett Health Care Centre 1 Princess Anne Drive, Georgetown, ON, L7G-2B8
LTC Home / Foyer de SLD :	Bennett Health Care Centre 1 Princess Anne Drive, Georgetown, ON, L7G-2B8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Brian Jackson

To Bennett Health Care Centre, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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 s. 19. (1) of the LTCHA.
Specifically the licensee must ensure that specified residents and all other residents are protected from abuse by anyone.

Grounds / Motifs :

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

a) This inspection was completed related to a complaint and Critical Incident (CI), submitted to the Ministry Of Health and Long Term Care (MOHLTC) which reported an allegation of resident to resident physical abuse.

Record review stated that an identified resident was found on the floor with injury and another identified resident was present in the room at the time of the incident.

An identified Registered Nurse (RN) stated that a staff approached them and informed them that an identified resident was on the floor. They noted that the resident was lying on the floor and appeared injured. They also observed another resident in the room at the time of the incident.

The Director of Care (DOC) stated that the identified resident sustained a significant injury.

(532)

2. b) A CI submitted to the MOHLTC reported an allegation of resident to resident physical abuse that resulted in an injury.

Record review stated that the identified resident reported to an RN an altercation with another resident that resulted in an injury.

The RN and the DOC acknowledged that the resident sustained an injury related to the altercation with another resident.

(532)

3. c) Review of another CI submitted to the MOHLTC reported an allegation of staff to resident physical and verbal abuse.

Record review indicated that two identified residents had responsive behaviours.

Further review of the critical incident stated that identified staff members were providing care to the residents at which time the residents displayed responsive behaviours.

An identified staff was witnessed verbally abusing and rough handling the residents during care.

The DOC acknowledged that the home completed an investigation and concluded that the staff had provided care to the residents in an abusive manner.

The licensee failed to ensure that residents were protected from abuse by anyone. (606)

The severity of this issue was determined to be a level three as there was actual harm to the residents. The scope of the issue was level three widespread as three out of three residents reviewed were affected. The home had a level three history, one or more related non-compliance in the last three years that included: Compliance Order (CO) #001 issued on January 17, 2017 with a compliance

due date of March 31, 2017 (2016_449619_0032). (606)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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).

Order / Ordre :

The licensee must be compliant with s. 20. (1) of the LTCHA.
Specifically the licensee must 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.

Grounds / Motifs :

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

Specifically, staff did not comply with the licensee's policy section: "1. Resident Rights, subsection: 1.3 Non Abuse Program."

This inspection was completed related to a complaint and CI related to an allegation of resident to resident physical abuse.

a) Record review stated that an identified resident was found on the floor with injury and another resident was present in the room at the time of the incident.

Record review stated that the identified resident sustained an injury and was assessed by the Nurse Practitioner (NP).

The RN said that the resident present in the room at the time of the incident was not assessed by the physician or the NP as stated in the policy.

(532)

2. b) A CI submitted to the MOHLTC reported an allegation of resident to resident physical abuse that resulted in an injury.

Record review stated that the identified resident reported an altercation with another resident that resulted in an injury.

A progress note stated that there was no assessment documented for the identified residents.

The DOC stated that the registered staff were to notify the physician in relation to the incidents, but the physician would not come immediately to do an assessment on the residents. The DOC shared that there was no immediate medical assessment done on either of the identified residents involved in the altercation. (532)

3. c) Review of a CI submitted to the MOHLTC reported an allegation of staff to resident physical and verbal abuse.

An identified staff was witnessed by another staff verbally abusing and rough handling the identified residents during care.

The identified staff stated that they witnessed the abuse during care, but did not report the incident immediately. (606)

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

The severity of this issue was determined to be a level two as there was potential for actual harm to the residents. The scope of the issue was a level two as two out of five program policies reviewed were not complied with. The home had a level four history, as they had on-going non-compliance with this section of the LTCHA that included:
Voluntary Plan of Correction (VPC) issued January 17, 2017 (2016_449619_0032);
VPC issued June 1, 2017, (2017_543561_0007). (606)

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2018

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(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).

Order / Ordre :

The licensee must be complaint with s. 53. (4) of the Regulations.
Specifically the licensee must ensure that:
1. Specified residents and all other residents demonstrating responsive behaviours specifically wandering, that strategies are developed and implemented to respond to these behaviours, where possible.
2. The process shall include staff roles and responsibilities including which staff are responsible for the implementation of the strategies and monitoring of resident's responses to the strategies.

Grounds / Motifs :

1. The licensee has failed to ensure that strategies were developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

a) A CI was submitted to the MOHLTC which reported an allegation of resident to resident physical abuse that resulted in an injury.

The CI report indicated that the identified resident exhibited a behaviour.

Record review stated that as a consequence of the behaviour there was an altercation with another resident that caused an injury.

Review of progress notes for the identified resident indicated that there were a number of behavioural occurrences.

The plan of care for the resident did not identify strategies to address the behaviour for the identified resident.

The RN reviewed the plan of care and acknowledged that the identified behaviour was not part of the plan of care and there were no strategies developed and implemented to respond to the behaviour.

The DOC stated that the behaviours should have been identified in the plan of care and strategies developed and implemented to respond to and manage the behaviour. (532)

2. b) This inspection was completed related to a complaint and CI submitted to the MOHLTC in relation to an allegation of resident to resident physical abuse.

Record review stated that an identified resident was found on the floor with injury and another resident was present in the room at the time of the incident.

The plan of care did not identify any strategies to respond to the resident demonstrating responsive behaviours.

Review of progress notes stated that there were number of incidents where the identified resident exhibited the specified responsive behaviour.

A number of staff reported that the resident exhibited the specified responsive behaviours.

BSO RN/Lead reported that the identified resident had responsive behaviours. The BSO/RN indicated that they had not tried other interventions or strategies.

The DOC indicated that there were no strategies or interventions in place to address the specified responsive behaviour.

The licensee has failed to ensure that strategies were developed and implemented to respond to the resident demonstrating responsive behaviours.

[s. 53. (4) (b)]

The severity of this issue was determined to be a level three as there was actual harm to the residents. The scope of the issue was a level two as it related to two out of three residents reviewed were affected. The home had a level two history, one or more unrelated non-compliance in the last three years. (532)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2018

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 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, 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 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 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 de la Santé et 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 de la Santé et 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 30th day of November, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Nuzhat Uddin

Service Area Office /
Bureau régional de services : Central West Service Area Office