Ontario

Inspection Report Under the
**Fixing Long-Term Care Act, 2021**

**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**Central East District**
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

# Amended Public Report Cover Sheet (A1)

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|---|---|
| **Amended Report Issue Date:** April 10, 2024 | |
| **Original Report Issue Date:** March 25, 2024 | |
| **Inspection Number:** 2024-1387-0001 (A1) | |
| **Inspection Type:**<br>Critical Incident<br>Follow up | |
| **Licensee:** Centennial Place Millbrook Inc. | |
| **Long Term Care Home and City:** Centennial Place Long-Term Care Home, Millbrook | |
| **Amended By**<br>Reethamol Sebastian (741747) | **Inspector who Amended Digital Signature**<br>Reethamol Sebastian Digitally signed by Reethamol Sebastian<br>Date: 2024.04.11 10:05:41 -04'00' |

## AMENDED INSPECTION SUMMARY

This report has been amended to:
This inspection report has been amended to: The Compliance Due Date for Compliance Order (CO) #001 and CO #002 extended to June 1, 2024.

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| **Licensee:** Centennial Place Millbrook Inc. | |
| **Long Term Care Home and City:** Centennial Place Long-Term Care Home, Millbrook | |
| **Lead Inspector**<br>Reethamol Sebastian (741747) | **Additional Inspector(s)**<br>Sheri Williams (741748) |
| **Amended By**<br>Reethamol Sebastian (741747) | **Inspector who Amended Digital Signature**<br>Reethamol Sebastian<br>Digitally signed by Reethamol Sebastian<br>Date: 2024.04.11 10:06:10 -04'00' |

## AMENDED INSPECTION SUMMARY

This report has been amended to:
This inspection report has been amended to: The Compliance Due Date for Compliance Order (CO) #001 and CO #002 extended to June 1, 2024.

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 26- 29, 2024, and March 1, 4- 7, 2024

The following intake(s) were inspected:
- One Critical Incident Report (CIR) intake related to Resident transfer to hospital due to hypoglycemia.
- One CIR intake related to resident-to-resident abuse incident resulted in injury.
- One CIR intake related to injury due to a fall and transferred to the hospital.
- One CIR intake related to a fall of a resident transferred to the hospital unresponsive
- One CIR intake related to the unexpected death of a resident
- An intake related to Follow-up #1 - O. Reg 246/22 s. 102 (2) (b) related to infection prevention and control.
- Five CIR intakes related to resident-to-resident abuse incidents.

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1387-0004 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Reethamol Sebastian (741747)

The following **Inspection Protocols** were used during this inspection:

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

# AMENDED INSPECTION RESULTS

## WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 54 (1)**

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

The licensee has failed to provide strategies for a resident to reduce or mitigate falls.

**Rationale and Summary**

A CIR was submitted for a resident for unexpected death following a fall.

A review of a resident's clinical health record indicated they had a recent fall ending in injuries for which they were transferred to the hospital. The plan of care for a resident indicated they were assessed to be a low fall risk and they had in place fall prevention interventions.

The resident fell on two specified dates and there were no new interventions or strategies implemented to prevent falls. On a later date, the resident fell again, and an assistive safety device was implemented. The resident's health was declining following this fall and they were transferred to hospital and subsequently passed away in hospital.

The death certificate indicated that the resident's cause of death was an accident. Interviews with staff and the Director of Care (DOC) acknowledged that other fall interventions could have been put in place but were not.

Failing to ensure that fall intervention strategies were put in place to reduce the risk of falls for a resident resulted in actual physical harm when the resident fell, resulting in injuries.

**Sources:** CIR, Clinical health record of resident, home's investigation notes. interviews with staff and DOC.
[741748]

## WRITTEN NOTIFICATION: Skin and wound care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)**
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives 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,

The licensee has failed to ensure that when a resident exhibited altered skin integrity, they received a skin and wound assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

**Rationale and Summary**

1. A CIR was submitted to the Director related to a resident-to-resident incident of allegations of abuse incident resulting in injuries.

The licensee's Skin and Wound Care Treatment policy directed registered nursing staff to complete a skin assessment on residents at risk for altered skin integrity when there was a change in health status that affected the resident's skin integrity. The licensee's policy and DOC confirmed that the head-to-toe assessment is the clinically appropriate instrument used to assess the resident's altered skin integrity.

An interview with staff indicated that the incident between the two residents caused injuries to a resident. A review of the clinical records indicated that a head to toe assessment completed on a specified date was incomplete. The DOC confirmed that staff were required to fill in the required information when completing the head to toe assessment.

Failing to ensure that a resident had a skin and wound care assessment completed, resulted in staff not monitoring and managing the resident's skin conditions.

**Sources**: CIR, Policy on Head-to-Toe Assessment, Resident clinical records, home's incident notes, interviews with staff and DOC.
[741747]

2. A CIR was submitted to the Director related to a resident-to-resident incident of allegations of abuse incident resulting in injuries.

The licensee's Skin and Wound Care Treatment policy directed registered nursing staff to complete a skin assessment on residents at risk for altered skin integrity when there was a change in health status that affected the resident's skin integrity. The licensee's policy and DOC confirmed that the head-to-toe assessment is the clinically appropriate instrument used to assess the resident's altered skin integrity.

An interview with staff indicated they were present in the resident's home area when a resident-to-resident incident of abuse incident occurred resulting in injuries. A review of the clinical records indicated that the assessment was

incomplete. The DOC confirmed that staff were required to fill out all areas when completing the assessment.

Failing to ensure that the resident had a skin and wound care assessment completed, resulted in staff not monitoring and managing the resident's skin conditions.

**Sources:** CIR, Policy on Head to Toe Assessment, Resident's clinical records, incident investigation notes, interviews with staff and DOC.
[741747]

3. A CIR was submitted to the Director related to a resident-to-resident incident of allegations of abuse incident which resulted in injuries.

The licensee's Skin and Wound Care Treatment policy directed registered nursing staff to complete a skin assessment on residents at risk for altered skin integrity when there was a change in health status that affected the resident's skin integrity. The licensee's policy and DOC confirmed that the head-to-toe assessment is the clinically appropriate instrument used to assess the resident's altered skin integrity.

An interview with staff indicated that the resident hit another resident which resulted in injuries to both residents. A review of the clinical records indicated that a head to toe assessment was incomplete. The DOC #100 confirmed that staff were required to complete all areas when completing the head to toe assessment.

Failing to ensure that a resident had a skin and wound care assessment, might have impacted staff from monitoring and managing the resident's skin conditions.

**Sources:** CIR, Policy on Head to Toe Assessment, Resident clinical records, homes investigation notes, interviews with staff and DOC.
[741747]

4. A CIR was submitted to the Director related to a resident-to-resident incident of allegations of abuse incident resulting in injuries.

The licensee's Skin and Wound Care Treatment policy directed registered nursing staff to complete a skin assessment on residents at risk for altered skin integrity when there was a change in health status that affected the resident's skin integrity. The licensee's policy and DOC confirmed that the head-to-toe assessment is the clinically appropriate instrument used to assess the resident's altered skin integrity.

An interview with staff indicated that the resident had an injury related to this incident.

A review of the clinical records indicated that a head to toe assessment completed on a specified date was incomplete. The DOC confirmed that staff were required to fill in all areas completing the head to toe assessment.

Failing to ensure that a resident had a skin and wound care assessment, resulted in staff not monitoring and managing the resident's skin conditions.

**Sources:** CIR, Policy Head to Toe Assessment, Resident clinical records, home's incident notes, interviews with staff and DOC.
[741747]

5. A CIR was submitted to the Director related to a resident-to-resident incident of allegations of abuse incident resulting in injuries.

The licensee's Skin and Wound Care Treatment policy directed registered nursing staff to complete a skin assessment on residents at risk for altered skin integrity when there was a change in health status that affected the resident's skin integrity. The licensee's policy and DOC confirmed that the head-to-toe assessment is the clinically appropriate instrument used to assess the site, type, length, width, depth, and stage of resident altered skin integrity.

An interview with staff indicated that the incident caused injuries to a resident. A review of the clinical records indicated that that the head to toe assessment was

incomplete. The DOC confirmed that staff were required to fill in all areas when completing the head to toe assessment.

Failing to ensure that a resident had a skin and wound care assessment completed, might have impacted staff from monitoring and managing the resident's skin conditions.

**Sources:** CIR, Policy Head to Toe Assessment, Resident's clinical records, home's investigation notes, interviews with staff, Associate Director of Care (ADOC), and DOC.
[741747]

## WRITTEN NOTIFICATION: Responsive Behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)**
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(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.

The licensee has failed to ensure to complete a resident's Dementia Observation System (DOS) to assess a resident with responsive behaviours.

**Rationale and Summary**

1. A CIR was submitted to the Director regarding a witnessed incident of resident-to-resident abuse incident.

A review of the resident's clinical records indicated DOS was initiated on a specified date related to a physical altercation. The DOS tool was implemented to monitor the residents' responsive behaviours but was incomplete for many shifts.

Staff indicated a DOS monitoring tool should be initiated and completed by any staff member for five days, or as needed, following a resident-to-resident altercation. Staff indicated the BSO would evaluate the DOS upon completion and report the findings to the registered staff. BSO acknowledged that the DOS documentation tool for the resident was incomplete for multiple shifts.

The residents and others were at risk of further altercations when the triggers and patterns were not identified using the DOS monitoring tool due to incomplete documentation.

**Sources:** Interviews with staff and Resident's clinical records, Behavior Management Policy.
[741747]

2. A CIR was submitted to the Director related to a physical altercation between two residents.

A review of a resident's clinical records indicated a DOS was initiated related to a physical altercation. The DOS tools implemented to monitor the residents' responsive behaviours were incomplete for many shifts.

BSO indicated a DOS monitoring tool should be initiated and completed by any staff member for five days, or as needed, following a resident-to-resident altercation. Staff indicated the BSO would evaluate the DOS upon completion and report the findings to the registered staff. BSO acknowledged that DOS documentation was incomplete for multiple shifts for the resident.

The residents and others were at risk of further altercations when the triggers and patterns were not identified using the DOS monitoring tool due to incomplete documentation.

**Sources:** CIR, Interviews with staff and DOC, resident's clinical records and DOS monitoring sheet, Behavior Management Policy.
[741747]

3. A CIR was submitted to the Director related to a physical altercation between two residents.

A review of resident's clinical records indicated a DOS was initiated related to a physical altercation with another resident The DOS tool that was implemented to monitor the residents' responsive behaviours was incomplete for many shifts.

BSO indicated a DOS monitoring tool should be initiated and completed by any staff member for five days, or as needed, following a resident-to-resident altercation. Staff indicated the BSO would evaluate the DOS upon completion and report the findings to the registered staff. BSO acknowledged that DOS documentation was incomplete for multiple shifts for the resident.

The residents and others were at risk of further altercations, when the triggers and patterns were not identified using the DOS monitoring tool due to incomplete documentation.

**Sources:** CIR, Interviews with staff and DOC, resident's clinical records and DOS monitoring sheet, Behavior Management Policy.
[741747]

## WRITTEN NOTIFICATION: ALTERCATIONS AND OTHER INTERACTIONS BETWEEN RESIDENTS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 59 (b)**
Altercations and other interactions between residents
s. 59. 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,
(b) identifying and implementing interventions.

The licensee failed to ensure that the interventions to minimize the risk of altercations and potentially harmful interactions between residents were implemented.

**Rationale and Summary**

A CIR was submitted to the Director regarding a resident-to-resident incident of abuse.

In a review of a resident's written care plan, the resident was to have enhanced monitoring 24 hours per day due to responsive behaviours towards co-residents. The care plan directs that the enhanced monitoring staff is to maintain their position between the resident and other residents to promote safety.

The homes investigation notes indicated that a resident was walking through the dining room and that a security guard providing supervision to another resident asked them to move over so the resident could pass by. The resident they were supervising had responsive behaviors of aggression toward the other resident causing them injuries.

BSO and the DOC acknowledged that they expected staff to follow the plan of care and that the enhanced monitoring staff did not do so, putting residents at risk for physical aggression from the resident on one-to-one supervision.

Failing to implement interventions to minimize the risk of potentially harmful interactions resulted in actual physical injury to a resident.

**Sources:** CIR, Home's Investigation Notes, residents' clinical health record, interviews with BSO and the DOC.
[741748]

## WRITTEN NOTIFICATION: BEHAVIOURS AND ALTERCATIONS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 60 (b)**

Behaviours and altercations

s. 60. Every licensee of a long-term care home shall ensure that,

(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others.

The licensee failed to ensure that one on one support staff for a resident they were supervised were advised at the beginning of every shift of the resident's responsive behaviours that required heightened monitoring because those behaviours posed a potential risk to the resident or others.

**Rationale and Summary**

A CIR was submitted to the Director reporting a witnessed resident-to-resident altercation in which a resident was physically aggressive to another resident causing them injuries.

The interventions in the resident's plan of care indicate the enhanced monitoring staff is to position themselves between the resident and other residents to redirect them to protect other residents from being injured.

BSO and the DOC acknowledged that enhanced monitoring staff were not aware of the resident's need for heightened monitoring and the need to position themselves between the resident they were supervising and other residents.

Failing to ensure that enhanced monitoring support staff for a resident on enhanced supervision were aware of the interventions for heightened monitoring for the resident posed an actual risk to a co-resident when they were injured.

**Sources:** CIR Home's investigation notes, clinical health records of residents, and interviews with BSO and the DOC.
[741748]

## WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)**
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was implemented. Specifically, the licensee failed to ensure that additional precaution shall include additional Personal Protective Equipment (PPE) requirements including appropriate selection, application, removal, and disposal were followed as is required by Additional Requirement 9.1 (f) under the IPAC Standard for Long Term Care Homes.

**Rationale and Summary**

During the inspection, it was observed that a resident was on contact precautions. Signage was posted on the door for contact precautions. The inspector observed a staff entering the room to provide direct care without wearing a gown.

During an interview, staff acknowledged they use gloves only for toileting residents on contact precaution and they do not wear a gown. The IPAC Lead confirmed that gloves and gowns should be used if staff will be in direct contact with the resident who is on contact precaution.

Failing to don and doff the appropriate PPE in the identified contact precaution room increased the risk of the spread of infection in the home.

**Sources:** Observations, interviews with staff and IPAC Lead, and (Guidelines - Contact Precautions).doc
[741747]

## WRITTEN NOTIFICATION: SAFE STORAGE OF DRUGS

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)**
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee failed to ensure that drugs were stored in a medication area that is secure and locked.

**Rationale and Summary**

A CIR was submitted to the Director for a hypoglycemic incident resulting in a resident being transferred to the hospital.

During an observation in the resident's room, two medication containers labeled with the resident's name were observed on top of the resident's bedside dresser.

The ADOC acknowledged that the home expects all medications to be kept locked and secure in a medication cart or room.

Failing to store medications in a secure and locked area poses a risk to residents that they could consume or use medications unsafely.

**Sources:** CIR, Policy Drug Security and Storage, and interview with ADOC. [741748]

## WRITTEN NOTIFICATION: DRUG DESTRUCTION AND DISPOSAL

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 148 (1) (a)**
Drug destruction and disposal
s. 148 (1) Every licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of,
(a) all expired drugs;

The licensee failed to ensure that the written Medication Destruction and Disposal policy as part of the medication management system was implemented for expired medications.

In accordance with O. Reg 246/22 s.11. (1) (b), the licensee was required to ensure the medication management system has in place written policies and protocols and must be complied with. Specifically, staff did not comply with the home's Medication Destruction and Disposal Policy.

**Rationale and Summary**

A CIR was submitted to the director related to a medical incident resulting in a resident transferring to the hospital.

During an observation in a resident's room, two medication containers labeled with the resident's name were observed on top of the bedside dresser. The labels of both medications indicated they were expired.

The home's policy on Medication Destruction and Disposal directs staff to dispose of and destroy medications when they are expired.

The ADOC acknowledged that expired medications should have been destroyed and disposed of in accordance with the home's drug and destruction policy.

Failing to dispose of expired medications poses a risk that medications could be used past their date of effectiveness or indication for use.

**Sources:** CIR, Policy "Medication Destruction and Disposal Policy, observations in the home, and interview with ADOC.
[741748]

## COMPLIANCE ORDER CO #001 Transferring and positioning techniques

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 40**
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**

1. Re-educate Personal Support Worker (PSW) #108 on the home's policy on Safe Lifting, transferring, and positioning. Test the retention of staff knowledge by observations of care with safe lifting, transferring, and positioning interventions. Keep a documented record of the education provided along with a documented record of how the staff knowledge was verified. This is to be made immediately available to Inspectors upon request.

2. Falls Lead and Director of Care to complete a documented audit of resident activities of daily living (ADL) requiring 1-2 staff to review that ADL can be safely completed with one staff. The documented audit tool is to include the date of audit, resident name, who participated in the audit, and if the plan of care was updated to

change ADL interventions as a result of the audit. Make available the documented audit to Inspectors upon request.

**Grounds**

The licensee failed to ensure that staff used safe positioning techniques when assisting residents with care.

**Rationale and Summary**

A CIR was submitted to the director for a fall incident for which a resident was transferred to the hospital.

The plan of care for the resident directs that they require 1-2 staff to provide extensive care for activities of daily living for dressing.

The home's internal investigation notes indicate that staff was providing the resident's assistance with personal care staff indicated they had forgotten the resident's clothing and went to retrieve it, leaving the resident unattended. The resident fell forward and was found unresponsive on the ground.

During an interview, the RAI Coordinator acknowledged that the resident required extensive assistance with all activities of daily living indicating this means that staff are to provide weight-bearing assistance and support to the resident with all of their activities of living including dressing. The ADL (Activities of Daily Living) Score for the resident indicated that they require extensive assistance for their ADL with two staff in all areas including dressing.

Failing to ensure that staff use safe positioning techniques when providing care to the resident posed actual significant harm as the injuries resulted in the resident passing away in the hospital.

**Sources**: CIR, homes investigation notes, clinical health record, interview with staff and RAI Coordinator.
[741748]

**This order must be complied with by June 1, 2024.**

## COMPLIANCE ORDER CO #002 Duty to protect

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: FLTCA, 2021, s. 24 (1)**
Duty to protect
s. 24 (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.

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**

The licensee shall:

1. Provide all direct care staff in identified home areas, with in-person education on the prevention of abuse and neglect of residents.

2. The training will include the definitions and scenarios of types of abuse and neglect, including physical abuse, the duty of staff to protect residents from all types of abuse and neglect, and the staff roles and responsibilities for any alleged, suspected, or witnessed incidents of resident abuse or neglect.

3. The training will include a method for the staff to demonstrate their understanding of the training provided. A documented record will be kept of this demonstration.

4. Maintain a record of the training completed, including but not limited to, dates of training, names of staff who provided the training and who attended the training, and the content of the training. Retain the training records, and the records are to be made immediately available to Inspectors upon request.

5. Conduct education on the one-to-one assignment process on their role in preventing abuse to residents, responsibilities when providing enhanced monitoring care including constant supervision, communication at the beginning/end of each shift, and coverage requirements, with all direct care staff and enhanced monitoring staff. Maintain documentation of the enhanced monitoring staff education, including the names of the staff, their designation, and the date training was provided. Keep a documented record of education and make it available to inspectors immediately on request.

**Grounds**

The licensee has failed to protect the resident from abuse.

**Rationale and Summary**

1. A CIR was submitted to the Director related to a resident-to-resident incident of allegations of abuse.

The home investigation notes indicated that the resident was found on the floor with another resident with them. The clinical health record for the resident documents they sustained injuries.

The staff and BSO indicated that the resident primary trigger was anyone in their personal space and that the other resident wandering into the same area could have triggered them to react with aggression. BSO indicated that interventions such as wander guards were ineffective as they were removed by other residents.

Staff and BSO acknowledged the home expected that residents are protected from abuse and that this incident constituted abuse and it was reported immediately.

Failing to ensure that resident was protected from abuse resulted in their receiving injuries.

**Sources:** CIR, home investigation notes, clinical health records of the residents, interviews with staff, RN, and BSO Nurse.
[741748]

2. The licensee has failed to protect the resident from abuse.

A CIR was submitted to the Director related to a resident-to-resident incident of allegations of abuse. The CIR indicated that the resident was walking through the dining room and that a security guard supervising another resident asked them to move over so the resident could pass by, and the resident was physically aggressive to another resident causing them injuries.

BSO and the DOC indicated that enhanced monitoring security staffing supervision was in place twenty-four hours per day for the resident and that their role was to position themselves between the resident and other residents to prevent them from physical aggression toward others. BSO and the DOC acknowledged that enhanced monitoring staff failed to meet the expectations of their role and protect the resident from physical aggression.

Failing to ensure that the resident was protected from abuse resulted in their receiving injuries.

**Sources:** CIR, homes investigation notes, interviews with BSO Nurse and DOC.
[741748]

3. The licensee has failed to protect the resident from abuse.

A CIR was submitted to the Director related to a resident-to-resident incident of allegations of physical abuse. The CIR indicated that a resident pushed another resident resulting in a fall with injury.

An interview with the RN indicated the incident caused injury to the resident. The BSO indicated resident who pushed the other resident has a high risk of responsive behaviour including physical aggression and was followed by the BSO team. The

intervention identified in the care plan to reduce their risk of wandering was to monitor for safety, was ineffective and there were no other interventions in place.

The DOC confirmed that the abuse was found, the home has a policy for zero tolerance of abuse and neglect, and that this incident constituted abuse and was reported immediately.

Failing to ensure that the resident was protected from abuse resulted in an altercation and injury.

**Sources:** CIR, Resident clinical records, home incident notes, interviews with RN, BSO, ADOC, and DOC
[741747]

4. The licensee has failed to protect the resident from abuse.

A CIR was submitted to the Director related to a resident-to-resident incident of allegations of physical abuse. The CIR indicated that a resident pushed another resident which resulted in a fall with injury.

An interview with staff indicated they were present in the resident's home area when the resident pushed another resident. BSO indicated the resident has a history of verbal aggression and wandering. The intervention identified in the care plan to reduce their risk of wandering was to monitor for safety and no other interventions were in place. This intervention was ineffective as the resident entered the personal space of another resident.

The home's investigation report indicated that a resident pushed another resident resulting in injury.

The DOC acknowledged that this incident constituted abuse and was reported immediately.

Failing to ensure that the resident was protected from abuse resulted in an altercation and injury.

**Sources:** CIR, the resident clinical records, home incident notes, interviews with staff, RPN, RN, BSO Nurse, and DOC.
[741747]

5. The licensee has failed to protect the resident from abuse.

A CIR was submitted to the Director related to a resident-to-resident incident of allegations of physical abuse. The CIR indicated that a resident hit another resident which resulted in an injury.

An interview with staff indicated they were present in the resident's home area when the resident hit another resident. The BSO indicated the resident has a high risk of responsive behaviour including unprovoked physical aggression and was followed by the BSO team. The interventions identified in the care plan to reduce wander was to use wander guards to deter access to inappropriate locations. This intervention was ineffective as the incident happened in the hallway and no other interventions were in place.

The home's investigation report and the DOC confirmed that the abuse was found.

The DOC acknowledged that this incident constituted abuse and was reported immediately.

Failing to ensure that the resident was protected from abuse resulted in their receiving injuries.

**Sources:** CIR, the resident clinical records, home incident notes, interviews with staff, RN, BSO Nurse, and DOC.
[741747]

6. The licensee has failed to protect the resident from abuse.

A CIR was submitted to the Director related to a resident-to-resident incident of allegations of physical abuse. The CIR indicated that a resident hit another resident resulting in injury.

An interview with staff and RPN indicated they overheard the screaming in the resident's dining area between the resident and another resident. RPN confirmed the resident sustained an injury as a result of this incident. BSO indicated the resident has a history of verbal aggression and wandering. The intervention identified in the care plan was to reduce their risk of wandering was to monitor for safety and no other interventions were in place. This intervention was ineffective as they entered the personal space of the other resident.

The home's investigation report indicated that the resident hit another resident resulting in injury. The home's investigation report and the DOC confirmed that the abuse was founded and was reported immediately.

Failing to ensure that the resident was protected from abuse resulted in an altercation and injury.

**Sources:** CIR, the resident clinical records, home incident notes, interviews with staff, RPN, BSO Nurse, and DOC.
[741747]

**This order must be complied with by June 1, 2024**

## REVIEW/APPEAL INFORMATION

**TAKE NOTICE**The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

**Director**
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

**Health Services Appeal and Review Board**
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

**Director**
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.