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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**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 |
|---|---|---|---|
| Sep 16, 2019 | 2019_659189_0011 | 011807-19 | Critical Incident System |

## Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Streetsville Care Community
1742 Bristol Road West MISSISSAUGA ON L5M 1X9

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

NICOLE RANGER (189)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): September 5, 6, 9, 2019**

**During the course of the inspection, the following Critical Incident System (CIS) intake log was inspected: 011807-19**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Assistant Director of Care (ADOC), Behavioual Support Ontario (BSO) Lead, registered nurse, recreation aide, personal support workers and residents.**

**During the course of the inspection, the inspector conducted observations of resident to resident interactions, staff to resident interactions and provision of care, review of resident and home records, review of staff training records, and review of relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The home submitted a Critical Incident System (CIS) report to the Ministry of Long Term Care (MLTC) related to an incident of resident to resident abuse. According to the CIS report, resident #002 was placed beside an identified room to await assistance with a particular care activity. At an identified time, resident #001 was seen by PSW #101 to be inappropriately touching resident #002. PSW #101 intervened and removed resident #001 from the area.

A review of resident #002's plan of care identifies that resident #002 required close monitoring and identifies a location where this should occur.

Interview with the Behavioral Support Ontario (BSO) lead #104 revealed the team had identified that resident #002 is a trigger for resident #001, and that staff had been made aware of resident #002's interventions, including the location for the provision of close monitoring of resident #002.

Interview with PSW #101 identified that they had observed this incident, and that they intervened and removed resident #001 from the area. PSW #101 identified that resident #002 is usually in the area identified in the plan of care for close observation.

Interview with recreation aide #103 identified that they had moved resident #002 from the area identified in the plan of care to the location where the incident occurred as they thought resident #002 would be next to receive care. Recreation aide #103 was not sure how long resident #002 remained unattended in that location. Recreation aide #103 was aware of the need to separate resident #002 from resident #001.

During an interview with the Executive Director (ED) they acknowledged that the plan of care regarding location for the provision of close observation had not been followed for resident #002.

***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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

**Specifically failed to comply with the following:**

**s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

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

The home submitted a Critical Incident System (CIS) report to the Ministry of Long Term Care (MLTC) related to an incident of resident to resident abuse. According to the CIS report, resident #002 was placed beside an identified room to await assistance with a particular care activity. At an identified time, resident #001 was seen by PSW #101 to be inappropriately touching resident #002. PSW #101 intervened and removed resident #001 from the area.

A review of resident #002's plan of care identifies that resident #002 required close monitoring and identifies a location where this should occur.

Interview with PSW #101 identified that they had observed this incident, and that they intervened and removed resident #001 from the area. PSW #101 identified that resident #002 is usually in the area identified in the plan of care for close observation.

Interview with RN #102 revealed that resident #002 had been placed in the location identified in the plan of care after meal service. RN #102 identified that resident #002 was next moved by recreation aide #103 as described below. RN #102 further identified that resident #001 left an activity program and was found in the hallway by PSW #101. RN #102 was aware of previous incidents between the two residents and reported that staff were aware of the interventions in place for monitoring of resident #002.

Interview with recreation aide #103 identified that they had moved resident #002 from the area identified in the plan of care to the location where the incident occurred as they thought resident #002 would be next to receive care. Recreation aide #103 was not sure how long resident #002 remained unattended in that location. Recreation aide #103 was aware of the need to separate resident #002 from resident #001.

A review of resident #001's progress notes revealed four incidents of inappropriate behaviour by resident #001 towards resident #002.

During an interview with the Executive Director (ED), they acknowledged that the plan of care for resident #002 had not been followed.

By failing to follow the interventions pertaining to observation of resident #002, the home failed to ensure resident #002’s safety and failed to protect resident #002 from abuse.

***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 the home shall protect residents from abuse by anyone, to be implemented voluntarily.***

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**Issued on this 19th day of September, 2019**

[redacted]

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

**Original report signed by the inspector.**