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 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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 22, 2016	2016_377502_0012	015623-16, 015836-16	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE GUILDWOOD
60 GUILDWOOD PARKWAY SCARBOROUGH ON M1E 1N9

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

JULIENNE NGONLOGA (502)

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): July 27, 28, 29, September 16, 20, 26, and November 10, 2016.

During the course of the inspection, the following Critical Incident System reports were inspected:
2164-000007-16: related to staff to resident abuse
2164-000007-16: related to resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Physician, Social Worker (SW), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Receptionist Clerk, Recreation Aide, Private Care Giver, Volunteer, and residents.

The inspector conducted observations of resident to resident interactions, staff to resident interactions, provision of care, review of resident and home records, staff training records, staffing schedules and 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)**
- **1 VPC(s)**
- **1 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	Legendé 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 are protected from abuse by anyone.

On an identified date, a Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to alleged resident to resident abuse. Review of the CIS report revealed that on an identified date resident #002 was found in an identified area with resident #003.

Review of resident #003's progress notes revealed in addition to the above incident of alleged abuse there were multiple other identified responsive behaviours as involving resident #002 and #006.

Review of resident's #003's written plan of care for an identified time period revealed the resident has a cognitive impairment and identified responsive behaviours. Further review of the written plan of care for resident #003 revealed staff are required not to allow resident #003 to have identified co-residents in his/her room and is also not to be left alone with identified co-residents.

During an interview with resident #003, he/she stated that he/she did not remember the above incidents.

Review of resident's #002's plan of care revealed resident #002 has moderate cognitive impairment and upon further review of resident #002's health records there were no prior identified responsive exhibited.

During an interview with resident #002, he/she told the inspector that the interaction was unpleasant.

Staff #100 in an interview stated he/she was first to observe the above mentioned incident, but was afraid to intervene and called staff #105 for assistance. Staff #100 stated that he/she believed both residents were fine because neither of the residents appeared to be upset and resident #002 had not complained.

In an interview, staff #105 stated that when he/she observed the above mentioned incident, he/she separated the residents three times. Staff #105 stated that he/she believed the interaction was consensual, as neither of the residents wanted to be separated. Staff #105 confirmed that he/she did not ask the residents if they had consented to the interaction after he/she separated them the first time.

In an interview, staff #110 confirmed the above mentioned incident and stated he/she had never witnessed resident #002 requesting to engage with them. Staff #103 also

stated that resident #002 had a good memory with staff and residents' names, knows everything that happens in the unit, but does have a cognitive impairment.

In an interview staff #114 stated he/she met with resident #002 one day after the above mentioned incident. Staff #114 stated he/she discussed the incident and provided education. staff #114 stated that resident #002 told him/her that he/she did not like what happened, but staff#114 believed resident #002 consented to the interaction. Staff #114 further stated that resident #002 had the ability to consent to an identified engagement as he/she initiated the contact. Staff #114 confirmed that resident #002's written plan of care had not been revised to include identified responsive behaviours.

In interviews, staff #114 and staff #102 stated resident #002 and resident #003 were interviewed after the above mentioned incident occurred and both residents told them that the interaction was consensual. When asked to explain why staff #102 believes the residents are consenting to the identified engagement, staff #102 stated that he/she based his/her opinion on the Cognitive performance scale (CPS), the fact that resident #002 did not call for help or push resident #003 away from him/her, both residents sought each other out. Staff #102 further acknowledged that resident #003 had a cognitive impairment and was not able to remember the above mentioned incident; he/she still believed that resident #003 was able to consent. Staff #102 stated that both of the residents were interviewed separately, one day after the above mentioned incident. Resident #002 told staff #102 that resident #003 is his/her friend. Staff #102 also acknowledged that resident #003 had exhibited inappropriate responsive behaviours toward co-residents at least once per week but had not been successful. Staff #102's statement is inconsistent with resident #003's progress notes which states that on an identified date, resident #006 was observed with resident #003 in an identified area exhibiting inappropriate responsive behaviours toward resident #006. Resident #006 was redirected to the nursing station, and evening charge nurse was informed.

In an interview staff #115 stated that during the home's investigation of the above mentioned incident, resident #003 told him/her and the staff to leave them alone. Staff #115 believed that the residents are in their home and they have the right to have a relationship, and for their lifestyle to be respected.

In an interview staff #106 told the inspector that he/she had met with resident #002 one day after the above mentioned incident. Staff #106 stated that resident #002 was very upset during their meeting as everyone told him/her that what he/she did was wrong. Staff #106 stated that resident #002 had identified responsive behaviours and stated that

he/she had not assessed the resident for their capacity to consent, but based on his/her observations, both residents lacked the capacity to consent to a mutual engagement. The staff told the inspector that he/she was not asked by staff #115 or staff #102 about the residents capacity to consent and did not share his/her view regarding the resident's capacity to consent with any other staff at the home.

Review of the Behavioural Support Ontario (BSO) meeting minutes for an identified date revealed that residents #002 and #003 had been referred to the BSO. In an interview, staff #115 told the inspector that the above mentioned incident had not been considered by the home as alleged abuse based on the home's investigation and because residents #002 and #003 involved in that incident had consented.

Although the staff #114 and staff #102 and Administrator #115 said they believed that resident #002 consented to the engagement between resident #002 and #003; staff #115 and staff #106 told the inspector that there was no formal capacity assessment completed for residents #002 and #003 to determine their ability to consent to the identified. Furthermore, staff #115 stated that to assess the capacity to consent is expensive and none of the residents is able to afford the cost.

Based on the above facts, the licensee did not protect resident #002 from abuse by resident #003. [s. 19. (1)]

2. During the inspection of an identified critical incident report for an identified date, resident #002 had complained to the inspector that resident #005 had exhibited identified responsive behaviours toward him/her. Resident #002 stated that on an identified date, resident #005 had exhibited identified responsive behaviours toward him/her, which he/she did not like, and reported to staff member #101.

In an interview staff member #101, confirmed resident #002 had reported the above mentioned alleged abuse to him/her on the same day. The staff member stated that he/she had reported the incident to staff #103 and the staff #102.

Review of resident #005's progress notes revealed that this resident was admitted on an identified date in 2015; he/she exhibited identified responsive behaviours and had a pattern of alleged abuse toward co-residents #002 and #005.

Further review of the progress notes failed to reveal any record of the alleged incident of abuse that occurred on the above mentioned date, and reported by resident #002, even

though in an interview, staff member # 101, confirmed resident #002 had reported the above mentioned alleged abuse to him/her. The staff member stated that he/she had reported the incident to staff #103 and staff #102.

Review of resident #006's written plan of care printed revealed that the resident was admitted in the home in 2011, and identified with a cognitive impairment. Further review of resident #006's written plan of care revealed resident #006 had cognitive loss and he/she is unable to communicate his/her needs and had an identified responsive behaviour. Further review of the plan of care revealed following interventions had been implemented for resident #006's safety:

Review of resident #005's plan of care revealed this resident exhibited inappropriate responsive behaviour and attempting to bring identified co-residents residents to his/her room. Interventions were implemented to keep residents safe.

Review of resident #002's progress notes and the home's investigation revealed after the incident involving resident #002 and resident #005 on the above mentioned identified date, staff #102 and Administrator #115 met with both residents and documented that both residents stated they are adults.

Further review failed to identify an assessment for a capacity was conducted for resident #002 or #005.

In an interview, resident #005 confirmed he/she exhibited inappropriate responsive behaviours toward resident #002 on the above mentioned identified date. Resident #005 stated that both enjoyed the interaction, however, he/she did not understand why resident #002 had been running away from him/her since the incident. Resident #005 stated that he/she was aware that he/she was inappropriate.

The inspector brought resident #002's complaint of the alleged abuse on the above mentioned date, to staff #102's attention. Staff #102 stated that he/she had not been aware of the alleged incident of abuse between resident #002 and resident #005 on this date. Staff #102's statement is inconsistent with the statement from staff member #101 who told the inspector that resident #002 had reported the alleged abuse to him/her and that he/she had reported the incident to staff #103 and Staff #102. However, staff #102 stated being aware of two incidents of inappropriate interactions that had occurred on the reported identified date, involving both residents #002 and #005 that had been witnessed by PC #104 and an unidentified PSW respectively.

In an interview, PC #104 confirmed that on the reported above mentioned date, he/she had observed resident #005 exhibiting responsive behaviours toward resident #002 in an identified area of the home and had reported the incident to nursing staff.

In an interview, staff #117 stated that resident #002 had not been assessed as having inappropriate responsive behaviour. He/she further stated that after both incidents on the above mentioned date, involving resident #005, resident #002 was not upset.

Staff #103 and staff #102 told the inspector that they have been aware of the reported incidents. They also stated that they had not reported the incidents to the Director or contacted the police as they believed abuse had not occurred. Staff #102 stated that both residents had been interviewed on the same day during the home's investigation. When asked to explain why staff #102 believes the incident was not abuse was because both residents had no cognitive impairment and that they were able to make their own decisions. Staff #102 confirmed both residents had not been assessed for capacity to consent.

Staff #106 and the staff #102 stated that resident #005 has identified responsive behaviours that may be exhibited toward co-residents. Staff #106 stated that he/she had not assessed the residents for their capacity to consent, but based on his/her observations, resident #002 lacked the capacity to consent. Staff #106 told the inspector that he/she was not asked by Administrator #115 or staff #102 about the residents capacity to consent and did not share his/her view regarding the resident's capacity to consent with the other staff at the home.

Review of the home's Determining Capacity policy, #RESI-02-05-03 dated November 2003, revealed a resident is presumed to be capable to make decisions about treatment, admission and personal assistance services, and a heath practitioner is entitled to rely on this presumption of capacity unless he/she has reasonable grounds to believe otherwise. Further review of the policy revealed that capacity is specific. It relates to the particular decision at hand and a person should not be considered capable simply because he/she agrees or does not object to a proposed treatment or other act.

In interview with staff #115 stated the incident involving residents #002 and #003, as well as incidents involving resident #002 and #005 had not been considered by the home as alleged abuse as resident #002, resident #005, and #003 are adults, however, staff #102 and staff #106 told the inspector that both residents had not been assessed for capacity

to consent and the inspector did not see an assessment for a capacity.

Review of the CIS report from the MOHLTC website failed to reveal that the above identified incidents of inappropriate behaviour involving resident #002 and #005, residents #003 and #006, and resident #005 and #006 were reported to the Director as specified in the Long-Term Care Home Act.

During the inspection, staff #102 told the inspector that the above identified incidents of inappropriate responsive behaviours from resident #005 toward #006 that occurred for an identified time period, had not been reported to the Director as alleged abuse.

Based on the above facts and in particular the licensee's knowledge of resident #005's history of inappropriate responsive behaviour with respect to identified residents, the licensee failed to protect resident #002 from abuse when they failed to take sufficient action to protect resident #002 from abuse by resident #005 when the first incidents occurred. Furthermore, because the licensee did not take sufficient action after the reported incidents, the licensee failed to protect resident #002 from further abuse.

In addition to this, residents #003 and #005 sought out resident #006 on multiple occasions. Resident #006 needed to be protected by staff as evidenced by the interventions already put in place by the licensee, however, it took the licensee, which is 59 days in which multiple incidents of inappropriate responsive behaviour from resident #005 toward resident #006 occurred, before resident #005 was transferred to another area of the home for resident #002's safety.

The scope of this finding was a pattern related to four incidents of alleged abuse of resident #002 by residents #003 and #005, as well as 13 documented incidents of abuse of resident #006 by residents #003 and #005 both of whom the licensee was aware had a history of seeking out identified co-residents. The severity showed minimal harm/risk or a potential for actual/harm risk. The Compliance History Report showed ongoing non-compliance with VPC 2014_251512_0022. As a result of scope, severity and previous compliance history a compliance order is warranted. [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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

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

During a critical incident inspection on an identified date, resident #002 had complained to the inspector that resident #005 had exhibited inappropriate responsive behaviours toward him/her. Resident #002 stated that on an identified date, resident #005 had exhibited inappropriate responsive behaviours toward him/her and he/she did not like that and had reported the incident to staff member #101.

In an interview staff member #101 confirmed resident #002 had reported the above alleged abuse to him/her. The staff member stated that he/she had reported the incident to nursing and management staff.

In an interview, resident #005 confirmed he/she exhibited inappropriate responsive behaviours toward resident #002. Resident #005 stated that he/she was aware that exhibiting a responsive behaviour in this manner was inappropriate.

The inspector brought resident #002's complaint of the alleged abuse to staff #102's attention. Staff #102 stated that he/she had not been aware of the alleged incident of abuse between resident #002 and resident #005 on this date. Staff #102's statement is inconsistent with the statement from staff member #101 who told the inspector that resident #002 had reported the alleged abuse to him/her and that he/she had reported the incident to staff #103 and staff #102. However, the staff stated being aware of two incidents of inappropriate responsive behaviour involving both residents #002 and #005 that had been witnessed by PC #104 and an unidentified staff respectively. Neither of the incidents that occurred, were reported to the Director.

Review of resident #005's progress notes revealed that resident #005 was admitted with identified responsive behaviours. Further review revealed that for an identified time period, resident #005 had exhibited 12 incidents of inappropriate responsive behaviour toward resident #006. In addition, resident #005 was observed exhibiting inappropriate responsive behaviours while seated beside co-residents.

Review of resident #002's progress notes and the home's investigation revealed after the incident involving resident #002 and resident #005, staff #102 and staff #115 met with both residents and documented that both residents stated they are adults. Further review revealed that there was no documentation to indicate resident #002 or #005 had been assessed for capacity of consent.

Staff #106 stated that resident #005 exhibits identified inappropriate responsive behaviours toward co-residents. Staff #106 stated that he/she had not assessed resident #002 for his/her capacity, but based on his/her observations, resident #002 lacked the capacity. Staff #106 told the inspector that he/she was not asked by staff #115 or staff #102 about the residents capacity to consent and did not share his/her view regarding the resident's capacity with the other staff at the home.

In an interview staff #102 confirmed that the incidents of abuse between resident #002 and resident #005 were reported to him/her on the same day after each incident. The staff stated that both residents had been interviewed on the same day during the home's investigation led by the Administrator and indicated that both residents were able to make their own decisions. Staff #102 confirmed both residents had not been assessed for capacity to consent.

In an interview, staff #115 stated the, incidents had not been reported to the Director as per legislation as the outcome of the home's investigation revealed resident #002 and

resident #005 had consented to the interaction. Staff #115 also stated that residents #002 and #005 are adults. Based on their CPS score, he/she stated that both residents are alert and know what they are agreeing to. The Administrator further stated that the Abuse Tree provided by the MOHLTC does not require the home to report any interaction between two residents; therefore the incidents were not reported to the Director as specified in the Long-Term Care Home Act. [s. 24. (1)]. However, the Administrator confirmed that both residents had not been assessed for capacity as the assessment is expensive and none of the residents is able to afford the cost, and the inspection revealed that there was no documentation to indicate resident #002 or #005 had been assessed for capacity.

Based on the above and in particular that the incidents of suspected abuse on two identified dates were not reported to the Director, the licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident #002 by resident #005 has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

Issued on this 3rd day of March, 2017

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

Ministére 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) :	JULIENNE NGONLOGA (502)
Inspection No. / No de l'inspection :	2016_377502_0012
Log No. / Registre no:	015623-16, 015836-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 22, 2016
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE GUILDWOOD 60 GUILDWOOD PARKWAY, SCARBOROUGH, ON, M1E-1N9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Zafulah Rahaman

To EXTENDICARE (CANADA) INC., 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

Ministére 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) (b)

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 shall prepare, submit and implement a plan to ensure that residents are protected from abuse. The plan shall include, but not be limited to the following:
1. Develop a plan in consultation with the medical Director of the home to ensure that resident #002 is protected from abuse by resident #003, resident #005, and any other male residents in the home.
2. Provide training to ensure that staff and managers are aware and can demonstrate an understanding with respect to capacity and consent to inappropriate responsive behaviour between residents who may have cognitive impairments.
3. Develop and implement interventions for resident #005's responsive behavior to ensure residents are safe from his/her inappropriate responsive behaviour.
4. Review resident #003 plan of care to include a focus, goal, and interventions to address resident #003 responsive behaviour and ensure staff are aware of the content of the plan.
5. Develop a process to monitor the interventions that have been developed for resident #003, resident #005, and resident #006 to ensure they have been implemented.

The plan must be submitted by January 16, 2017, to Juliene.ngonloga@ontario.ca.

Grounds / Motifs :

1. The licensee has failed to ensure that residents are protected from abuse by anyone.

On an identified date, a Critical Incident System (CIS) report was submitted to

the Ministry of Health and Long-Term Care (MOHLTC) related to alleged resident to resident abuse. Review of the CIS report revealed that on an identified date resident #002 was found in an identified area with resident #003.

Review of resident #003's progress notes revealed in addition to the above incident of alleged abuse there were multiple other identified responsive behaviours as involving resident #002 and #006.

Review of resident's #003's written plan of care for an identified time period revealed the resident has a cognitive impairment and identified responsive behaviours. Further review of the written plan of care for resident #003 revealed staff are required not to allow resident #003 to have identified co-residents in his/her room and is also not to be left alone with identified co-residents.

During an interview with resident #003, he/she stated that he/she did not remember the above incidents.

Review of resident's #002's plan of care revealed resident #002 has moderate cognitive impairment and upon further review of resident #002's health records there were no prior identified responsive exhibited.

During an interview with resident #002, he/she told the inspector that the interaction was unpleasant.

Staff #100 in an interview stated he/she was first to observe the above mentioned incident, but was afraid to intervene and called staff #105 for assistance. Staff #100 stated that he/she believed both residents were fine because neither of the residents appeared to be upset and resident #002 had not complained.

In an interview, staff #105 stated that when he/she observed the above mentioned incident, he/she separated the residents three times. Staff #105 stated that he/she believed the interaction was consensual, as neither of the residents wanted to be separated. Staff #105 confirmed that he/she did not ask the residents if they had consented to the interaction after he/she separated them the first time.

In an interview, staff #110 confirmed the above mentioned incident and stated he/she had never witnessed resident #002 requesting to engage with them. Staff

#103 also stated that resident #002 had a good memory with staff and residents' names, knows everything that happens in the unit, but does have a cognitive impairment.

In an interview staff #114 stated he/she met with resident #002 one day after the above mentioned incident. Staff #114 stated he/she discussed the incident and provided education. staff #114 stated that resident #002 told him/her that he/she did not like what happened, but staff#114 believed resident #002 consented to the interaction. Staff #114 further stated that resident #002 had the ability to consent to an identified engagement as he/she initiated the contact. Staff #114 confirmed that resident #002's written plan of care had not been revised to include identified responsive behaviours.

In interviews, staff #114 and staff #102 stated resident #002 and resident #003 were interviewed after the above mentioned incident occurred and both residents told them that the interaction was consensual. When asked to explain why staff #102 believes the residents are consenting to the identified engagement, staff #102 stated that he/she based his/her opinion on the Cognitive performance scale (CPS), the fact that resident #002 did not call for help or push resident #003 away from him/her, both residents sought each other out. Staff #102 further acknowledged that resident #003 had a cognitive impairment and was not able to remember the above mentioned incident; he/she still believed that resident #003 was able to consent. Staff #102 stated that both of the residents were interviewed separately, one day after the above mentioned incident. Resident #002 told staff #102 that resident #003 is his/her friend. Staff #102 also acknowledged that resident #003 had exhibited inappropriate responsive behaviours toward co-residents at least once per week but had not been successful. Staff #102's statement is inconsistent with resident #003's progress notes which states that on an identified date, resident #006 was observed with resident #003 in an identified area exhibiting inappropriate responsive behaviours toward resident #006. Resident #006 was redirected to the nursing station, and evening charge nurse was informed.

In an interview staff #115 stated that during the home's investigation of the above mentioned incident, resident #003 told him/her and the staff to leave them alone. Staff #115 believed that the residents are in their home and they have the right to have a relationship, and for their lifestyle to be respected.

In an interview staff #106 told the inspector that he/she had met with resident

#002 one day after the above mentioned incident. Staff #106 stated that resident #002 was very upset during their meeting as everyone told him/her that what he/she did was wrong. Staff #106 stated that resident #002 had identified responsive behaviours and stated that he/she had not assessed the resident for their capacity to consent, but based on his/her observations, both residents lacked the capacity to consent to a mutual engagement. The staff told the inspector that he/she was not asked by staff #115 or staff #102 about the residents capacity to consent and did not share his/her view regarding the resident's capacity to consent with any other staff at the home.

Review of the Behavioural Support Ontario (BSO) meeting minutes for an identified date revealed that residents #002 and #003 had been referred to the BSO. In an interview, staff #115 told the inspector that the above mentioned incident had not been considered by the home as alleged abuse based on the home's investigation and because residents #002 and #003 involved in that incident had consented.

Although the staff #114 and staff #102 and Administrator #115 said they believed that resident #002 consented to the engagement between resident #002 and #003; staff #115 and staff #106 told the inspector that there was no formal capacity assessment completed for residents #002 and #003 to determine their ability to consent to the identified. Furthermore, staff #115 stated that to assess the capacity to consent is expensive and none of the residents is able to afford the cost.

Based on the above facts, the licensee did not protect resident #002 from abuse by resident #003. [s. 19. (1)] (502)

2. During the inspection of an identified critical incident report for an identified date, resident #002 had complained to the inspector that resident #005 had exhibited identified responsive behaviours toward him/her. Resident #002 stated that on an identified date, resident #005 had exhibited identified responsive behaviours toward him/her, which he/she did not like, and reported to staff member #101.

In an interview staff member #101, confirmed resident #002 had reported the above mentioned alleged abuse to him/her on the same day. The staff member stated that he/she had reported the incident to staff #103 and the staff #102.

Review of resident #005's progress notes revealed that this resident was admitted on an identified date in 2015; he/she exhibited identified responsive behaviours and had a pattern of alleged abuse toward co-residents #002 and #005.

Further review of the progress notes failed to reveal any record of the alleged incident of abuse that occurred on the above mentioned date, and reported by resident #002, even though in an interview, staff member # 101, confirmed resident #002 had reported the above mentioned alleged abuse to him/her. The staff member stated that he/she had reported the incident to staff #103 and staff #102.

Review of resident #006's written plan of care printed revealed that the resident was admitted in the home in 2011, and identified with a cognitive impairment. Further review of resident #006's written plan of care revealed resident #006 had cognitive loss and he/she is unable to communicate his/her needs and had an identified responsive behaviour. Further review of the plan of care revealed following interventions had been implemented for resident #006's safety:

Review of resident #005's plan of care revealed this resident exhibited inappropriate responsive behaviour and attempting to bring identified co-residents residents to his/her room. Interventions were implemented to keep residents safe.

Review of resident #002's progress notes and the home's investigation revealed after the incident involving resident #002 and resident #005 on the above mentioned identified date, staff #102 and Administrator #115 met with both residents and documented that both residents stated they are adults.

Further review failed to identify an assessment for a capacity was conducted for resident #002 or #005.

In an interview, resident #005 confirmed he/she exhibited inappropriate responsive behaviours toward resident #002 on the above mentioned identified date. Resident #005 stated that both enjoyed the interaction, however, he/she did not understand why resident #002 had been running away from him/her since the incident. Resident #005 stated that he/she was aware that he/she was inappropriate.

The inspector brought resident #002's complaint of the alleged abuse on the above mentioned date, to staff #102's attention. Staff #102 stated that he/she had not been aware of the alleged incident of abuse between resident #002 and resident #005 on this date. Staff #102's statement is inconsistent with the statement from staff member #101 who told the inspector that resident #002 had reported the alleged abuse to him/her and that he/she had reported the incident to staff #103 and Staff #102. However, staff #102 stated being aware of two incidents of inappropriate interactions that had occurred on the reported identified date, involving both residents #002 and #005 that had been witnessed by PC #104 and an unidentified PSW respectively.

In an interview, PC #104 confirmed that on the reported above mentioned date, he/she had observed resident #005 exhibiting responsive behaviours toward resident #002 in an identified area of the home and had reported the incident to nursing staff.

In an interview, staff #117 stated that resident #002 had not been assessed as having inappropriate responsive behaviour. He/she further stated that after both incidents on the above mentioned date, involving resident #005, resident #002 was not upset.

Staff #103 and staff #102 told the inspector that they have been aware of the reported incidents. They also stated that they had not reported the incidents to the Director or contacted the police as they believed abuse had not occurred. Staff #102 stated that both residents had been interviewed on the same day during the home's investigation. When asked to explain why staff #102 believes the incident was not abuse was because both residents had no cognitive impairment and that they were able to make their own decisions. Staff #102 confirmed both residents had not been assessed for capacity to consent.

Staff #106 and the staff #102 stated that resident #005 has identified responsive behaviours that may be exhibited toward co-residents. Staff #106 stated that he/she had not assessed the residents for their capacity to consent, but based on his/her observations, resident #002 lacked the capacity to consent. Staff #106 told the inspector that he/she was not asked by Administrator #115 or staff #102 about the residents capacity to consent and did not share his/her view regarding the resident's capacity to consent with the other staff at the home.

Review of the home's Determining Capacity policy, #RESI-02-05-03 dated

November 2003, revealed a resident is presumed to be capable to make decisions about treatment, admission and personal assistance services, and a heath practitioner is entitled to rely on this presumption of capacity unless he/she has reasonable grounds to believe otherwise. Further review of the policy revealed that capacity is specific. It relates to the particular decision at hand and a person should not be considered capable simply because he/she agrees or does not object to a proposed treatment or other act.

In interview with staff #115 stated the incident involving residents #002 and #003, as well as incidents involving resident #002 and #005 had not been considered by the home as alleged abuse as resident #002, resident #005, and #003 are adults, however, staff #102 and staff #106 told the inspector that both residents had not been assessed for capacity to consent and the inspector did not see an assessment for a capacity.

Review of the CIS report from the MOHLTC website failed to reveal that the above identified incidents of inappropriate behaviour involving resident #002 and #005, residents #003 and #006, and resident #005 and #006 were reported to the Director as specified in the Long-Term Care Home Act.

During the inspection, staff #102 told the inspector that the above identified incidents of inappropriate responsive behaviours from resident #005 toward #006 that occurred for an identified time period, had not been reported to the Director as alleged abuse.

Based on the above facts and in particular the licensee's knowledge of resident #005's history of inappropriate responsive behaviour with respect to identified residents, the licensee failed to protect resident #002 from abuse when they failed to take sufficient action to protect resident #002 from abuse by resident #005 when the first incidents occurred. Furthermore, because the licensee did not take sufficient action after the reported incidents, the licensee failed to protect resident #002 from further abuse.

In addition to this, residents #003 and #005 sought out resident #006 on multiple occasions. Resident #006 needed to be protected by staff as evidenced by the interventions already put in place by the licensee, however, it took the licensee, which is 59 days in which multiple incidents of inappropriate responsive behaviour from resident #005 toward resident #006 occurred, before resident #005 was transferred to the another area of the home for resident #002's safety.

The scope of this finding was a pattern related to four incidents of alleged abuse of resident #002 by residents #003 and #005, as well as 13 documented incidents of abuse of resident #006 by residents #003 and #005 both of whom the licensee was aware had a history of seeking out identified co-residents. The severity showed minimal harm/risk or a potential for actual/harm risk. The Compliance History Report showed ongoing non-compliance with VPC 2014_251512_0022. As a result of scope, severity and previous compliance history a compliance order is warranted. [s. 19. (1)] (502)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2017

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 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 22nd day of December, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julienne NgoNloga

Service Area Office /
Bureau régional de services : Toronto Service Area Office