Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Nov 26, 2018	2018_741178_0010 (A1) (Appeal\Dir#: DR# 098)	009970-18, 010049-18	Complaint

Licensee/Titulaire de permis

Gem Health Care Group Limited
470 Raglan Street North RENFREW ON K7V 1P5

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

Groves Park Lodge
470 Raglan Street North RENFREW ON K7V 1P5

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

Amended by Wendy Lewis (Director) - (A1)(Appeal\Dir#: DR# 098)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

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NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector's order(s): CO#001.
The Director's review was completed on November 26, 2018.
Order(s) was/were rescinded and substituted with a Director Order to reflect the Director's review DR# 098.
A copy of the Director Order is attached.

Issued on this 26th day of November, 2018 (A1)(Appeal\Dir#: DR# 098)

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

Inspection Report under *the Long-Term Care Homes Act, 2007*

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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Amended by Wendy Lewis (Director) - (A1)(Appeal/Dir# DR# 098)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 27, 28, 29, July 4, 12, 13, 16, 27, 2018.

The following Logs were inspected as part of this inspection:

-Complaint Log #010049-18/IL-56970-OT, involving a complaint about alleged resident to resident abuse.

-Critical Incident Log # 009970-18/CIR #2646-000002-18, involving alleged resident to resident abuse.

This inspection report also contains evidence from Inspection #2018_761178_0014, which concerned Critical Incident Log 023724-17/CIR #2646 -000012-17, involving alleged resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with residents, family of a resident, the Administrator, the Director of Care (DOC), the Clinical Supervisor, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs).

During the course of this inspection, the inspector observed residents and resident care, reviewed residents' health records, reviewed home records including relevant training records and policies, reviewed critical incident reports and documents related to the licensee's investigation into the identified alleged incidents of abuse.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

3 WN(s)
2 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	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.) Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #001, #003, #004 and #005 were protected from abuse by resident #002.

The Long-Term Care Homes Act, 2007 defines resident to resident physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Resident #002 lived in the home for several years. Review of Resident #002's health record indicated that the resident had longstanding identified responsive behaviours which sometimes led to altercations with other residents.

Family member #109 indicated to inspector #178 on June 25, 2018, that resident #002 physically assaulted resident #001 on multiple occasions over a two year period, often when resident #002 entered the room of resident #001 without permission. Family member #109 alleged the following:
-On an identified date approximately two years ago, resident #002 hit resident #001 with their fists, bruising resident #001.
-On an identified date approximately one and one half years ago, resident #002 kicked resident #001, causing blood blisters which led to infection. Family member #109 indicated that the home did not notify them about the incident, and it was discovered by the family member when they observed a bandage on resident #001, and inquired about the reason.
-On an identified date approximately one month ago, resident #002 kicked resident #001 multiple times causing bruises.

The health record for resident # 002 was reviewed by Inspector #178. Resident #002's current plan of care indicated that resident #002 exhibited an identified responsive behaviour. Resident #002 was to be monitored to prevent altercations with other residents, and staff were to redirect resident #002 back to their own room when resident #002 exhibited the identified responsive behaviour. The plan of care indicated that resident #002 was on one half hour visual checks for safety, and had been for nearly two years. The plan of care indicated that approximately three years ago, resident #002 was placed in a private room to attempt to decrease behaviours and maintain safety for resident #002 and other residents.

Resident #001's progress notes were reviewed, and indicated that resident #001 experienced the following resident to resident altercations:

-RN #104 documented that on an identified date approximately two years ago, resident #001 reported that resident #002 entered resident #001's room and resident #001 attempted to prevent resident #002 from coming further into the room. Resident #001 reported that resident #002 hit them twice on an identified body part. Resident #001 reported no pain or injury at the time. Resident #001 was encouraged to call staff when other residents enter their room, rather than deal with it independently. A progress note written by RPN #108 on the day after the altercation, indicated that resident #001's identified body part was noted to be bruised from the incident with a co-resident which occurred the previous evening.
-RN #106 documented that on an identified date approximately one and one half years ago, that resident #001 presented to staff with an identified skin injury. Resident #001 stated that another resident ran into them with a walker. Resident #001 was reminded to inform staff at the time of an incident so an investigation could be done. Progress notes on the days following the discovery of the skin injury, indicated that resident #001 was experiencing pain from the skin injury, requiring analgesic to be administered.
- RPN #103 documented on an identified date approximately one month ago, that staff reported that early in the shift resident #001 stated that that a person had hit them. When staff stated resident #002's name, resident #001 answered yes. Later in the shift when staff observed a bruise on resident #001, the staff reported resident #001's earlier allegation to the Registered Nurse in charge. Resident #002 was not witnessed hitting resident #001. A progress note three days after the incident, indicated that resident #001's had a large hematoma on the identified body part. A progress note written by resident #001's physician ten days after the incident, indicated the physician was called to see resident #001 regarding a black hematoma on the identified body part. The progress note indicated that according to the nurse, resident #001 was hit by another resident.

Inspector #178 interviewed RPN #108 on July 4, 2018, at which time RPN #108 indicated that there have been altercations between resident #001 and resident #002. RPN #108 indicated that on an identified date approximately two years ago, resident #001 reported being hit on an identified body part by resident # 001, and that bruising appeared on resident #001's body part the following day. RPN #108 indicated that after the incident, identified interventions were put into place to discourage and prevent other residents from entering resident #001's room. Interventions were also put into place to attempt to discourage resident #002's identified responsive behaviour. RPN #108 indicated that resident #002 recently had a change in health status, and was no longer exhibiting the identified

responsive behaviour which led to altercations with other residents.

Inspector #178 interviewed RN #106 on July 27, 2018. RN #106 indicated that resident #002 tended to go into resident #001's room, and the two residents have had altercations in the past. RN #106 indicated that on an identified date approximately one and one half years ago, resident #001 presented to staff with a skin injury on an identified body part. When asked what had caused it, resident #001 reported that someone had knocked into them with a walker, and resident #001 did not know who the resident was. RN #106 indicated that resident #002 often went into resident #001's room, but no one had seen resident #002 in resident #001's room that evening. RN #106 re-approached resident #001 later in the evening, but resident #001 still would not tell the nurse who had run into them with the walker. RN #106 indicated that they were unsure what actually caused resident's #001's injury because resident #001 would frequently bump objects causing skin injury to their identified body part.

Inspector #178 interviewed RPN #103 on June 28, 2018. RPN #103 indicated that on an identified date approximately one month ago, resident #001 told PSW #105 that resident #002 had hit resident #001. RPN #103 indicated that they reported this information to the charge nurse, RN #104.

Inspector #178 interviewed PSW #105 on June 29, 2018. PSW #105 indicated that resident #002 was sometimes aggressive with other residents. PSW #105 indicated that resident #001 had reported on an evening shift that resident #002 had kicked or hit them with a walker, and showed PSW #105 a bruise on an identified body part caused as a result. PSW #105 indicated that resident #001 was very upset at the time. PSW #105 indicated that they had seen resident #002 in the hallway near resident #001's room that same afternoon, and felt that it was possible that resident #002 had kicked or hit resident #001 with the walker, causing the bruise on resident #001's identified body part. PSW #105 indicated that there was an identified intervention in place to discourage resident #002 from entering resident #001's room, and that it was effective most times, but not always. PSW #105 also indicated that resident #002's room was recently moved further away from resident #001's room, and to a higher traffic area to allow the staff to better watch resident #002, to prevent altercations. PSW #105 indicated that staff tried to always keep an eye on resident #002, and that there was always a staff member at the nurse's station near the resident's new room. PSW #105 indicated that if resident #002 was on their assignment, they would monitor resident #002 approximately every hour. PSW #105 also indicated that staff

would attempt to distract or redirect resident #002 if the resident was approaching another resident, or observed in another resident hallway.

On June 29, 2018, the Administrator indicated to Inspector #178 that on an identified date approximately two years ago, resident #002 entered the room of resident #001. Resident #001 grabbed resident #002's mobility aid and resident #002 hit resident #001 on an identified body part. There was no immediate evidence of injury to resident #001, but resident #001 later developed two bruise like areas on the identified body part. The Administrator indicated that resident #001 bruised easily as a side effect of the resident's medication, and when staff documented in resident #001's health record that the bruising was from the incident between the two residents, the staff was assuming.

On June 29, 2018, the home's Administrator indicated to Inspector #178 that on an identified date approximately one and one half years ago, staff observed blood on resident #001's clothing as the result of a skin injury. When the staff questioned resident #001 as to the cause, resident #001 told them someone had bumped resident #001 with their walker. When asked the next day about the incident, resident #001 denied having an incident with anyone. The resident's family was not notified of the skin injury until approximately one week later. The Administrator further indicated that the rooms for resident #001 and resident #002 were at opposite ends of the same hallway, but resident #002 tended to wander down the hall towards resident #001's room. After the most recent altercation between resident #001 and resident #002 approximately one month ago, resident #002 was moved to a different room, in an attempt to discourage resident #002 from wandering towards resident #001's room. The Administrator indicated that the room change was made at this time because the new room happened to be available, and resident #002 had had a change in health status, and was therefore less aware of where their room was than in the past.

On July 4, 2018, the DOC indicated to Inspector #178 that on an identified date approximately one month ago, staff noticed a bruise on resident #001's identified body part. When asked what it was from, resident #001 indicated that a person had hit or bumped resident #001. Staff then asked resident #001 directly if it had been resident #002 who had hit or bumped them, and resident #001 indicated yes. The incident was not witnessed and no staff could verify that resident #002 hit or bumped resident #001. The DOC indicated that resident #002 was monitored for responsive behaviours, and was on an almost constant visual checks. On July 12, 2018, the DOC indicated that resident #002 has had a

change in health status and is no longer mobilizing independently.

The following incidents of resident to resident altercations were inspected in Inspection #2018_761178_0014, and the following evidence of non-compliance comes from that inspection:

Review of resident #002's health record indicated that resident #002 was involved in three altercations with other residents between March 2016 and October 2017, which resulted in harm to the other residents. Resident #002's progress notes indicated the following:
-On an identified date, resident #002 entered the room of resident #003. Resident #003 who had been across the hall at the time, then entered their room and confronted resident #002. Both residents struck out at each other. Resident #002 struck at resident #003's, causing a scratch. Staff intervened and separated the residents.
-On an identified date, shouting was heard from the room of resident #004. Three staff attended and observed resident #002 and resident #004 both tugging on an article of clothing and swinging at each other. Resident #004 sustained an identified skin injury as a result of the altercation.
-On an identified date, resident #002 was found in resident #005's room at the other end of the building. The two residents had raised voices and were physically swatting at each other. Review of progress notes for resident #005 indicated that resident #005 sustained an identified skin injury as a result of the altercation.

Inspector #178 interviewed RPN #112 on July 16, 2018. RPN #112 indicated that until the resident's recent change in health status, resident #002 would get into verbal and occasionally physical altercations with other residents. RPN #112 indicated that on an identified date, resident #002 and resident #003 were involved in a physical altercation. As a result, resident #003 sustained a small scratch to an identified body part.

Inspector #178 interviewed RPN #113 on July 13, 2018. RPN #113 indicated that on an identified date, resident #002 entered resident #004's room and the two residents became involved in a physical altercation. Resident #004 sustained an identified skin injury as a result of the altercation. RPN #113 further indicated that on an identified date, resident #002 entered the room of resident #005 and sat in their chair. Resident #005 attempted to make resident #002 leave the room and an altercation took place between the two residents. As a result of the altercation,

resident #005 sustained an identified skin injury. RPN #113 indicated that resident #002 was mainly kept in open areas so the resident could be easily watched by all staff, to prevent responsive behaviours and altercations with co-residents.

Review of resident #002's health record and interviews with staff indicated that while interventions were in place to prevent altercations between resident #002 and other residents, these interventions were unsuccessful in preventing altercations with other residents, resulting in physical harm on at least five occasions since the spring of 2016. These altercations resulted in physical injuries to residents #001, #003, #004, and #005. [s. 19. (1)]

Additional Required Actions:

(A1)(Appeal/Dir# DR# 098)
The following order(s) have been rescinded: CO# 001

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 reported the suspicion and the information upon which it was based to the Director.

Critical Incident Report(CIR) #2646-000002-18, which the licensee submitted to the MOHLTC on an identified date approximately one moth ago, indicated that two days ago, resident #001 reported to staff that a person had hit them. Staff then inquired if it was resident #002 who hit them, and resident #001 replied "yes". Later in the shift when staff was getting resident #001 ready for bathing, a bruise was noted on resident #001's identified body part.

RPN #103 documented in resident #001's progress notes on an identified date, that staff reported that early in the shift, resident #001 stated that a person had hit them. When staff asked if it was resident #002 who hit them, resident #001 answered yes. Later in the shift when staff observed a bruise on resident #001's identified body part, they reported resident #001's earlier allegation to the Registered Nurse in charge. Resident #002 was not witnessed hitting resident #001. A progress note written three days after the incident, indicated that resident #001 had a large hematoma on an identified body. A progress note written by

resident #001's physician ten days after the incident, indicated the physician was called to see resident #001 regarding an identified black hematoma. The note indicated that according to the nurse, resident #001 was hit by another resident.

Inspector #178 interviewed PSW #105 on June 29, 2018. PSW #105 indicated that resident #001 had reported on an evening shift on an identified date, that resident #002 had kicked or hit them with a walker, and showed PSW #105 a bruise on an identified body part, caused as a result. PSW #105 indicated that resident #001 was very upset at the time. PSW #105 indicated that they had seen resident #002 in the hallway near resident #001's room that same afternoon, believed resident #001 when they said that resident #002 had kicked or hit them with the walker, causing the bruise. PSW #105 indicated that they passed this allegation on to RPN #103.

During an interview with Inspector #178 on June 28, 2018, RPN #103 indicated that on an identified date approximately one month ago, PSW #105 reported to them that resident #001 alleged that resident #002 had hit them. RPN #103 inspected the bruise on resident #001's identified body part, and reported the allegation to RN #104. RPN #103 also called and left a message for resident #001's SDM, asking them to call the home.

Inspector #178 interviewed RN #104 on June 29, 2018. RN #104 indicated that on an identified date approximately one month ago, staff reported that resident #001 had an injury to an identified body part, and resident #001 alleged to have been hit by resident #002. RN #104 indicated that it was reported to them that the PSW had asked resident #001 in a suggestible manner, did resident #002 hit you. RN #104 further indicated that the alleged hitting was not witnessed and no staff had seen resident #002 in the area of resident #001. Therefore, RN #104 indicated that they could not be certain that the allegation was true. RN #104 indicated that they investigated the incident by speaking to RPN #103 and asking staff whether anyone had seen resident #002 around resident #001. RN #104 indicated that they instructed RPN #103 to notify the resident's SDM of the injury of unknown cause, and to ensure that all current interventions for wandering residents were in place. RN #104 indicated that they passed the information on to night shift in report, but did not inform the MOHLTC, the police or home management of the allegation. RN #104 indicated that if a resident alleges abuse, they should report it to the home's management and the DOC will report it to the MOHLTC.

Inspector #178 interviewed the home's DOC on July 4, 2018. The DOC indicated that they became aware of resident #001's allegation of abuse when they received report on the day after the resident made the allegation that they had been hit by resident #002. The DOC indicated that they began investigating the allegation the day they were made aware of it, and reported the incident to the MOHLTC the following day. The DOC indicated that they should have been notified of the allegation as soon as the staff discovered it had happened. [s. 24. (1)]

2. RN #104 documented in resident #001's progress notes that on an identified date approximately two years ago, resident #001 reported that resident #002 entered resident #001's room and resident #001 attempted to prevent resident #002 from coming further into the room. Resident #001 reported that resident #002 hit them twice on an identified body part. Resident #001 reported no pain or injury at the time. Resident #001 was encouraged to call staff when other residents enter their room, rather than deal with it independently. A progress note by RPN #108 on the day after the incident, indicated that resident #001's identified body part was noted to be bruised from the incident with a co-resident which occurred the previous evening.

Inspector #178 interviewed RPN #108 on July 4, 2018, at which time RPN #108 indicated that there have been altercations between resident #001 and resident #002. RPN #108 indicated that on an identified date approximately two years ago, resident #001 reported being hit on an identified body part by resident # 001, and that bruising appeared on that body part the following day. RPN #108 indicated that an attempt was made to contact the SDM regarding the incident and the charge nurse was informed. RPN #108 indicated that this incident would constitute resident to resident abuse as per the licensee's abuse prevention policy, and that when they have a suspicion of abuse, they report it to the charge nurse, who would bring it to management. The DOC would then report it to the MOHLTC in the form of a CIR.

On June 29, 2018, the Administrator indicated to Inspector #178 that on an identified date approximately two years ago, resident #002 entered the room of resident #001. Resident #001 grabbed resident #002's mobility aid, and resident #002 hit resident #001 on an identified body part. There was no immediate evidence of injury to resident #001, but resident #001 later developed two bruise like areas on the identified body part. The Administrator indicated that resident #001 bruised easily as a side effect of the resident's medication, and when staff

documented in resident #001's health record that the bruising was from the incident between the two residents, the staff was assuming. The Administrator indicated that the MOHLTC was not informed of the incident because they did not feel there was an injury. [s. 24. (1)]

3. RN #106 documented in resident #001's progress notes that on an identified date approximately one and one half years ago, resident #001 presented with a skin injury to the lower leg. Resident #001 stated that another resident ran into them with a walker. Resident #001 was reminded to inform staff at the time of an incident so an investigation could be done. Progress notes written two and six days after the incident, indicated that resident #001 was experiencing pain from the skin injury, requiring that analgesic be administered.

Inspector #178 interviewed RN #106 on July 27, 2018. RN #106 indicated that resident #002 tended to go into resident #001's room, and the two residents have had altercations in the past. RN #106 indicated that on an identified date approximately one and one half years ago, resident #001 presented with an identified skin injury. When asked what had caused it, resident #001 reported that someone had knocked into them with a walker, and resident #001 did not know who the resident was. RN #106 indicated that resident #002 frequently wandered up and down the hall, and often went into resident #001's room, but no one had seen resident #002 in resident #001's room that evening. RN #106 re-approached resident #001 later in the evening, but resident #001 still would not tell the nurse who had run into them with the walker. RN #106 indicated that they were unsure what actually caused resident's #001's injury because resident #001 would frequently bump the identified body part. RN #106 indicated that they did not inform the DOC or Administrator of resident #001's allegation, but passed the information on to the night nurse, who would have informed the DOC and Administrator the next day.

On June 29, 2018, the home's Administrator indicated to Inspector #178 that on an identified date approximately one and one half years ago, staff observed that resident #001 had a skin injury. When the staff questioned resident #001 as to the cause, resident #001 told them someone had bumped resident #001 with their walker. When asked the next day about the incident, resident #001 denied having an incident with anyone. The resident's family was not notified of the skin injury until approximately one week later. The Administrator indicated that the MOHLTC was not notified of the incident because there was no abuse or aggressive incident that was seen or reported by the resident. [s. 24. (1)]

4. The following evidence of non compliance is from Inspection #2018_761178_0014:

Review of resident #002's progress notes indicated that on an identified date approximately two years ago, resident #002 entered the room of resident #003. Resident #003 who had been across the hall at the time, then entered their room and confronted resident #002. Both residents struck out at each other. Resident #002 struck at resident #003, causing a scratch. Staff intervened and separated the residents.

Inspector #178 interviewed RPN #112 on July 16, 2018. RPN #112 indicated that on an identified date approximately two years ago, resident #002 and resident #003 were involved in a physical altercation. As a result, resident #003 sustained a small scratch to an identified body part. RPN #112 indicated that the incident would "technically" constitute resident to resident abuse. RPN #112 indicated that they cannot specifically remember doing so, but they are sure they would have reported the incident to the charge RN. RPN #112 indicated that the charge RN would notify the DOC, who would report the incident the MOHLTC by submitting a Critical Incident Report. RPN #112 did not believe that this incident had been reported to the MOHLTC, but had no explanation as to why.

Inspector #178 interviewed the DOC on July 16, 2018. The DOC indicated that the mark on resident #003's identified body part was so small that staff did not feel it constituted a wound and therefore there was no injury. The DOC indicated that had there been an injury to resident #003, RPN #112 would have contacted the DOC, who would have reported the incident to the MOHLTC.

The licensee's policy titled Abuse and Neglect (un-numbered), dated last revised January 2015, Appendix-1 defined abuse as the use of force by a resident that causes physical injury to another resident, regardless of cognitive capacity. Appendix-1 defined injury as damage or harm suffered by a person, an act that damages or hurts, harm, wound or trauma, hurt, damage or loss sustained. Harm was defined as physical or mental damage. Can include but is not limited to: bruise, cut, scrape, skin tear, abrasion, bite, slap, hit, pinch, hair pull, shake, burn, scratch, etc.

As such, 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 reported 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 reports the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's SDM was immediately notified upon becoming aware of the alleged, suspected or witnessed incident of

abuse or neglect of the resident that resulted in a physical injury or pain to the resident.

Family member #109 indicated to inspector #178 on June 25, 2018, that on an identified date approximately one and one half years ago, resident #002 kicked resident #001, causing blood blisters which led to infection. Family member #109 indicated that the home did not notify them about the incident, and it was discovered by the family member the following week when they observed a bandage on resident #001 and inquired about the reason.

The progress notes for resident #001 were reviewed by Inspector #178. RN #106 documented on an identified date approximately one and one half years ago, that resident #001 presented with a skin injury to an identified body part. Resident #001 stated that another resident ran into them with a walker, causing the injury. Resident #001 was reminded to inform staff at the time of an incident so an investigation could be done. Progress notes written two and six days after the incident, indicated that resident #001 was experiencing pain from the skin injury, and analgesic was administered.

Inspector #178 interviewed RN #106 on July 27, 2018. RN #106 indicated that on an identified date approximately one and one half years ago, resident #001 presented with a skin injury. When asked what had caused it, resident #001 reported that someone had knocked into them with a walker, and resident #001 did not know who the resident was. RN #106 indicated that resident #002 would wander up and down the hall, and often went into resident #001's room, but no one had seen resident #002 in resident #001's room that evening. RN #106 re-approached resident #001 later in the evening, but resident #001 still would not tell the nurse who had run into them with the walker. RN #106 indicated that they were uncertain as to what had actually caused resident's #001's injury because resident #001 would frequently bump the identified body part. RN #106 indicated that resident #001's substitute decision maker (SDM) was not notified of the incident because at that time it was not the home's practice to always inform SDMs when a resident sustained a skin injury.

On June 29, 2018, the home's Administrator indicated to Inspector #178 that on an identified date approximately one and one half years ago, staff observed that resident #001 had sustained a skin injury. When the staff questioned resident #001 as to the cause, resident #001 told them someone had bumped resident #001 with their walker. When asked the next day about the incident, resident

#001 denied having an incident with anyone. The Administrator indicated that the resident's SDM was not notified of the skin tear until approximately one week later. The Administrator indicated that at the time, they did not consider the incident to be abuse. [s. 97. (1) (a)]

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 resident's SDM and any other person specified by the resident, are immediately notified upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident, to be implemented voluntarily.

Issued on this 26th day of November, 2018 (A1)(Appeal/Dir# DR# 098)

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

Ministère de la Santé et des Soins de longue durée

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by Wendy Lewis (Director) - (A1) (Appeal/Dir# DR# 098)
Inspection No. / No de l'inspection :	2018_741178_0010 (A1)(Appeal/Dir# DR# 098)
Appeal/Dir# / Appel/Dir#:	DR# 098 (A1)
Log No. / No de registre :	009970-18, 010049-18 (A1)(Appeal/Dir# DR# 098)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 26, 2018(A1)(Appeal/Dir# DR# 098)
Licensee / Titulaire de permis :	Gem Health Care Group Limited 470 Raglan Street North, RENFREW, ON, K7V-1P5
LTC Home / Foyer de SLD :	Groves Park Lodge 470 Raglan Street North, RENFREW, ON, K7V-1P5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Donna Pinkham

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

(A1)(Appeal/Dir# DR# 098)
The following Order(s) have been rescinded:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order/ Lien vers ordre existant :

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).

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 26th day of November, 2018 (A1)(Appeal/Dir# DR# 098)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by Wendy Lewis (Director) - (A1)
(Appeal/Dir# DR# 098)

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

Ministry of Health and Long-Term Care
Long-Term Care Homes Division
Long-Term Care Inspections Branch

Ministère de la Santé et des Soins de longue durée
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	☐ **Licensee Copy/Copie du Titulaire** ✕ **Public Copy/Copie Public**
Name of Director:	Wendy Lewis
Order Type:	☐ Amend or Impose Conditions on Licence Order, section 104 ☐ Renovation of Municipal Home Order, section 135 ✕ Compliance Order, section 153 ☐ Work and Activity Order, section 154 ☐ Return of Funding Order, section 155 ☐ Mandatory Management Order, section 156 ☐ Revocation of License Order, section 157 ☐ Interim Manager Order, section 157
Intake Log # of original inspection (if applicable):	009970-18, 010049-18
Original Inspection #:	2018_741178_0010
Licensee:	Gem Health Care Group Limited 470 Raglan Street North, RENFREW, ON, K7V-1P5
LTC Home:	Groves Park Lodge 470 Raglan Street North, RENFREW, ON, K7V-1P5
Name of Administrator:	Donna Pinkham

Background:

Ministry of Health and Long-Term Care (MOHLTC) Inspector #178 conducted an inspection at Groves Park Lodge (LTC Home) on the following dates: June 27, 28, 29, July 4, 12, 13, 16 and 27, 2018. The inspection was a Complaint Inspection at which time two intake logs (009970-18, 010049-18) were inspected. The inspection also contains information and evidence from a Critical Incident Inspection (2018_761178_0014) related to intake log #023724-17. This inspection was conducted concurrently with Inspection No. 2018_741178_0010.

During the inspection, the Inspector found that the Licensee, Gem Health Care Group Limited (Groves Park Lodge or the Licensee) failed to comply with subsection 19(1) of the Long-Term Care Homes Act, 2007 (LTCHA) and issued Compliance Order #001 which stated the following:

The licensee must be compliant with s.19(1) of the LTCHA.

Specifically, the licensee shall ensure that all residents are protected from abuse by any resident with responsive behaviours that put others at risk of harm.
The licensee shall develop and implement a process to ensure that
a) all resident to resident altercations in the home are tracked and reviewed at least daily by registered nursing staff; and as a result of this analysis,
b) implement effective interventions to ensure that all residents are safe and free from physical abuse.

This order must be complied with by: December 1, 2018.

Following the conclusion of a Director's review under section 163 of the LTCHA, the above order has been altered and substituted with the Director's Order below.

Order #:	001

To **Gem Health Care Group Limited**, you are hereby required to comply with the following order by the date set out below:

Pursuant To:

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:

The licensee must be compliant with s.19(1) of the LTCHA.

Specifically, the Licensee shall ensure that all residents are protected from abuse by Resident #002 and any other resident with responsive behaviours that put others at risk of harm.

The Licensee must develop and implement effective interventions for residents with responsive behaviours to ensure that all residents are safe and protected from physical abuse.

The Licensee shall trial the use of 1-1 staffing when residents have ongoing responsive behaviours that put themselves or other residents at risk of harm and cannot be managed through other interventions.

Grounds:

The Licensee has failed to ensure that Residents #001, #003, #004 and #005 were protected from physical abuse by Resident #002.

Subsection 2(1) of Ontario Regulation 79/10 under the Long-Term Care Homes Act, 2007 defines resident to resident physical abuse as the use of physical force by a resident that causes physical injury to another resident.

On May 17, 2018 MOHLTC received a complaint from the substitute decision-maker of Resident #001 regarding the alleged physical abuse by Resident #002 toward Resident #001 on four separate occasions. The complainant indicated that the alleged assaults took place in April 2016, February 2017, June 2017 and May 2018.

On June 25, 2018, during an interview with Resident #001's substitute decision-maker, the Inspector was told that Resident #002 physically assaulted Resident #001 on multiple occasions over a two-year period, often when Resident #002 entered the room of Resident #001 without permission. Resident #001's substitute decision-maker further stated that:
? In April 2016, Resident #002 hit Resident #001, causing an injury to Resident #001's forearm.
? In February 2017, Resident #002 kicked Resident #001, causing an injury which led to an infection. The substitute decision-maker indicated that the LTC home did not notify them about the incident and they discovered it when they observed a bandage on Resident #001's leg and inquired about the reason.
? On May 14, 2018, within Resident #001's room, Resident #002 struck Resident #001 multiple times causing injuries.

The health care record for Resident #002 was reviewed by Inspector #178. The health record identified that Resident #002 had a history of wandering into other residents' rooms and removing their belongings, believing that the belongings were theirs, and that this behaviour sometimes led to altercations with other residents.

The plan of care indicated that in May 2015, Resident #002 was placed in a private room to attempt to decrease behaviours and maintain safety for Resident #002 and others.

Resident #002 could become physically responsive if the resident saw staff removing items that they had collected from the rooms of other residents, so this was to be done when the resident was out of the room or sleeping. This intervention had been in place since January 2016.

The current plan of care indicated that Resident #002 would wander into other resident's rooms and take items. Interventions included monitoring to prevent altercations with other residents and staff were to redirect Resident #002 back to their room and attempt to remove items and return them to the rightful owners.

The health care record for Resident #001 was reviewed by Inspector #178 and identified the following:

? April 2016, Resident #001 reported that Resident #002 entered their room and they grabbed Resident #002's walker to prevent them from coming further into the room. Resident #001 reported that Resident #002 hit them twice.
? In April 2016, a progress note indicated that Resident #001 was bruised from the incident with a co-resident which occurred the previous evening.

In February 2017, RN #106 documented that Resident #001 came to the dining room and had a injury to their lower leg. Resident #001 stated that another resident ran into them with a walker.

In May 2018, RPN #103 documented that staff reported early in the shift, that Resident #001 stated that "that person hit me". When staff stated Resident #002's name, Resident #001 answered yes. Later in the shift when staff observed a bruise on Resident #001's leg, they reported Resident #001's earlier allegation to the Registered Nurse in charge. Resident #002 was not witnessed hitting Resident #001.

On May 17, 2018, a progress note indicated that Resident #001 had a large hematoma, about five centimetres across.

On May 24, 2018 a progress note by Resident #001's physician indicated the physician was called to see the resident regarding an injury on their leg. The note indicated that according to the nurse, Resident #001 was hit by another resident.

On July 27, 2018 during an interview, RN # 106 told the Inspector that,
? Resident #002 was not cognitively aware of their actions.
? They have been present when Resident #002 and Resident #001 have had altercations.
? Resident #002 tends to go down to Resident #001’s room.
? Resident #002 would come out of their room and say get out of my way to nobody in particular and may push them with their walker to get them out of the way.

On June 28, 2018 during an interview with the Inspector, RPN #103 stated that on May 14, 2018, Resident #001 told PSW #105 that Resident #002 had hit them. RPN #103 indicated that they reported this information to the charge nurse, RN #104.

On June 29, 2018 during an interview with the Inspector, PSW #105 stated the following:
? Resident #002 was sometimes aggressive with other residents.
? Resident #001 had reported in February 2017 that Resident #002 had kicked or hit them with a walker and showed PSW #105 a bruise on the lower leg caused as a result.
? PSW #105 indicated that resident #001 was very upset at the time.

On June 29, 2018 during an interview with the Inspector, the Administrator stated the following:
? The rooms for Resident #001 and Resident #002 were at opposite ends of the same hallway. Resident #002 tended to wander down the hall towards resident #001's room, and turn around there, which home staff felt might be leading Resident #002 to enter Resident #001's room.
? After the most recent altercation between Resident #001 and Resident #002 in May 2018, Resident #002 was moved to a different room in an attempt to discourage them from wandering towards Resident #001's room.

On July 4, 2018 during an interview with the Inspector, RPN #108 stated the following:
? There have been altercations between Resident #001 and Resident #002.
? In April 2016, Resident #001 reported being hit on the arm by Resident #002, and that bruising appeared on Resident #001's arm the following day.
? Resident #002's health has recently declined, and they are no longer wandering into other residents' rooms.

On July 4, 2018 during an interview with the Inspector, the DOC stated the following:
? In May 2018, staff noticed a bruise on Resident #001's shin. When asked what it was from, they indicated that "a person" had hit or bumped them. Staff then asked Resident #001 directly if it had been Resident #002 who had hit or bumped them, and they said yes.
? The incident was unwitnessed, and staff could not verify that it was Resident #002 who hit or bumped Resident #001.

During a concurrent Critical Incident Inspection (2018_761178_0014) related to resident to resident altercations, evidence regarding Resident #002's involvement in altercations with other residents was gathered and are included as grounds to support this Order. This included:

? Inspector #178 reviewed the health care record for Resident #002 and identified that this resident was involved in three altercations with other residents between March 2016 and October 2017, which resulted in harm to the other residents.
o In March 2016, Resident #002 entered the room of Resident #003. Resident #003 who had been across the hall at the time, then entered their room and confronted Resident #002. Both residents struck out at each other. Resident #002 struck at Resident #003's face, causing a scratch. Staff intervened and separated the residents.
o In August 2017, shouting was heard from the room of Resident #004. Three staff attended and observed Resident #002 and Resident #004 both tugging on a shirt and swinging at each other. Resident #004 sustained an injury and scratches on the as a result of the altercation.
o In October 2017, Resident #002 was found in Resident #005's room at the other end of the building. The two residents had raised voices and were physically swatting at each other. Review of the progress notes for Resident #005 indicated that they sustained an injury as a result of the altercation.

Further review of Resident #002's health record by Inspector #178 and interviews with staff indicated that while interventions were in place to prevent altercations between Resident #002 and other residents, these interventions were unsuccessful in preventing altercations with other residents, resulting in physical harm on at least five occasions since April 2016. These altercations resulted in physical injuries to Residents #001, #003, #004, and #005.

The application of factors taken into account under section 299(1) of the Regulation requires a Compliance Order to be issued. I have assessed the severity of the non-compliance as a level 3, which means there was actual harm to residents as a result of physical abuse by Resident #002. The scope is

assessed as a level 2 as there was a pattern of behaviour by Resident #002 that resulted in physical injuries to Resident #001 who has been affected by repeated occurrences, as well as Resident #003, #004, #005. The compliance history is a level 2 as there was one or more unrelated non-compliances within the last 36 months.

This order must be complied with by:	December 14, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Long-Term Care Inspections Branch
1075 Bay St., 11th Floor, Suite 1100
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.

Issued on this 26th day of November, 2018	
Signature of Director:	
Name of Director:	Wendy Lewis