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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 24, 2018	2018_578672_0009	009235-18	Critical Incident System

Licensee/Titulaire de permis

Regional Municipality of Durham
605 Rossland Road East WHITBY ON L1N 6A3

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

Hillsdale Estates
590 Oshawa Blvd. North OSHAWA ON L1G 5T9

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

JENNIFER BATTEN (672)

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): May 8-11, 2018

During this inspection, the following Critical Incident Reports (CIRs) were inspected:

Log #009235-18, related to an alleged incident of resident to resident abuse, which resulted in a significant change in status due to an injury

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Care Coordinators (RCC), RAI Coordinator, Manager of Nursing Practice, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Behavioural Support Ontario Personal Support Workers (BSO PSW), residents, and family members.

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.
- **6 WN(s)**
- **1 VPC(s)**
- **4 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff and others who provided direct care to

residents #001, #002 and #003 were kept aware of the contents of the plan of care.

Related to Log# 009235-18:

Two Critical Incident Reports were submitted to the Director on a specified date, related to an incident of resident to resident abuse. According to the CIRs, resident #001, #002, and #003 were in an identified area of one of the resident home areas, when residents #001 and #002 became involved in an incident which resulted in an injury to resident #002. Following the incident, resident #003 approached resident #001, and a second incident occurred, which resulted in an injury to resident #003.

During observations made by Inspector #672 on three specified dates, it was noted that the home had two specialized identified resident home areas. The identified home areas were attached to each other through a communal resident area, where the doors were kept open at all times, which allowed the residents from one identified resident home area to travel onto the other identified resident home area freely.

During record review, Inspector #672 reviewed resident #001's written plan of care in place prior to the incident. The written plan of care indicated that resident #001 had a history of exhibited responsive behaviours towards others. There were no goals or interventions listed for this care plan focus, for staff to implement.

Inspector #672 then reviewed resident #002's written plan of care in place prior to the incident. The written plan of care indicated that resident #002 had a history of exhibited responsive behaviours towards others, which were often triggered by a specified cause. Interventions were listed for staff to implement for resident #002.

Inspector #672 reviewed resident #003's written plan of care in place prior to the incident. The written plan of care indicated that resident #003 had a history of exhibited responsive behaviours towards others. Interventions were in place for staff to implement for resident #003.

During an interview, Personal Support Worker (PSW) #116 indicated being assigned to provide an intervention for resident #001 for a specified shift. PSW #116 further indicated being unaware of the incident which occurred with resident #001, and had not received any type of report regarding resident #001, except for reading through a previous documentation tool and previous note from the Behavioural Support Ontario (BSO) team.

During separate interviews, PSWs #106, #107, #110, and #114 indicated that the doors between the two specialized identified resident home areas were left open at all times, but staff on one identified resident home area would not receive report or was aware of resident's histories, responsive behaviours, or interventions from the other identified resident home area, even though residents from that identified resident home area were frequently on the other identified resident home area, and being assisted by the staff. The PSWs further indicated that staff from one identified resident home area would not have access to care plans for residents who resided on the other identified resident home area, and PSWs #106, #107, #110 were not aware of any responsive behaviours or interventions for residents #002 or #003, and PSW #114 was not familiar with resident #001, even though all of the residents frequented the other resident home area.

During an interview, RN #104 indicated a belief that the incident occurred due to the noise level in the identified communal resident area, as a result of that the doors between the two specialized identified resident home areas being left open at all times, which allowed for residents with an identified behaviour to be interacting amongst each other, and staff only possessed familiarity of half of the residents. RN #104 further indicated these concerns had been brought forward previously to RCC #108, but direction had been given to leave the doors open between the specialized identified resident home areas, to allow the residents more room to move around. RN #104 indicated no plan was in place to ensure that staff working on one identified resident home area would have access to plans of care for the residents from the other identified resident home area, or for conducting a shift report as a group from both identified resident home areas, so that staff from one area would be knowledgeable of incidents or concerns with residents from the other identified resident home area, that they may need to interact with throughout the shift, due to the interaction of residents.

During a telephone interview, RCC #108 indicated that the doors between the two specialized identified resident home areas were left open at all times, to allow the residents the most room to move around, and acknowledged that staff working on one of the identified resident home areas would frequently interact with residents from the other identified resident home area. RCC #108 further indicated that there was not currently a plan in place which allowed staff from one identified resident home area to have access to the plans of care for residents from the other identified resident home area, nor was shift report conducted between the entire group of staff from both specialized identified resident home areas, therefore staff could be intervening, redirecting or assisting residents, without having knowledge of the resident's plan of care. RCC #108 indicated

that this had been brought forward from the staff working on the specialized identified resident home areas, regarding possible safety risks to the residents and staff. RCC #108 provided direction to the staff that the doors could be closed during a specialized time to manage the situation, but the doors were only to be closed after all other interventions had been attempted.

During an interview, the ED indicated that the home was preparing to trial a program on another resident home area in the home, which was not one of the specialized identified resident home areas. The ED further indicated there was no specific date or plan in place to implement the program on either of the specialized identified resident home areas.

The licensee failed to ensure that all staff and others who provided direct care to the residents were kept aware of the contents of the plan of care, as staff were not provided access to the resident plans of care. [s. 6. (8)]

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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knew of, was immediately investigated.

Related to Log# 009235-18:

Two Critical Incident Reports were submitted to the Director on a specified date, related to an incident of resident to resident physical abuse. According to the CIRs, resident #001, #002, and #003 were in an identified area of one of the resident home areas, when residents #001 and #002 became involved in an incident which resulted in an injury to resident #002. Following the incident, resident #003 approached resident #001, and a second incident occurred, which resulted in an injury to resident #003.

Inspector #672 arrived at the home on a specified date, and requested a copy of the home's internal investigation notes. The DOC informed Inspector #672 that the notes were not available, as the investigation had been initiated by RCC #108, but RCC #108 was not present in the home, due to illness, and the DOC did not have access to the investigation notes.

During review of the CIRs, Inspector #672 observed that RN #104, RPN #105, and PSWs #106 and #107 had been directly involved in the incident.

During separate interviews, PSWs #106 and #107 indicated that the Manager of Nursing Practice approached them in the late afternoon of a specified date, did not ask any questions regarding the incident, but provided paperwork for them to complete, regarding their written statement of facts regarding the incident.

During separate interviews, RN #104 and RPN #105 indicated that no one from the management team had requested a formal statement regarding the incident, and no statement, verbal or written had been provided by the staff members. RN #104 further indicated that RCC #108 had been called following the incident, and was informed of what had occurred. RCC #108 responded by sending an email, to provide direction to RN #104 for the tasks which needed to be completed, such as informing the Director immediately.

During an interview, the Manager of Nursing Practice indicated providing paperwork to two of the PSWs involved in the incident during the late afternoon of a specified date, at

the request of the DOC. The Manager of Nursing Practice further indicated not being involved in the internal investigation into the incident in any other way, and was not familiar with the specifics of the incident.

During an interview, the DOC indicated that the expectation in the home was that the RCC responsible for the resident home area where an incident occurred would be responsible for conducting an internal investigation. The DOC further indicated that in the event that the RCC for the resident home area was away from the home, another RCC would fill in, and conduct the internal investigation. The DOC indicated this had not occurred for the incident between residents #001, #002 and #003, as the DOC had expected RCC #108 to return to the home the following day, after calling in sick but that had not occurred, and the DOC had not requested assistance from any of the other RCCs in the home to conduct the internal investigation, other than requesting the Manager of Nursing Practice to hand out incident reports to be completed by PSWs #106 and #107, following Inspector #672 arriving at the home. The DOC was unsure why the internal investigation had not been immediately initiated, following the incident.

During a telephone interview, RCC #108 indicated being present in the home on a specified date following the incident, and did not return to the home until six days later, due to illness. RCC #108 further indicated that the internal investigation had not been initiated on a specified date, and was unsure if an internal investigation had been conducted into the incident at all, as no follow up with other team members had been completed.

The licensee failed to ensure that the incident which occurred between residents #001, #002, and #003 was immediately investigated, despite being aware of the incident. [s. 23. (1) (a)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that behavioural triggers were identified for residents #002 and #003, when responsive behaviours were demonstrated.

Related to Log# 009235-18:

Two Critical Incident Reports were submitted to the Director on a specified date, related to an incident of resident to resident physical abuse. According to the CIRs, resident #001, #002, and #003 were in an identified area of one of the resident home areas, when residents #001 and #002 became involved in an incident which resulted in an injury to resident #002. Following the incident, resident #003 approached resident #001, and a second incident occurred, which resulted in an injury to resident #003.

During separate interviews, PSWs #106, #112, and #115, RPN #117, and RNs #104 and #113 indicated that resident #002 had responsive behaviours, which included exhibited responsive behaviours towards staff and co-residents. RNs #104 and #113 and PSWs #112 and #115 further indicated possible triggers for resident #002's responsive behaviours, which would possibly lead to resident #002 exhibiting identified responsive behaviours towards others. PSW #106 and RPN #117 were unsure of possible triggers to resident #002's responsive behaviours.

Inspector #672 reviewed the CIRs submitted to the Director regarding the incident. One of the CIRs indicated that resident #002 was questioned following the incident, and resident #002 indicated that the incident occurred as a result of their belief that resident #001 was exhibiting specified responsive behaviours.

Inspector #672 reviewed the written plan of care for resident #002 which was in place at the time of the incident. The written plan of care indicated that resident #002 had a history of identified exhibited responsive behaviours towards others. The written plan of care identified that resident #002's responsive behaviours may be triggered by two possible causes. It did not identify that resident #002 exhibited other identified exhibited responsive behaviours towards others, which led to identified incidents in the past.

During record review, Inspector #672 reviewed resident #001's written plan of care in place prior to the incident. The written plan of care indicated that resident #001 had a history of identified exhibited responsive behaviours towards others. There were no goals or interventions listed for this care plan focus, for staff to implement.

Inspector #672 reviewed the progress notes for resident #003 for a specified time period. The progress notes indicated that an identified number of incidents occurred during that period of time.

During separate interviews, PSWs #106 and #115, RPN #117, and RNs #104 and #113 indicated that resident #003 had identified exhibited responsive behaviours towards others. PSW #115 and RN #113 further indicated possible triggers for resident #003's exhibited responsive behaviours. PSW #106, RPN #117, and RN #104 were unsure of triggers to resident #003's responsive behaviours.

Inspector #672 reviewed resident #003's written plan of care in place at the time of the incident. The written plan of care indicated that resident #003 had a history of identified exhibited responsive behaviours. There were no triggers listed within the written plan of care for staff to be aware of, or intervene if possible, other than directing staff to "try to determine what triggered/led up to behaviour and remove the trigger". An identified section of resident #003's written plan of care did not identify that resident #003 could exhibited an identified responsive behaviour, or had a history of identified exhibited responsive behaviours.

During an interview, the DOC indicated that the expectation in the home was that the written plans of care for all residents demonstrating responsive behaviours should list the triggers to the responsive behaviours, if they are known.

The licensee failed to ensure that the written plans of care for residents #002 and #003 identified the triggers to the demonstrated responsive behaviours. [s. 53. (4) (a)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002 and resident #003 was protected from abuse by resident #001.

Related to Log# 009235-18:

Two Critical Incident Reports were submitted to the Director on a specified date, related to an incident of resident to resident physical abuse. According to the CIRs, resident #001, #002, and #003 were in an identified area of one of the resident home areas, when residents #001 and #002 became involved in an incident which resulted in an injury to resident #002. Following the incident, resident #003 approached resident #001, and a second incident occurred, which resulted in an injury to resident #003.

During observations made by Inspector #672, it was noted that the home had identified specialized resident home areas. The specialized resident home areas were attached to each other through a communal resident area, where the doors were kept open at all times, which allowed the residents from one specialized resident home area to move around onto the other specialized resident home area freely.

Inspector #672 reviewed the "Incidents" section in the electronic documentation system for resident #001 for a specified time period, which revealed that resident #001 had been involved in an identified number of incidents of exhibited responsive behaviours towards others.

During record review, Inspector #672 reviewed resident #001's written plan of care in place prior to the incident. The written plan of care indicated that resident #001 had a history of identified exhibited responsive behaviours. There were no goals or interventions listed for this care plan focus, for staff to implement.

Inspector #672 then reviewed resident #002's written plan of care in place prior to the incident. The written plan of care indicated that resident #002 had a history of identified exhibited responsive behaviours towards others, which was often triggered by an identified cause. Interventions were listed for staff to implement, related to resident #002's responsive behaviours.

Inspector #672 reviewed resident #003's written plan of care in place prior to the incident. The written plan of care indicated that resident #003 had a history of identified exhibited responsive behaviours towards others. Interventions were listed for staff to implement, related to resident #003's responsive behaviours.

During separate interviews, PSWs #106, #107, #110 and #114 indicated that the doors between the identified specialized resident home areas were left open at all times, but staff on one specialized resident home area would not get report or be aware of resident's histories, responsive behaviours, or interventions from the other specialized resident home area, even though residents from that specialized resident home area were frequently on the other specialized resident home area, and being assisted by the staff. The PSWs further indicated that staff from one specialized resident home area would not have access to care plans for residents who resided on the other specialized resident home area. PSWs #106, #107, #110 indicated not being aware of any responsive behaviours or interventions for residents #002 or #003 and PSW #114 indicated not being familiar with resident #001, even though all of the residents frequented the opposite resident home area.

During a telephone interview, RPN #117 indicated being the charge nurse and responsible for the resident home area that resident #001 resided on, during the incident. RPN #117 further indicated not being aware that resident #001 had a history of responsive behaviours.

During an interview, RPN #105 indicated being the charge nurse and responsible for the resident home area that resident #002 and #003 resided on, during the incident. RPN #105 further indicated being unaware that either resident #002 or resident #003 had any

responsive behaviours, and was unaware of any interventions in place for either resident.

During an interview, RN #104 indicated a belief that the incident occurred due to an environmental factor in the identified area, as a result of the doors between the identified specialized resident home areas being left open at all times. RN #104 further indicated that leaving the doors opened between the specialized resident home areas allowed for a number of residents to interact with each other, with staff providing redirection, without having information pertaining to all resident's plan of care. RN #104 indicated those concerns had been brought forward previously to RCC #108, but direction had been given to leave the doors open between the specialized resident home areas, to allow the residents more room to move between the areas. RN #104 further indicated no plan was in place to ensure that staff working on one specialized resident home area would have access to plans of care for the residents from the other specialized resident home area, or for conducting a shift report as a group from both specialized resident home areas, so that staff from one specialized resident home area would be knowledgeable of behaviours, incidents, or concerns with residents from the other specialized resident home area.

During a telephone interview, RCC #108 indicated that the doors between the identified specialized resident home areas were left open at all times, to allow the residents the most room to move about freely. RCC #108 acknowledged that by leaving the doors opened between the identified specialized resident home areas, staff working on one of the specialized resident home areas would frequently interact with residents from the other specialized resident home area. RCC #108 indicated that there was not a plan in place which allowed staff from one specialized resident home area to have access to the plans of care for residents from the other specialized resident home area, nor was shift report conducted between both groups of staff. RCC #108 further indicated that staff could be intervening, redirecting, or assisting residents, without having knowledge of the resident's plan of care. RCC #108 indicated that concerns had been brought forward previously from the staff working on the identified specialized resident home areas, regarding possible safety risks to the residents and staff, by leaving the doors opened between the home areas. RCC #108 indicated direction had been provided to the staff that the doors could be closed during a specified time, but the doors were only to be closed after all other interventions had been attempted. RCC #108 further indicated that the home was preparing to implement a new pilot program, which would allow staff and others to identify residents at risk of exhibiting identified responsive behaviours. RCC #108 indicated that the pilot program was initially being trialed on other resident home

areas in the home, and did not have a date of when the program may be trialed on resident #001, #002 and #003's resident home area. RCC #108 did indicate being aware of the legislative requirements which state that all residents in the home must be protected from abuse and neglect by anyone, at all times.

The licensee failed to ensure that residents #002 and #003 were protected from abuse by resident #001. [s. 19. (1)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff members have received retraining annually regarding prevention of resident abuse and neglect.

Related to Log# 009235-18:

Two Critical Incident Reports were submitted to the Director on a specified date, related to an incident of resident to resident physical abuse. According to the CIRs, resident #001, #002, and #003 were in an identified area of one of the resident home areas, when residents #001 and #002 became involved in an incident which resulted in an injury to resident #002. Following the incident, resident #003 approached resident #001, and a second incident occurred, which resulted in an injury to resident #003.

During an interview, PSW #114 indicated they had not completed the mandatory training regarding prevention of resident abuse and neglect, the licensee's policy to promote zero tolerance of abuse and neglect of residents, the licensee's policy regarding the duty to make mandatory reports under section 24, or the whistle-blowing protections, within a designated time period.

During an interview, the DOC indicated that PSW #114 had been off work during a specified time period, but was allowed to return to active duty of providing direct resident care, prior to completing specified mandatory education. The DOC further indicated being aware of the legislative requirements that all staff were to receive specified mandatory education within specified time periods, as a condition of working in the home.

The licensee has failed to ensure that PSW #114 received specified mandatory education within a specified period of time, prior to providing direct resident care.

A VPC is being issued related to this area of non-compliance, as a WN was issued to the licensee in October 2017, regarding non-compliance specific to s. 76. (4). [s. 76. (4)]

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 all staff in the home receive mandatory retraining annually regarding prevention of resident abuse and neglect,, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

Related to Log# 009235-18:

Two Critical Incident Reports were submitted to the Director on a specified date, related to an incident of resident to resident physical abuse. According to the CIRs, resident #001, #002, and #003 were in an identified area of one of the resident home areas, when residents #001 and #002 became involved in an incident which resulted in an injury to resident #002. Following the incident, resident #003 approached resident #001, and a second incident occurred, which resulted in an injury to resident #003.

During separate interviews, PSWs #106, #112, and #115, RPN #117, and RNs #104 and

#113 indicated that resident #002 had identified exhibited responsive behaviours towards staff and co-residents. RNs #104 and #113 and PSWs #112 and #115 further indicated possible triggers for resident #002's responsive behaviours, which could possibly lead to resident #002 exhibiting identified responsive behaviours towards others. PSW #106 and RPN #117 were unsure of possible triggers to resident #002's responsive behaviours.

Inspector #672 reviewed the CIRs submitted to the Director regarding the incident. One of the CIRs indicated that resident #002 was questioned following the incident, and resident #002 indicated that the incident occurred due to resident #001's exhibited identified responsive behaviours towards others. None of the other residents who were present during the incident indicated they had observed the identified responsive behaviours resident #002 indicated resident #001 had exhibited.

Inspector #672 reviewed the written plan of care for resident #002 which was in place at the time of the incident. The written plan of care indicated that resident #002 had a history of identified exhibited responsive behaviours towards staff and residents. The written plan of care identified that resident #002's responsive behaviours may be triggered by two possible causes. It did not identify that resident #002 had identified exhibited responsive behaviours, which led to specified incidents in the past.

Resident #002 returned to the home on at a specified date and time. Inspector #672 reviewed the written plan of care in place for resident #002, following the incident. Inspector #672 observed that no changes had been made to resident #002's written plan of care regarding responsive behaviours, related to the incident.

Inspector #672 reviewed the progress notes for resident #003 during a specified time period. The progress notes indicated that an identified number of incidents occurred during that period of time.

During separate interviews, PSWs #106 and #115, RPN #117, and RNs #104 and #113 indicated that resident #003 had identified exhibited responsive behaviours towards others. PSW #115 and RN #113 further indicated possible triggers for resident #003's exhibited responsive behaviours. PSW #106, RPN #117 and RN #104 were unsure of triggers to resident #003's responsive behaviours.

Inspector #672 reviewed resident #003's written plan of care in place at the time of the incident. The written plan of care indicated that resident #003 had a history of identified exhibited responsive behaviours towards others. There were no triggers listed within the

written plan of care. An identified section of resident #003's written plan of care did not identify that resident #003 had other identified responsive behaviours, or a history of exhibiting specified responsive behaviours.

Inspector #672 then reviewed the written plan of care in place for resident #003 following the incident, and observed that no changes had been made to resident #003's written plan of care regarding responsive behaviours since an identified date, during the routine quarterly review.

During an interview, the DOC indicated that the expectation in the home was that the written plans of care for all residents demonstrating responsive behaviours should be reviewed and revised following each incident of exhibited responsive behaviours.

The licensee failed to ensure that steps were taken to minimize the risk of altercations regarding residents #002 and #003, by identifying and implementing interventions.

A WN was issued during this inspection under r. 54 (b), as a Compliance Order had been issued during an inspection on June 26, 2018, with a compliance date of September 27, 2018. [s. 54. (b)]

Issued on this 9th day of November, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JENNIFER BATTEN (672)
Inspection No. / No de l'inspection :	2018_578672_0009
Log No. / No de registre :	009235-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 24, 2018
Licensee / Titulaire de permis :	Regional Municipality of Durham 605 Rossland Road East, WHITBY, ON, L1N-6A3
LTC Home / Foyer de SLD :	Hillsdale Estates 590 Oshawa Blvd. North, OSHAWA, ON, L1G-5T9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gina Peragine

To Regional Municipality of Durham, you are hereby required to comply with the following order(s) by the date(s) set out below:

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. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Order / Ordre :

The licensee must be compliant with s. 6 of the LTCHA.

Specifically, the licensee shall ensure the following:

1) Develop and implement a plan to ensure that front line staff members (PSWs, RPNs, RNs, or any other staff member providing direct care to the resident) are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, when working with the resident, specifically all front line staff members, including those conducting one to one nursing observation, agency staff, or any replacement staff scheduled to work in the home.

2) Develop and implement a plan for ensuring that all front line staff members (PSWs, RPNs, RNs, or any other staff member providing direct care to the resident) working with a resident with a history of aggression are kept informed of the resident's history of responsive behaviours, along with their triggers, and interventions listed within the plan of care.

3) Develop and implement a corrective action plan which outlines measures to be taken and by whom, if staff fail to implement the interventions as identified.

4) Educate all front line staff on the plan(s) developed and implemented.

5) Keep a documented record of all plans developed and implemented, and education of the staff.

The plan is to be submitted to the CESAO within 10 business days, to the email address of CentralEastSAO.MOH@ontario.ca, attention Inspector #672, Jennifer Batten.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff and others who provided direct care to residents #001, #002 and #003 were kept aware of the contents of the plan of care.

Related to Log# 009235-18:

Two Critical Incident Reports were submitted to the Director on a specified date,

related to an incident of resident to resident abuse. According to the CIRs, resident #001, #002, and #003 were in an identified area of one of the resident home areas, when residents #001 and #002 became involved in an incident which resulted in an injury to resident #002. Following the incident, resident #003 approached resident #001, and a second incident occurred, which resulted in an injury to resident #003.

During observations made by Inspector #672 on three specified dates, it was noted that the home had two specialized identified resident home areas. The identified resident home areas were attached to each other through a communal resident area, where the doors were kept open at all times, which allowed the residents from one identified resident home area to travel onto the other identified resident home area freely.

During record review, Inspector #672 reviewed resident #001's written plan of care in place prior to the incident. The written plan of care indicated that resident #001 had a history of exhibited responsive behaviours towards others. There were no goals or interventions listed for this care plan focus, for staff to implement.

Inspector #672 then reviewed resident #002's written plan of care in place prior to the incident. The written plan of care indicated that resident #002 had a history of exhibited responsive behaviours towards others, which were often triggered by a specified cause. Interventions were listed for staff to implement for resident #002.

Inspector #672 reviewed resident #003's written plan of care in place prior to the incident. The written plan of care indicated that resident #003 had a history of exhibited responsive behaviours towards others. Interventions were in place for staff to implement for resident #003.

During an interview, Personal Support Worker (PSW) #116 indicated being assigned to provide an intervention for resident #001 for a specified shift. PSW #116 further indicated being unaware of the incident which occurred with resident #001, and had not received any type of report regarding resident #001, except for reading through a previous documentation tool and previous note from the Behavioural Support Ontario (BSO) team.

During separate interviews, PSWs #106, #107, #110, and #114 indicated that the doors between the two specialized identified resident home areas were left open at all times, but staff on one identified resident home area would not receive report or was aware of resident's histories, responsive behaviours, or interventions from the other identified resident home area, even though residents from that identified resident home area were frequently on the other identified resident home area, and being assisted by the staff. The PSWs further indicated that staff from one identified resident home area would not have access to care plans for residents who resided on the other identified resident home area, and PSWs #106, #107, #110 were not aware of any responsive behaviours or interventions for residents #002 or #003, and PSW #114 was not familiar with resident #001, even though all of the residents frequented the other resident home area.

During an interview, RN #104 indicated a belief that the incident occurred due to the noise level in the identified communal resident area, as a result of that the doors between the two specialized identified resident home areas being left open at all times, which allowed for residents with an identified behaviour to be interacting amongst each other, and staff only possessed familiarity of half of the residents. RN #104 further indicated these concerns had been brought forward previously to RCC #108, but direction had been given to leave the doors open between the specialized identified resident home areas, to allow the residents more room to move around. RN #104 indicated no plan was in place to ensure that staff working on one identified resident home area would have access to plans of care for the residents from the other identified resident home area, or for conducting a shift report as a group from both identified resident home areas, so that staff from one area would be knowledgeable of incidents or concerns with residents from the other identified resident home area, that they may need to interact with throughout the shift, due to the interaction of residents.

During a telephone interview, RCC #108 indicated that the doors between the two specialized identified resident home areas were left open at all times, to allow the residents the most room to move around, and acknowledged that staff working on one of the identified resident home areas would frequently interact with residents from the other identified resident home area. RCC #108 further indicated that there was not currently a plan in place which allowed staff from

one identified resident home area to have access to the plans of care for residents from the other identified resident home area, nor was shift report conducted between the entire group of staff from both specialized identified resident home areas, therefore staff could be intervening, redirecting or assisting residents, without having knowledge of the resident's plan of care. RCC #108 indicated that this had been brought forward from the staff working on the specialized identified resident home areas, regarding possible safety risks to the residents and staff. RCC #108 provided direction to the staff that the doors could be closed during a specialized time to manage the situation, but the doors were only to be closed after all other interventions had been attempted.

During an interview, the ED indicated that the home was preparing to trial a program on another resident home area in the home, which was not one of the specialized identified resident home areas. The ED further indicated there was no specific date or plan in place to implement the program on either of the specialized identified resident home areas.

The licensee failed to ensure that all staff and others who provided direct care to the residents were kept aware of the contents of the plan of care, as staff were not provided access to the resident plans of care.

The severity of this issue was determined to be a level 3, as there was actual harm to residents #002 and #003 related to the staff who provided direct care to the residents not having direct access to, or being kept aware of the contents of each resident's plan of care. The scope of the issue was determined to be 2, as there was a pattern of staff not having access to resident's plans of care for the residents on identified resident home areas of the home. The home had a level 3 compliance history, as a VPC was issued during the following inspections, under LTCHA, 2007, s.6 - Resident Quality Inspection on July 9, 2015;
Complaint Inspection on September 30, 2015;
Resident Quality Inspection on April 18, 2016;
Critical Incident System Inspection on July 20, 2016;
Resident Quality Inspection on January 9, 2017.
A CO (#901) was then issued during a Critical Incident System Inspection on July 18, 2017, under LTCHA, 2007, s.6. (672). (672)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 17, 2018

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 23. (1) Every licensee of a long-term care home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:

(i) abuse of a resident by anyone,

(ii) neglect of a resident by the licensee or staff, or

(iii) anything else provided for in the regulations;

(b) appropriate action is taken in response to every such incident; and

(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Order / Ordre :

The licensee must be compliant with s. 23 (1) of the LTCHA.

Specifically, the licensee shall ensure the following:

(1) Develop and implement a plan to ensure that every alleged, suspected or witnessed incident of abuse that occurs in the home and of which the licensee is aware, is immediately investigated, specifically during weekends, holidays, and when the manager responsible for initiating/conducting the investigation is not available within the home.

2) Develop and implement a plan which outlines corrective actions taken and by whom, if staff fail to implement the interventions as identified.

3) Educate all staff members who will be involved in the investigation process within the home, of the plans developed.

4) Keep a documented record of all plans developed and implemented, and education of the staff. Evidence of the implementation should be reflected within the investigations completed by the licensee.

The plan is to be submitted to the CESAO within 10 business days, to the email address of CentralEastSAO.MOH@ontario.ca, attention Inspector #672, Jennifer Batten.

Grounds / Motifs :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knew of, was immediately investigated.

Related to Log# 009235-18:

Two Critical Incident Reports were submitted to the Director on a specified date, related to an incident of resident to resident physical abuse. According to the CIRs, resident #001, #002, and #003 were in an identified area of one of the resident home areas, when residents #001 and #002 became involved in an incident which resulted in an injury to resident #002. Following the incident, resident #003 approached resident #001, and a second incident occurred, which resulted in an injury to resident #003.

Inspector #672 arrived at the home on a specified date, and requested a copy of the home's internal investigation notes. The DOC informed Inspector #672 that the notes were not available, as the investigation had been initiated by RCC #108, but RCC #108 was not present in the home, due to illness, and the DOC did not have access to the investigation notes.

During review of the CIRs, Inspector #672 observed that RN #104, RPN #105, and PSWs #106 and #107 had been directly involved in the incident.

During separate interviews, PSWs #106 and #107 indicated that the Manager of Nursing Practice approached them in the late afternoon of a specified date, did not ask any questions regarding the incident, but provided paperwork for them to complete, regarding their written statement of facts regarding the incident.

During separate interviews, RN #104 and RPN #105 indicated that no one from the management team had requested a formal statement regarding the incident, and no statement, verbal or written had been provided by the staff members. RN #104 further indicated that RCC #108 had been called following the incident, and was informed of what had occurred. RCC #108 responded by sending an email, to provide direction to RN #104 for the tasks which needed to be completed, such as informing the Director immediately.

During an interview, the Manager of Nursing Practice indicated providing paperwork to two of the PSWs involved in the incident during the late afternoon of a specified date, at the request of the DOC. The Manager of Nursing Practice further indicated not being involved in the internal investigation into the incident in any other way, and was not familiar with the specifics of the incident.

During an interview, the DOC indicated that the expectation in the home was that the RCC responsible for the resident home area where an incident occurred would be responsible for conducting an internal investigation. The DOC further indicated that in the event that the RCC for the resident home area was away from the home, another RCC would fill in, and conduct the internal investigation. The DOC indicated this had not occurred for the incident between residents #001, #002 and #003, as the DOC had expected RCC #108 to return to the home the following day, after calling in sick but that had not occurred, and the

DOC had not requested assistance from any of the other RCCs in the home to conduct the internal investigation, other than requesting the Manager of Nursing Practice to hand out incident reports to be completed by PSWs #106 and #107, following Inspector #672 arriving at the home. The DOC was unsure why the internal investigation had not been immediately initiated, following the incident.

During a telephone interview, RCC #108 indicated being present in the home on a specified date following the incident, and did not return to the home until six days later, due to illness. RCC #108 further indicated that the internal investigation had not been initiated on a specified date, and was unsure if an internal investigation had been conducted into the incident at all, as no follow up with other team members had been completed.

The licensee failed to ensure that the incident which occurred between residents #001, #002, and #003 was immediately investigated, despite being aware of the incident.

The severity of this issue was determined to be a level 3, as there was actual harm to residents #002 and #003. The scope of the issue was determined to be a level 1, as it was the one incident of alleged resident to resident abuse which was not immediately investigated by the home. The home had a level 3 compliance history, as a WN was issued under LTCHA, 2007, s. 23 (1) during a Resident Quality Inspection on July 9, 2015.
A second WN was issued under LTCHA, 2007, s. 23 (1) during a Critical Incident System Inspection on July 18, 2017.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 17, 2018

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee must be compliant with r. 53 (4) of the LTCHA.

Specifically, the licensee shall ensure the following:

(1) Review the plans of care residents #002 and #003, to ensure that (a) the behavioural triggers for the resident are identified, (b) strategies are developed and implemented to respond to these behaviours; and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

(2) The written plans of care must be reviewed with all direct care staff who provide care to residents #002 and #003.

(3) Keep a documented record of the care plan review and communications with staff.

Grounds / Motifs :

1. The licensee has failed to ensure that behavioural triggers were identified for residents #002 and #003, when responsive behaviours were demonstrated.

Related to Log# 009235-18:

Two Critical Incident Reports were submitted to the Director on a specified date, related to an incident of resident to resident physical abuse. According to the CIRs, resident #001, #002, and #003 were in an identified area of one of the resident home areas, when residents #001 and #002 became involved in an incident which resulted in an injury to resident #002. Following the incident, resident #003 approached resident #001, and a second incident occurred, which resulted in an injury to resident #003.

During separate interviews, PSWs #106, #112, and #115, RPN #117, and RNs #104 and #113 indicated that resident #002 had responsive behaviours, which included exhibited responsive behaviours towards staff and co-residents. RNs #104 and #113 and PSWs #112 and #115 further indicated possible triggers for resident #002's responsive behaviours, which would possibly lead to resident #002 exhibiting identified responsive behaviours towards others. PSW #106 and RPN #117 were unsure of possible triggers to resident #002's responsive behaviours.

Inspector #672 reviewed the CIRs submitted to the Director regarding the incident. One of the CIRs indicated that resident #002 was questioned following the incident, and resident #002 indicated that the incident occurred as a result of their belief that resident #001 was exhibiting specified responsive behaviours.

Inspector #672 reviewed the written plan of care for resident #002 which was in place at the time of the incident. The written plan of care indicated that resident #002 had a history of identified exhibited responsive behaviours towards others. The written plan of care identified that resident #002's responsive behaviours may be triggered by two possible causes. It did not identify that resident #002 exhibited other identified exhibited responsive behaviours towards others, which led to identified incidents in the past.

During record review, Inspector #672 reviewed resident #001's written plan of care in place prior to the incident. The written plan of care indicated that resident #001 had a history of identified exhibited responsive behaviours towards others. There were no goals or interventions listed for this care plan focus, for staff to implement.

Inspector #672 reviewed the progress notes for resident #003 for a specified two month time period. The progress notes indicated that nine incidents occurred during that period of time.

During separate interviews, PSWs #106 and #115, RPN #117, and RNs #104 and #113 indicated that resident #003 had identified exhibited responsive behaviours towards others. PSW #115 and RN #113 further indicated possible triggers for resident #003's exhibited responsive behaviours. PSW #106, RPN #117, and RN #104 were unsure of triggers to resident #003's responsive behaviours.

Inspector #672 reviewed resident #003's written plan of care in place at the time of the incident. The written plan of care indicated that resident #003 had a history of identified exhibited responsive behaviours. There were no triggers listed within the written plan of care for staff to be aware of, or intervene if possible, other than directing staff to "try to determine what triggered/led up to behaviour and remove the trigger". An identified section of resident #003's written plan of care did not identify that resident #003 could exhibited an identified responsive behaviour, or had a history of identified exhibited responsive behaviours.

During an interview, the DOC indicated that the expectation in the home was that the written plans of care for all residents demonstrating responsive behaviours should list the triggers to the responsive behaviours, if they are known.

The licensee failed to ensure that the written plans of care for residents #002 and #003 identified the triggers to the demonstrated responsive behaviours.

The severity of this issue was determined to be a level 3, as there was actual harm to residents #002 and #003. The scope of the issue was determined to be a level 1, as it was two residents who were looked into in the home, who were missing the triggers to demonstrated responsive behaviours in the written plans of care. The home had a level 4 compliance history, as a CO was issued under LTCHA, 2007, r. 53 during a Resident Quality Inspection on July 9, 2015, which was complied on January 29, 2016. (672)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 17, 2018

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # /
Ordre no : 004

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

Specifically, the licensee shall ensure the following:

1) Develop and implement a communication and reporting protocol between RNs, RPNs, and PSWs, so that information regarding residents exhibiting new and/or potentially harmful responsive behaviours, experiencing poor effect with interventions currently listed within the plan of care, or a significant change in condition, is clear, accurate and acted upon immediately, including updating the written plan of care

2) Ensure steps are taken to minimize the risk of altercations and potentially harmful
interactions between residents demonstrating physically abusive responsive behaviours by implementing identified interventions. Ensure this information is documented in the resident's plan of care.

3) Develop and implement a communication and reporting protocol between RNs, RPNs,
and PSWs between each of the identified resident home areas, to ensure that all staff members are familiar with each resident exhibiting new and/or potentially harmful responsive behaviours, are familiar with interventions currently documented within the resident's plan of care, and are aware of any resident experiencing a significant change in condition, if residents are able to move freely from one of the identified resident home areas to the other.

4) Develop and implement a plan which outlines corrective actions taken and by whom, if staff fail to implement the interventions as identified.

5) Educate all front line staff on the plan(s) developed and implemented.

6) Keep a documented record of all plans developed and implemented, and education provided to the staff.

The plan is to be submitted to the CESAO within 10 business days, to the email address of CentralEastSAO.MOH@ontario.ca, attention Inspector #672, Jennifer Batten.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #002 and resident #003 was protected from abuse by resident #001.

Related to Log# 009235-18:

Two Critical Incident Reports were submitted to the Director on a specified date, related to an incident of resident to resident physical abuse. According to the CIRs, resident #001, #002, and #003 were in an identified area of one of the resident home areas, when residents #001 and #002 became involved in an incident which resulted in an injury to resident #002. Following the incident, resident #003 approached resident #001, and a second incident occurred, which resulted in an injury to resident #003.

During observations made by Inspector #672, it was noted that the home had identified specialized resident home areas. The specialized resident home areas were attached to each other through a communal resident area, where the doors were kept open at all times, which allowed the residents from one specialized resident home area to move around onto the other specialized resident home area freely.

Inspector #672 reviewed the "Incidents" section in the electronic documentation system for resident #001 for a specified time period, which revealed that resident #001 had been involved in an identified number of incidents of exhibited responsive behaviours towards others.

During record review, Inspector #672 reviewed resident #001's written plan of care in place prior to the incident. The written plan of care indicated that resident #001 had a history of identified exhibited responsive behaviours. There were no goals or interventions listed for this care plan focus, for staff to implement.

Inspector #672 then reviewed resident #002's written plan of care in place prior to the incident. The written plan of care indicated that resident #002 had a history of identified exhibited responsive behaviours towards others, which was often triggered by an identified cause. Interventions were listed for staff to implement, related to resident #002's responsive behaviours.

Inspector #672 reviewed resident #003's written plan of care in place prior to the incident. The written plan of care indicated that resident #003 had a history of identified exhibited responsive behaviours towards others. Interventions were listed for staff to implement, related to resident #003's responsive behaviours.

During separate interviews, PSWs #106, #107, #110 and #114 indicated that the doors between the identified specialized resident home areas were left open at all times, but staff on one specialized resident home area would not get report or be aware of resident's histories, responsive behaviours, or interventions from the other specialized resident home area, even though residents from that specialized resident home area were frequently on the other specialized resident home area, and being assisted by the staff. The PSWs further indicated that staff from one specialized resident home area would not have access to care plans for residents who resided on the other specialized resident home area. PSWs #106, #107, #110 indicated not being aware of any responsive behaviours or interventions for residents #002 or #003 and PSW #114 indicated not being familiar with resident #001, even though all of the residents frequented the opposite resident home area.

During a telephone interview, RPN #117 indicated being the charge nurse and responsible for the resident home area that resident #001 resided on, during the incident. RPN #117 further indicated not being aware that resident #001 had a history of responsive behaviours.

During an interview, RPN #105 indicated being the charge nurse and responsible for the resident home area that resident #002 and #003 resided on, during the incident. RPN #105 further indicated being unaware that either resident #002 or resident #003 had any responsive behaviours, and was unaware of any interventions in place for either resident.

During an interview, RN #104 indicated a belief that the incident occurred due to an environmental factor in the identified area, as a result of the doors between the identified specialized resident home areas being left open at all times. RN #104 further indicated that leaving the doors opened between the specialized resident home areas allowed for a number of residents to interact with each other, with staff providing redirection, without having information pertaining to all

resident's plan of care. RN #104 indicated those concerns had been brought forward previously to RCC #108, but direction had been given to leave the doors open between the specialized resident home areas, to allow the residents more room to move between the areas. RN #104 further indicated no plan was in place to ensure that staff working on one specialized resident home area would have access to plans of care for the residents from the other specialized resident home area, or for conducting a shift report as a group from both specialized resident home areas, so that staff from one specialized resident home area would be knowledgeable of behaviours, incidents, or concerns with residents from the other specialized resident home area.

During a telephone interview, RCC #108 indicated that the doors between the identified specialized resident home areas were left open at all times, to allow the residents the most room to move about freely. RCC #108 acknowledged that by leaving the doors opened between the identified specialized resident home areas, staff working on one of the specialized resident home areas would frequently interact with residents from the other specialized resident home area. RCC #108 indicated that there was not a plan in place which allowed staff from one specialized resident home area to have access to the plans of care for residents from the other specialized resident home area, nor was shift report conducted between both groups of staff. RCC #108 further indicated that staff could be intervening, redirecting, or assisting residents, without having knowledge of the resident's plan of care. RCC #108 indicated that concerns had been brought forward previously from the staff working on the identified specialized resident home areas, regarding possible safety risks to the residents and staff, by leaving the doors opened between the home areas. RCC #108 indicated direction had been provided to the staff that the doors could be closed during a specified time, but the doors were only to be closed after all other interventions had been attempted. RCC #108 further indicated that the home was preparing to implement a new pilot program, which would allow staff and others to identify residents at risk of exhibiting identified responsive behaviours. RCC #108 indicated that the pilot program was initially being trialed on other resident home areas in the home, and did not have a date of when the program may be trialed on resident #001, #002 and #003's resident home area. RCC #108 did indicate being aware of the legislative requirements which state that all residents in the home must be protected from abuse and neglect by anyone, at all times.

The licensee failed to ensure that residents #002 and #003 were protected from abuse by resident #001.

The severity of this issue was determined to be a level 3, as there was actual harm to residents #002 and #003. The scope of the issue was determined to be a level 1, as it was two residents in the home the licensee failed to protect from one incident of alleged resident to resident abuse. The home had a level 4 compliance history, as a CO was issued under s. 19 (1) during a Resident Quality Inspection on July 9, 2015, which was complied on January 29, 2016. Another CO was issued under s. 19 (1) during a Critical Incident System Inspection on July 18, 2017, which was complied on June 26, 2018. (672)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 17, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 24th day of October, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Batten

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