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
Jan 10, 2019	2018_743536_0006 (A3) v1	022916-17, 024451-17, 026705-17, 007545-18, 008062-18, 009368-18	Complaint

Licensee/Titulaire de permis

Idlewyld Manor
449 Sanatorium Road HAMILTON ON L9C 2A7

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

Idlewyld Manor
449 Sanatorium Road HAMILTON ON L9C 2A7

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

Amended by CATHIE ROBITAILLE (536) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

It was identified that additional Personal Health Information had to be removed. It was also identified that the grounds were duplicated in CO #003 s. 76 so duplication removed.

Issued on this 16th day of January, 2019 (A3)

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

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Ministère de la Santé et des Soins de longue durée

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

Amended by CATHIE ROBITAILLE (536) - (A3)

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): May 1, 2, 3, 4, 8, 9, 10, 11, 14, 15 and May 16, 2018.

A Critical Incident System Report (CIS) Inspection was conducted concurrently during this Complaint. Non-compliance has been issued in relation to: Inspection: 2018_561583_0008 / 009396-18.

The following intakes were completed during this complaint inspection:

Inquiry

Log #009890-18, CIS #2631-000012-18-related to: prevention of abuse and neglect

Complaints

Log #007545-18-related to: prevention of abuse and neglect

Log #009368-18-related to: prevention of abuse and neglect

Log #022916-17-related to: prevention of abuse and neglect, continence care

Log #024451-17-related to: prevention of abuse and neglect, nutrition and hydration and change in condition

Log #026705-17-related to: prevention of abuse and neglect and change in condition

Critical Incidents (CIS's)

Log #008062-18, CIS #2631-000008-18-related to: prevention of abuse and neglect

During the course of the inspection, the inspector(s) spoke with residents, family members, reception staff, business office staff, Registered Nurses (RN's), Registered Practical Nurses(RPN's), Personal Support Workers (PSW's), the Behavioural Support Ontario staff (BSO), Resident Assessment Instrument (RAI) Coordinator, Manager of Program Development(MPD), Director of Nursing (DON) and the Administrator.

During the course of the inspection, the inspector(s) toured the home, observed residents, reviewed the home's investigation notes, employee files, training records, complaint logs, staffing schedules, clinical documentation, medical records and policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

During the course of the original inspection, Non-Compliances were issued.
11 WN(s)
6 VPC(s)
5 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 :

(A2)
The licensee has failed to protect residents from abuse by anyone and that residents are not neglected by the licensee or staff.

For the purpose of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A) On an identified date and time, a Critical Incident System (CIS) Report log #2931-000011-18 was submitted to the Ministry of Health and Long Term Care (MOHLTC) following a call to the After Hours Pager, reporting an incident of alleged resident to resident abuse between resident #011 and #012. In a progress note, it was documented by Registered Practical Nurse (RPN) #134 that resident #012 was seen hurrying away from resident #011, at which time the RPN went directly to resident #011 to check on the resident. When RPN #134 spoke to the resident #011, they could not recall what happened. An interview was completed with RPN #134 in 2018. It was identified that when the RPN went to resident #011, and observed and interviewed the resident there was a suspicion that abuse potentially could have occurred. RPN #134 shared that they completed an assessment of resident #011, and that staff were notified to provide increased monitoring of resident #011 and #012.

In an interview with RPN #134 in May 2018, they shared they reported the incident to the oncoming shift but, did not report the incident to the Registered Nurse (RN). On an identified date, resident #011 and #012's responsive behaviours as well as the incident that occurred, were discussed at risk management rounds and the Director of Nursing (DON) was present.

A review of the homes documented investigation notes identified that the investigation into the incident began three days later. In an interview with the DON in 2018, it was confirmed the investigation began after review of resident #011

and #012 clinical records of the documented incident.

In an interview with RPN #134 and #135 who worked on the resident's unit on the identified date, it was shared that staff provided increased monitoring of resident #011 and #012 after the incident, and that the need for increased monitoring had been communicated by word of mouth. In an interview with the DON and Manager of Program Development (MPD), it was identified that no changes were made to the resident's plans of care to direct staff. Dementia Observation System (DOS) charting, and one to one staffing for the resident were not initiated until an identified date.

On a specified date, resident #011 and #012's responsive behaviours were discussed at risk management rounds. It was documented in the meeting notes that resident #012 provoked the situation. A referral was faxed to the Specialty Clinics/Outreach/BSO program for resident #012 to be assessed, which identified the reason for the referral as being a risk to others.

During interviews completed with RPN #135 in May 2018, and with RPN #134 in May 2018, it was identified that resident #011's Substitute Decision Maker (SDM) phoned the home. At this time RPN #135 notified the SDM of the incident that had occurred. RPN #134 revealed they did not notify the SDM at the time of the suspected incident, and confirmed there was no documentation that the SDM was notified.

In interviews completed with registered staff and Personal Support Workers (PSWs) during the course of the inspection, it was shared that staff were separating resident #011 and #012 whose responsive behaviours put resident #011 at risk. Resident #011 and #012's progress notes were reviewed for an identified period of time. A number of incidents were documented that identified situation of potential risk related to behaviours.

On an identified date, it was documented in resident #012's plan of care by RPN #134 that resident #012 was seen approaching resident #011 and the PSW went directly to resident #011 to check on them. In an interview with the DON, in May 2018, it was shared the home did not complete an investigation into the incident that occurred.

A responsive behaviour focused care plan was created for resident #012, which identified interventions that staff were to follow to minimize the risk of potentially

harmful actions. It was confirmed that between two identified dates, no interventions were documented as being developed or implemented in resident #012's plan of care to minimize the risk of their responsive behaviours.

A responsive behaviours focused care plan was created for resident #011 on a specified date. The following interventions were put in place for staff to follow:

-constant supervision between resident #011 and #012
- distract resident #011 if possible
-document a summary of each episode. DOS charting

An interview was completed with the RPN/Documentation Coordinator #130, in May 2018. It was revealed that there was no constant supervision or one to one staff monitoring in place for resident #011 or #012, between two identified dates. The "patient observation records" were reviewed and it was identified DOS charting was completed for a period of seven days on identified dates, for resident #011 and #012 then discontinued. DOS charting was not completed again. It was confirmed by RPN/Documentation Coordinator #130, the intervention was not implemented.

In an interview with Behavioural Supports Ontario (BSO) staff #123, in May 2018, it was shared that they were not following resident #011 as the resident had not been referred. It was shared they received a referral for resident #012 after the incident. It was confirmed BSO was not asked to develop interventions to reduce the risk of potentially harmful interactions between resident #011 and #012.

An annual care conference was held for resident #011 on a specified date. The "resident care conference-interdisciplinary review" for resident #011 was reviewed with RPN #130. The form was incomplete and only identified the medical review from the physician. In an interview with RPN #130 it was shared that a care conference took place. It was also revealed that behaviours were not discussed and confirmed that outcomes and actions were not documented.

In an interview with the Resident Assessment Instrument (RAI) Coordinator in May 2018. Resident #011's and #012's last quarterly assessments, were reviewed. Section E, mood and behaviour patterns were reviewed, and neither resident was coded as having the specified behaviours. The behavioural symptoms Resident Assessment Protocol (RAP) was reviewed, and the RAI Coordinator confirmed that neither resident's specific responsive behaviours were

identified nor were interventions to manage the behaviours.

On an identified date in 2018, resident #011's and #012's electronic and paper records were reviewed with the DON and MPD for identified dates. The definition of neglect O. Reg 79/10 s. 5 was read to the DON and the MPD. The DON confirmed that the information reviewed demonstrated a pattern of inaction that jeopardized the well-being of resident #011. The licensee failed to protect the resident in spite of a history and potential risk related to specified behaviours. (583)

PLEASE NOTE: The above noted non-compliance was found during Inspection #2018_561583_0008 related to Critical Incident Inspection (CIS) log #009396-18.

B) i) A complaint was submitted to the MOHLTC ACTIONline on an identified date of an allegation of potential staff to resident abuse towards resident #010.

During the inspection, resident #010 was not able to be interviewed. An interview was completed with the Substitute Decision Makers who shared on an identified date resident #010 identified an incident occurred and shared an allegation of staff to resident abuse.

In a progress note documented on the day of the incident, RPN #110 identified resident #010 shared an incident of alleged staff to resident abuse and provided resident #010's SDM information on how to contact management staff in relation to the concerns.

In a progress note the following day, RN #112, received a call from resident #010's SDM at which time they again shared concerns related to the alleged incident of staff to resident abuse and it was documented that they listened to all of the SDM's concerns, and reassured them they would be investigated and addressed.

Two additional progress notes followed where the resident identified ongoing concerns related to the incident that occurred.

An interview was completed with RN #112. It was confirmed that they spoke to resident #010's SDM on the day following the incident and that they were told about an allegation of possible staff to resident abuse. RN #112 confirmed that there was no documentation that they spoke to the resident, or assessed the

resident after the complaint was received. RN #112 confirmed that there was no documentation that the alleged incident was reported to management, and they could not recall if this incident was reported. In interviews with the Administrator and the DON, it was confirmed that the home did not have any documentation of an investigation related to the alleged incident of abuse that occurred and that it was not reported to the Director. (583)

B) ii) A complaint was submitted to the MOHLTC ACTIONline on an identified date of an allegation of potential staff to resident neglect/abuse towards resident #010.

During the inspection, resident #010 was not able to be interviewed. An interview was completed with the SMD who shared they spoke to resident #010 on an identified date and time, at which time the resident shared concerns about the condition they were in. The resident shared that PSW #017 had recently provided care but, they were in a condition where they still required care. Resident #010 also shared an allegation of staff to resident abuse.

In an interview by the Inspector with SDM #002, it was shared that they spoke to RN #106 at the time of the alleged incident and shared the residents care concerns and asked the staff to follow up.

In a progress documented a few hours later by RPN #108, it was documented they received a message on the unit phone from resident #010's SDM sharing the SDM's and resident's concerns and identified that no staff had followed up with the resident for several hours. It was documented the RPN went to the resident's room and the resident was found in a condition where they required care. This information was confirmed in interviews with RN #106 and RPN #108.

At the time of this incident, RN #106 was the most responsible person in charge in the home. RN #106 confirmed that they did not report the incident to the DON or Administrator.

In interviews with the Administrator and the DON, it was confirmed that the home did not have any documentation of an investigation related to the alleged incident of abuse/neglect that was alleged on an identified date, and that it had not been reported to the Director.

A pattern of inaction occurred in which two incidents i) alleged staff to resident

abuse and ii) alleged staff to resident neglect were not investigated or reported to the Director, when allegations were brought forward by resident #010 and their SDM to registered staff members. The home neglected to look into resident #010's care concerns that jeopardized the health, safety or well-being of resident #010. (583)

B) iii) Resident #010's electronic and paper records were reviewed for a three month time period.

A review of the documentation identified resident #010 shared ongoing concerns over this time period, related to not receiving required care. Five incidents were documented in the progress notes that identified that concerns were observed by staff, or brought forward by the resident or SDM that resident #010 was not receiving the care they required.

During interviews conducted with Registered staff and PSW's, it was shared resident #010 had identified behaviours and the clinical record identified there was a change in the residents medical condition. In an interview with the management it was shared that the home never tried to identify strategies or interventions to help ensure resident #010's care needs could be met.

In an interview with PSW #138, they shared resident #010 specified care needs were regularly not met. RN #106 and #112 shared the frequency of the residents responsive behaviours increased during this time period and management put in place an intervention that increased the length of time it took for the resident to receive required care. The management confirmed this strategy was in place. Inspector #583 asked when this strategy was put in place but, the home was unable to provide documentation.

Resident #010's plan of care focus related to the identified behaviour, was not revised during the three month period reviewed. The quarterly review assessment of resident #010 completed during this time period, identified the resident continued to demonstrate the identified behaviour, but no triggers or strategies were documented on how to respond. Behavioural Supports Ontario (BSO) was not referred.

It was demonstrated through review of the homes investigation notes, interviews with the SDM's and staff and through a review of resident #010's plan of care, that resident #010 was not protected from neglect.

There was a pattern of inaction as the home did not develop strategies to respond to resident #010's behaviours and required care needs which contributed to the resident not receiving required care and being kept comfortable. (583)

2. The licensee has failed to protect residents from abuse by anyone and that residents are not neglected by the licensee or staff.

For the purpose of the Act and this Regulation, "Physical Abuse" means the use of physical force by a resident that causes physical injury to a resident.

A) On an identified date, a complaint was received at the MOHLTC with concerns that the home had not taken appropriate action in regards to alleged resident abuse. On an identified date and time, Personal Support Worker (PSW) #116 found resident #001 on the floor. Resident #001 was unable to tell staff what had happened. An Incident note in resident #001's progress notes by Registered Practical Nurse (RPN) #113 documented an assessment and description of visible injury. Resident #001 later developed other areas of injuries. A review of resident #001's clinical record and interviews completed by the Inspector, revealed that the resident was unable to get out of bed unassisted. As well, at the time of the inspection resident #001 was unable to communicate with the Inspector.

During interview with the Inspector, PSW #116 stated that resident #001 was unable to get out of bed on their own. During interview, PSW #116 confirmed with the Inspector that resident #001 was missing their bed sheet when they returned resident #001 to their bed. When PSW #116 was asked if they had seen any resident with a white top sheet, they stated that resident #002 had been seen with a bed sheet. The inspector asked PSW #116 if they did rounds on every resident before completing their shift and they stated yes. The Inspector then asked, when they did rounds did they find any other resident on the home area missing a bed sheet, and PSW #116 stated no.

Investigation notes provided by the home contained minutes from a meeting that the DON had met with one of resident #001's SDM's to discuss the incident. The SDM indicated that they suspected that resident #002 had done this. The home failed to ensure that resident #001 was protected from abuse by anyone. (536)

Please note: this non-compliance was issued as a result of complaint log #007545

-18 and CIS log # 008062-18.

B) On an identified date and time, it was documented in the progress incident notes that resident #002 brought specified articles and wrapped it around an identified part of co-resident #003 body. It then stated resident #002 probably thought they had to get dressed. It was also documented that resident #002 was physically aggressive when redirected. The resident was unable to be interviewed by the Inspector.

On an identified date and time, the progress notes of resident #002 stated: Resident #002 walked up to another resident #003. Staff went to check on resident #003 to make sure they were okay. The home failed to ensure that resident #003 was protected from abuse by anyone. (536)

C) On an identified date, one of the SDM's for resident #004 put in a written complaint to the home which was forwarded that same day to the MOHLTC. In the written complaint they voiced their concern that this was resident to resident abuse caused by resident #002. On a specified date and time, PSW #116 found resident #004 in an identified position in bed. Resident #004 was unable to tell staff what had happened. A review of resident #004's clinical record and interviews completed by the Inspector revealed, that the resident was unable to reposition themselves in bed.

During interview with the Inspector, PSW #116 and #124 both stated that resident #004 previously been found in this position, that there were aware of. Interview with PSW #116 revealed, that they had seen the resident approximately 6 to 10 minutes earlier. (536)

Please note: this non-compliance was issued as a result of complaint log #009368 -18.

D) On an identified date and time, the progress notes by RPN #113 for resident #002 stated: stated there had been an incident between resident #002 and #005 that put resident #002 at risk. Staff attended, gave redirection to resident #002 attended to resident #005. Resident #005 was unable to communicate with the Inspector.

The home failed to ensure that resident #005 was protected from abuse by anyone. (536)

E) On and identified date and time, the progress notes for resident #002 stated: Staff having to sit near resident's room to monitor resident's whereabouts as they were seen putting resident #003 resident #004 at specified risk. Redirection given to resident #002. Resident became upset with redirects then cooperates. Resident #003 and resident #004 were unable to communicate with the Inspector.

During interview with the Inspector, PSW #126 was asked how they came about this incident happening. The PSW stated that resident #002 was roaming around, and we couldn't see them so we checked on everyone. Staff #126 then stated they walked around and saw resident #003 and #004 and rectified what had occurred.

The home failed to ensure that residents' #003 and #004 were protected from abuse or neglect by anyone.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended: CO# 001

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 :

(A2)
The licensee has failed to ensure that (a) every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that was reported to the licensee, was immediately investigated (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff and (b) appropriate action is taken in response to every such incident.

The home's policy titled: "Resident Abuse", policy number: EP-09-01-01, stated: "Idlewyld Manor will take immediate action in response to any alleged, suspected or witnessed incident of abuse within the Manor. All allegations of abuse will be investigated thoroughly, documented and reported. Supervisor/Manager/Charge Nurse Actions include, but are not limited to: Taking corrective action when abuse has occurred, or where there exists a strong suspicion, but no conclusive proof, that abuse has occurred. Intervening and following up on the incident, in accordance with Ministry policies and applicable laws; ongoing monitoring of any situation where abuse is suspected."

A) On an identified date, it was suspected that resident #011 may have been abused by resident #012. An interview was completed with RPN #134 on a specified date, and it was confirmed that it was suspected that an incident of abuse may have occurred at this time.

The incident occurred on a specified date and time, a review of the home's

documented investigation notes identified their investigation began three days later. A monitoring intervention was put in place to monitor resident #011 a number of days later. Documentation to monitor the residents using the homes "patient observation record" was not initiated until a specified number of days later for resident #012, and resident #011. Prior to these dates a monitoring process had not been put in place.

In May 2018, resident #011 and #012's clinical records were reviewed with the DON and Manager of Programs Development (MPD). It was identified that there were known responsive behaviours prior to this incident and there had been previous incidents between the two residents that put resident #011 at risk. After review of the clinical records, the home's investigation note and interviews conducted with the staff it was identified the home did not take immediate action to investigate the incident of suspected abuse or appropriate action taken in response to every such incident involving resident #011. (583)

PLEASE NOTE: This evidence of non-compliance related to the above noted non-compliance was found during Inspection #2018_561583_0008 related to Critical Incident Inspection (CIS) log #009396-18. (583)

B) On an identified date and time, PSW #116 found resident #004's in an identified position in bed. Resident #004 was unable to tell staff what had happened. A review of resident #004's clinical record and interviews completed by the Inspector, revealed that the resident was unable to reposition themselves in bed.

The DON when interviewed in May 2018, confirmed that a formal investigation had not been completed. After review of the clinical records, the home's investigation note and interviews conducted with the staff, it was identified the home did not take immediate action to investigate the incident of suspected resident abuse or take appropriate action taken in response to every such incident involving resident #004. (536)

Please note: this non compliance was issued as a result of complaint log #009368 -18.

C) On another specified date and time, PSW #116 found resident #001 on the floor. Resident #001 was unable to tell staff what had happened. An Incident note in resident #001's progress notes by Registered Practical Nurse (RPN) #113

documented an assessment and description of visible injury. Resident #001 later developed other areas of injury. A review of resident #001's clinical record and interviews completed by the Inspector, revealed that the resident was unable to get out of bed unassisted.

In May 2018, the DON confirmed that staff interviews and a formal investigation were not started until fourteen days after the alleged incident. After review of the clinical records, the home's investigation note and interviews conducted with the staff, it was identified the home did not take immediate action to investigate the incident of suspected resident abuse or take appropriate action in response to every such incident involving resident #001. (536)

Please note: this non compliance was issued as a result of complaint log #007545 -18 and CIS log # 008062-18.

D) A complaint was submitted to the MOHLTC ACTIONline on an identified date documenting an allegation of potential staff to resident neglect/abuse towards resident #010.

During the inspection, resident #010 was not able to be interviewed. An interview was completed with the SMD who shared they spoke to resident #010 on an identified date and time, at which time the resident shared concerns about the condition they were in. The resident shared that PSW #017 had recently provided care but, they were in a condition where they still required care. Resident #010 also shared an allegation of staff to resident abuse.

In an interview by the Inspector with SDM #002, it was shared that they spoke to RN #106 at the time of the alleged incident and shared the residents care concerns and asked the staff to follow up. In a progress note documented a few hours later by RPN #108, it was documented they received a message on the unit phone from resident #010's SDM sharing the SDM's and resident's concerns and identified that no staff had followed up with the resident for several hours. It was documented the RPN went to the resident's room and the resident was found in a condition where they required care.

At the time of this incident, RN #106 was the most responsible person in charge in the home. RN #106 confirmed that they did not report the incident to the DON or Administrator.

During interviews with the Administrator and DON, it was confirmed that the home did not have any documentation of an investigation related to the alleged incident of abuse/neglect that occurred on the identified date. (583)

Please note: this non-compliance was issued as a result of complaint log #022916 -17, #024451-17 and 026705-17.

E) A complaint was submitted to the MOHLTC ACTIONline on an identified date of an allegation of potential staff to resident abuse towards resident #010.

During the inspection, resident #010 was not able to be interviewed. An interview was completed with the Substitute Decision Makers who identified on an identified date resident #010 identified an incident occurred and shared an allegation of alleged staff to resident abuse.

In a progress note documented on the day of the incident, RPN #110 identified resident #010 shared an incident of alleged staff to resident abuse and provided resident #020's SDM information on how to contact management staff in relation to the concerns.

In a progress note the following day, RN #112, received a call from resident #010's SDM at which time they again shared concerns related to the alleged incident of staff to resident abuse and it was documented that they listened to all of the SDM's concerns, and reassured them they would be investigated and addressed. Two additional progress notes followed where the resident identified ongoing concerns related to the incident that occurred.

An interview was completed with RN #112. It was confirmed that they spoke to resident #010's SDM on the day following the incident, and that an allegation of abuse was reported. During the interview, RN #112 confirmed that there was no documentation that they spoke to the resident or assessed the resident after the complaint was received. RN #112 confirmed that there was no documentation that the alleged incident was reported to management, and they could not recall if this incident was reported. During interviews with the Administrator and Director of Nursing (DON), it was confirmed that the home did not have any documentation of an investigation related to the alleged incident of abuse that occurred on the identified date. (583)

Please note: this non-compliance was issued as a result of complaint log #022916

-17, #024451-17 and 026705-17.

The licensee has failed to ensure that every alleged or suspected incident of abuse of resident #011, #010, #004 and #001 by anyone that the licensee knows of, or that was reported to the licensee, was immediately investigated (i)abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff and (b) appropriate action is taken in response to every such incident. [s. 23. (1)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended: CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Findings/Faits saillants :

(A3)
The licensee has failed to ensure that all staff at the home received training as required by the Act or the Regulations specifically s. 76 (4), and s. 76 (7) 1 and 3.

A) The licensee failed to ensure that all staff in the home received training under s. 76, subsection (2) 4, the duty under section 24 to make mandatory reports received retraining at times and intervals provided for in the regulations. In accordance with O. Reg. 79/10, s. 219. (1), the licensee was required to retrain all staff in the home annually for the purpose of 76(4) of the Act.

During the course of the inspection it was identified in accordance to O. Reg. LTCHA, s. 24 (1) where persons who had reasonable grounds to suspect the

following:

1. Improper or incompetent treatment or care of a resident that resulted in risk of harm to the resident or
2. Abuse of a resident by anyone or neglect of a resident by staff that resulted in risk of harm to the resident

The suspicion and information upon which it was based on was not reported to the Director.

In May 2018, training records of the education session which included training on the duty under section 24 to report were requested from the Administrator and Director of Nursing(DON) for all staff who completed training in 2017. A spreadsheet was provided and the documentation showed that 274 out of 305 (90 percent) of all staff were trained on "CO7 - resident abuse". During the inspection it was identified that the total of 305 staff in 2017 may not have been accurate so the home gathered more detailed information from their "My Trainer" records.

"My Trainer" records were provided and it was documented that 250 out of 257 (97 percent) all staff were trained on "CO7 - resident abuse".

In an interview with the Administrator and Director of Nursing (DON) it was confirmed that all staff in the home did not complete annual retraining related to the duty under section 24 to make mandatory reports. (583)

B) The licensee failed to ensure that all staff who provide direct care to residents, as a condition of continuing to have contact with residents, receive training in 1. Abuse recognition and prevention and 3. Behaviour management, at intervals provided for in the regulations. In accordance with O. Reg. 79/10, s. 221. (2) 1., the licensee was required to retrain all direct care staff in the home annually.

In May 2018, training records were requested from the Administrator and DOC. A spreadsheet was provided and the documentation showed that 235 out of 255 (92 percent) direct care staff were trained on "CO7 – resident abuse" and 241 out of 258 (93 percent) direct care staff were trained on "CO5 – managing behaviours". In addition to these numbers 2 out of 16 (12 percent) of Administration staff were not trained. In interviews with the home they were not able to determine which of these staff if any, provided direct care. During the inspection it was identified the total number of direct care staff varied for each identified area of required training

and may not have been accurate so the home gathered more detailed information from their "My Trainer" records.

"My Trainer" records were provided and it was documented that 190 out of 194 (98 percent) direct care staff were trained on "CO7 – resident abuse" and "CO5 – managing behaviours".

In an interview with the Administrator and DON it was confirmed that all direct care staff in the home did not complete annual retraining on abuse recognition and prevention or behaviour management.

When the "My Trainer" records were reviewed it was identified that there were no administration staff included in the totals. The home was unable to provide these records. In an interview with the DON in May 2018, it was shared that the "nursing" section included any administration staff that were Registered Nurses (RN's) or Registered Practical Nurses (RPN).

A review of the "My Trainer" nursing records showed that 180 out of 184 (98 percent) nurses had been trained and a list of the four nurses not trained were identified. During interviews in May 2018, two of four nurses were unable to confirm that they had received the training and could not provide documentation to the Inspector that it had been completed.

In May 2018, the Administrator shared that the designated lead for training in the home left the role. At the time of the inspection it was shared the home was in the process of changing the system in which education was provided to staff. At the time of the inspection, there was not a training process in place for any staff who had not complete their annual retaining requirements and no annual re-training had been completed for 2018. During the course of the inspection the total number of all staff and direct care who completed training in 2017 could not be confirmed. (583) [s. 76.]

Additional Required Actions:

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

(A3)
The following order(s) have been amended: CO# 003

WN #4: 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 :

(A2)
The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents including, (b) identifying and implementing interventions.

A) A Critical Incident System (CIS) Report log #2931-000011-18 was submitted following a call to the After Hours Pager reporting an incident of alleged resident to resident abuse between resident #011 and #012. The RPN went directly to resident #011 to check on the resident. When RPN #134 spoke to the resident #011, they could not recall what happened. An interview was completed with RPN #134 in May 2018. It was identified that when the RPN went to resident #011 and observed and interviewed the resident, there was a suspicion that abuse potentially could have occurred. RPN #134 shared that they completed an assessment of resident #011, and that staff were notified to provide increased monitoring of resident #011 and #012.

A Registered Nurse completed a Referral Form for resident #012 which identified the reason for the referral as being a risk to others.

In interviews completed with Registered staff and Personal Support Workers (PSWs) during the course of the inspection, it was shared that staff were separating resident #011 and #012 when they were found together prior to this incident, as there was a history and potential for responsive behaviours which put resident #011 at risk. Resident #011 and #012's progress notes were reviewed and the following incidents were identified:

During review of resident #011 and #012's clinical records it was identified in seven different progress notes that resident #011 was observed trying to have contact with resident #012.

In May 2018, resident #011's and #012's electronic and paper records were reviewed with the Director of Nursing (DON) and Manager of Programs Development(MPD). A responsive behaviours focused care plan was created for resident #012, which identified interventions that staff were to follow to minimize the risk of potentially harmful actions. It was confirmed that between two specified dates, no interventions were documented as being developed or implemented in resident #012's plan of care to minimize risk related to their responsive behaviours.

A responsive behaviours focused care plan was created for resident #011, and was not revised until an identified date.

An interview was completed with the RPN/Documentation Coordinator #130, in May 2018. It was identified that there were not interventions in place between two identified dates. The "patient observation records" were reviewed and it was identified that DOS charting was completed for a seven day period, for resident #011 and #012 then discontinued. DOS charting was not completed again.

In an interview with Behavioural Supports Ontario (BSO) staff #123, in May 2018, it was shared that they were not following resident #011 as they had not been referred. It was shared they received a referral for resident #012 after the incident. It was confirmed BSO was not asked to develop interventions to reduce the risk of potentially harmful interactions between resident #011 and #012.

An annual care conference was held for resident #011. The "resident care conference – interdisciplinary review" documentation was viewed with RPN #130. It was shared that responsive behaviours were not discussed, RPN #130 confirmed that the SDM was not in attendance.

In an interview with the Resident Assessment Instrument (RAI) Coordinator in May 2018. Resident #011's and #012's last quarterly assessments, were reviewed. Section E, mood and behaviour patterns were reviewed, and neither resident was coded as having the specified behaviours. The behavioural symptoms Resident Assessment Protocol (RAP) was reviewed, and the RAI Coordinator confirmed that neither resident's specific responsive behaviours were identified nor were interventions to manage the behaviours.

The requirements of O.Reg. 79/10, s. 54(b) were read to the Director of Nursing (DON) and Manager of Programs Development(MPD). The DON confirmed that steps were not taken to identify and implement interventions, to minimize the risk of potentially harmful interactions between resident #011 and #012. (583)

PLEASE NOTE: The above noted non-compliance was found during Inspection #2018_561583_0008 related to Critical Incident Inspection (CIS) log #009396-18.

B) Resident #002 was admitted to the home on an identified date. The resident at that time had Behavioural Support Ontario(BSO) transition services in place to assist with the resident's admission into the home. The BSO services continued following the resident's admission due to resident #002's behaviours.

A review of resident #002's progress notes was completed for the four months following the residents admission. A total of 15 different behaviours were documented in resident #002's progress notes as observed behaviours. The progress notes identified a total of 120 different incidents occurred in a four month period.

On a specified date, the BSO support staff identified strategies to help redirect resident #002 when needed. As specified it included seven different strategies.

BSO then implemented another strategy. The inspector interviewed direct care staff #114, #117, #127, #142, #143 and #144, and only fifty percent of staff were aware of this newest intervention. Four of six staff interviewed, were not aware of the various BSO interventions that had been put into place.

During review of resident #002's care plan the Inspector identified that the BSO strategies to help redirect resident #002 were not included in their care plan. In May 2018, the DON and the MPD both confirmed that the care plan for resident #002, did not include any of the BSO strategies that had been implemented from the specified dates. The home has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents including, implementing interventions. (536)

Please note: this non-compliance was issued as a result of complaint log #007545 -18 and CIS log # 008062-18. [s. 54. (b)]

Additional Required Actions:

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

(A3)
The following order(s) have been amended: CO# 004

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

(A2)
The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long term care home to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse

of a resident that the licensee suspects may constitute a criminal offense.

The home's policy titled: "Resident Abuse", policy number: EP-09-01-01, last revised: December 12, 2016, stated: "Police Notification – The appropriate police force will be immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that may constitute a criminal offense."

A) On an identified date, it was suspected that resident #011 may have been abused by resident #012. An interview was completed with RPN #134 in May 2018, and it was confirmed abuse was suspected at that time.

In interviews completed with registered staff and PSW's during the course of the inspection, it was shared that staff were separating resident #011 and #012 when they were found together, as there was a history of potential responsive behaviours which put resident #011 at risk.

The homes investigation records were reviewed with the DON in May 2018. After review of the clinical records, the home's investigation notes and interviews conducted with the staff identified the home did not immediately notify the police of the suspected incident of abuse that may have constituted a criminal offense. The incident occurred, and it was documented in the homes investigation notes that the police were notified three days later. (583)

PLEASE NOTE: This evidence of non-compliance related to the above noted non-compliance was found during Inspection #2018_561583_0008 related to Critical Incident Inspection (CIS) log #009396-18.

B) A complaint was received at the MOHLTC, with concerns that the home had not taken appropriate action in regards to alleged resident abuse. On an identified date, PSW #116 found resident #001 on the floor. Resident #001 was unable to tell staff what had happened.

An Incident note in resident #001's progress notes by Registered Practical Nurse (RPN) #113 documented an assessment and description of visible injury. Resident #001 later developed other areas of injury. A review of resident #001's clinical record and interviews completed by the Inspector, revealed that the resident was unable to get out of bed unassisted.

In May 2018, the DON provided the Inspector with the amended Critical Incident

System (CIS) Report which stated that 28 days after the incident they had spoken to the police. In June 2018, the Inspector spoke with the Senior Support Police Officer for the home who confirmed that they had called the home to follow up after the home had not contacted the police. The licensee failed to ensure that the appropriate police force was immediately notified of an alleged incident involving resident #001. (536)

Please note: this non compliance was issued as a result of complaint log #007545 -18 and CIS log # 008062-18.

C) A written complaint was received at the Ministry of Health and Long Term Care (MOHLTC). In the written complaint stated this was resident to resident abuse involving resident #002. On a specified date and time, PSW #116 found resident #004 in an identified position in bed. Resident #004 was unable to tell staff what had happened. Interview with PSW #116 revealed, that they had seen the resident earlier, and there were no concerns with resident #004. A review of resident #004's clinical record and interviews completed by the Inspector revealed, that the resident was unable to reposition themselves in bed.

In May 2018, during interview the DON confirmed that the police had not been contacted in regards to the allegation of abuse. The licensee failed to ensure that the appropriate police force was immediately notified of an alleged incident involving resident #004, that the licensee suspects may constitute a potential criminal offense. (536)

Please note: this non compliance was issued as a result of complaint log #009368 -18. [s. 98.]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended: CO# 005

WN #6: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of the resident.

Resident #002 was admitted to the home on an identified date. The resident at that time had Behavioural Support Ontario(BSO) transition services in place, to assist with the resident's admission into the home. The BSO services continued following resident's admission due to resident #002's behaviour's.

A review of resident #002's progress notes was completed for the four months following the residents admission. An identified number of different behaviours were documented in resident #002's progress notes as observed behaviours. The progress notes identified a total of specified different incidents occurred in a four month period.

On a specified date, the BSO support staff identified strategies to help redirect resident #002 when needed. As specified it included seven different strategies.

BSO then implemented another strategy. The inspector interviewed direct care staff #114, #117, #127, #142, #143 and #144, and only fifty percent of staff were aware of this newest intervention. Four of six staff interviewed, were not aware of the various BSO interventions that had been put into place. During review of resident #002's care plan, the Inspector identified that the BSO strategies to help redirect resident #002 were not included in their care plan.

In May 2018, BSO support staff #123 when interviewed stated they speak with the registered staff on duty about the interventions, and then it is their responsibility to share that information with other staff. The BSO support staff also stated they then send an email to the Manager of Program Development (MPD) on updates. A paper copy of the BSO interventions is also provided to the resident's registered staff following the visit. During interview with the RAI Coordinator in May 2018, they identified that registered staff are to inform them of BSO involvement being in place and then they will enter the BSO's focus into the resident's plan of care. In May 2018, the DON and the MPD both confirmed that the care plan for resident #002, did not include any of the BSO strategies that had been implemented from the specified dates. The home has failed to ensure that the care set out in the plan of care is based on an assessment of resident #002's needs and preferences of the resident. (536)

Please note: this non-compliance was issued as a result of complaint log #007545 -18 and CIS log # 008062-18. [s. 6. (2)]

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 and ensuring that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of the resident, to be implemented voluntarily.

WN #7: 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 :

(A2)
The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident.

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to a resident.

The licensee's policy titled: "Zero Tolerance of Abuse & Neglect", policy number: AM-02-01-08, stated:

Section three: Action to Be Taken by Staff Role and Responsibilities

Employee(s) or Board Members who are reporting that they have witnessed or suspect alleged incident of resident abuse or neglect

-Report any witnessed, suspected, or alleged abuse to a supervisor/manager, Administrator immediately.

Individual (Supervisor/Manager/Registered Nurse) receiving the report of alleged abuse or neglect

-Notify the Director of Nursing (DON) or designate immediately upon receipt of the report of alleged, witnessed or unwitnessed abuse or neglect, and initiate the investigation.

A) A Critical Incident System (CIS) Report log #2931-000011-18 was submitted following a call to the After Hours Pager reporting an incident of alleged resident to resident abuse between resident #011 and #012 that had occurred.

Interview was completed with Registered Practical Nurse (RPN) #134 in May 2018, who was the registered nursing staff working at the time of the incident. They shared that just after the incident occurred they completed an assessment of resident #011 and directed staff to provide increased monitoring at that time as a potential abuse may have occurred. They shared they reported the incident to the RPN and staff of the oncoming shift but, did not report the incident to the Registered Nurse (RN). On a specified date, resident #011 and #012's responsive behaviours were discussed at risk management rounds. During the risk management rounds, RPN #130 shared the incident that occurred with those present, including the Director of Nursing (DON).

In an interview with the Director of Nursing (DON) in May 2018, it was shared they first became aware of the incident was at the risk management meeting. The DON shared they looked into the incident in more detail, which included reviewing the resident #011 and #012 clinical records and speaking with resident #012. At this time the DON identified a CIS needed to be submitted for suspected abuse.

It was confirmed the incident of suspected abuse occurred, the DON became aware of the alleged abuse, and it was not reported to the Director until three days after the incident. (583)

PLEASE NOTE: This evidence of non-compliance related to the above noted non-compliance was found during Inspection #2018_561583_0008 related to Critical Incident Inspection (CIS) log #009396-18.

B) On an identified date, one of the SDM's for resident #004 put submitted a complaint that alleged resident to resident abuse caused by another resident. On

a specified date and time, PSW #116 found resident #004 in an identified position in bed. Resident #004 was unable to tell staff what had happened. A review of resident #004's clinical record and interviews completed by the Inspector revealed, that the resident was unable to reposition themselves in bed.

When interviewed in May 2018, the DON and Administrator confirmed that they had become aware of the allegation when they received the written complaint. The DON confirmed that they had not immediately filed a CIS in regards to an allegation of abuse as it was not witnessed. Forty-four days after the incident of alleged abuse occurred, a CIS was submitted to the MOHLTC. The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of resident #004 by anyone that resulted in harm or risk of harm, immediately reported the suspicion to the Director. (536)

Please note: this non-compliance was issued as a result of complaint log #009368 -18.

C) A review of resident #001's progress notes stated that on an identified date and time, Personal Support Worker (PSW) #116 found resident #001 on the floor. Resident #001 was unable to tell staff what had happened. An Incident note in resident #001's progress notes by Registered Practical Nurse (RPN) #113 documented an assessment and description of visible injury. Resident #001 later developed other areas of injuries. A review of resident #001's clinical record and interviews completed by the Inspector, revealed that the resident was unable to get out of bed unassisted. As well, at the time of the inspection resident #001 was unable to communicate with the Inspector.

The investigation notes provided by the home contained minutes from a meeting when the DON had met with one of the SDM's to discuss the incident. The SDM indicated that they suspected abuse by resident #002. The SDM also asked the DON whether this had been reported to the MOHLTC and requested for this to be done.

When interviewed, the DON confirmed that they filed the CIS fifteen days after the alleged incident because the family wanted it. The DON then stated that they had not filed a CIS at the time of the incident as they were still trying to confirm that resident #002 was involved as it was not witnessed. The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of resident #001 by anyone that resulted in harm or risk of harm, immediately reported the

suspicion to the Director. (536)

Please note: this non-compliance was issued as a result of complaint log #007545 -18 and CIS log # 008062-18.

D) A review was completed of a complaint submitted to the MOHLTC ACTIONline on an identified date. It was identified another incident occurred of potential staff to resident neglect/abuse towards resident #010.

During the inspection, resident #010 was not able to be interviewed. An interview was completed with the SMD #002 in May 2018. The SDM shared they spoke to resident #010 on an identified date and time, at which time the resident was upset about care that had been provided by PSW #107..

In an interview by the Inspector with SDM #002, it was shared that they spoke to RN #106 and conveyed the resident's concerns. The SDM shared they tried to reach a staff at the unit phone but, were unable to reach anyone.

In a progress note by RPN #108, it was documented they received a message on the unit phone from SDM #002, that the resident was upset as their care needs were not being provided.

In a progress note by RN #106, it was documented that they spoke to SMD #002 at an identified time. In an interview with RN #106 in May 2018, they confirmed that the SDM shared concerns that the resident alleged they received rough care from PSW #107, and requested that another staff member provide care. Concerns were shared related to the resident's current condition at the time of the call, and it was requested the RN follow up. RN #106 confirmed that they did not enter the resident's room, or speak to the resident when it had been asked of them.

In interviews with the Administrator and the DON it was confirmed that the home had not reported any allegations of abuse or neglect to the Director in relation to resident #010. Persons who had reasonable grounds to suspect that abuse or neglect of resident #010 by staff may have occurred on two different dates, failed to report the suspicion and the information upon which it was based to the Director. (583)

E) A complaint had been submitted to the MOHLTC ACTIONline. It was identified

an incident occurred, of potential staff to resident abuse towards resident #010.

At the time of the inspection, resident #010 was not able to be interviewed. An interview was completed with the Substitute Decision Maker (SDM) #001 in May 2018. The SDM shared they spoke to resident #010 on an identified date and time. Resident #010 shared with the SDM, that RPN #109 provided care without explaining first to the resident what they were going to do.

In a progress note on a specified date, RPN #110 documented that the resident said they were upset from what RPN #109 did during care. RPN #110 provided information on how to contact management, per the SDM's request.

In a progress note dated on an identified date, RN #112, received a call from one of resident #010's SDM's identifying the concerns. It was documented that the SDM shared that the resident remained upset. It was documented that RN #112 listened to all of the SDM's concerns, and reassured them they would be investigated and addressed.

In another progress note, RN #112, received a call from one of resident #010's SDM's requesting the resident be assessed.

An interview was completed with RN #112 in May 2018. It was confirmed that they again spoke to one of resident #010's SDMs, and that it was reported resident #010 was treated roughly by RPN #109. RN #112 confirmed that there was no documentation that they spoke to the resident, or assessed the resident after the complaint was received. RN #112 confirmed that there was no documentation that the alleged incident was reported to management, and they could not recall if this incident was reported. In interviews with the Administrator and the DON, it was confirmed that the home did not have any documentation of an investigation related to the alleged incident of abuse that occurred, and that it was not reported to the Director. (583)

Please note: this non-compliance was issued as a result of complaint log #022916 -17, #024451-17, and #026705-17. [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 and ensuring that a person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to a resident immediately reports the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

(A2)
The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments interventions and the resident's response to the interventions are documented.

A) On an identified date and time, the progress notes by RPN #113 for resident #002 stated: Resident #002 found resident #005 laying in their bed. Staff in the hall attending to another resident, observed resident #002 putting resident #005 at risk. Resident #005 had no footwear; resident #005 upset distracted and disoriented. Staff attended, gave redirection to resident #002 attended to resident #005. Resident #005 required staff assistance for care, and were unable to communicate with staff or the Inspector.

A review was completed of resident #005's progress notes with both the Director of DON and the MPD in May 2018 and both confirmed that the incident that occurred with resident #002, was not documented in resident #005's progress notes. The home failed to ensure that resident #005's SDM was notified of the

incident that occurred, and were not given the opportunity to participate fully in the development and implementation of the resident's plan of care.

B) On and identified date and time, the progress notes for resident #002 stated: Staff having to sit near resident's room to monitor resident's whereabouts as they were seen entering co-residents rooms and putting residents #003 and #004 at risk. Redirection given to resident #002. Resident became upset with redirects then cooperates.Resident #003 and resident #004 required staff assistance for care, and were unable to communicate with staff or the Inspector.

As per the schedules provided by the home and confirmed with the DON, one on one supervision by staff was put into place for resident #002 on an identified date.

During interview with the Inspector, the Inspector asked PSW #126 how they came to know about this incident happening. The PSW stated that resident #002 was roaming around so we checked on everyone.

A review was completed of resident #003 and resident #004's progress notes with both the DON and the MPD in May 2018 and both confirmed that the incident that occurred involving resident #002, was not documented in either resident #003 or resident #004's progress notes. The home failed to ensure that resident #003's SDM was notified following this incident, and were not given the opportunity to participate fully in the development and implementation of the resident's plan of care.

The home failed to ensure that any actions taken with respect to resident #003, #004 and #005 including assessments, reassessments interventions and the resident's response to the interventions were documented. [s. 30. (2)]

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 and ensuring that any actions taken with respect to a resident under a program, including assessments, reassessments interventions and the resident's response to the interventions are documented, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

(A3)
The licensee has failed to ensure that residents who required continence care products had sufficient changes to remain clean, dry and comfortable.

Resident #010's electronic and paper records were reviewed over a three month period.

A review of the documentation identified that resident #010 shared ongoing concerns over this time period, related to not receiving enough continence product changes to remain clean, dry and comfortable.

Review of the clinical record identified the following:

i) A progress note documented by Registered Practical Nurse (RPN) #109 on a specified date identified a Personal Support Worker (PSW) told the registered staff that resident #010 was not changed over a specified time period at which time they provided care.

ii) A progress note documented by Registered Nurse (RN) #112 on a specified date, identified they received a complaint that the residents brief had not been changed for a specified time period.

iii) A progress note documented by RPN #109 on two identified dates, identified that resident #010 did not receive continence care during an identified shift.

iv) On an identified date, it was documented that RPN #108 received a complaint that resident #010 was not clean dry and comfortable for an extended period of time. It was confirmed in an interview with RPN #108 and RN #106 that the resident was in this condition for a specified time period despite the staff being made aware of the concerns.

Direct care staff confirmed that resident #010 was not clean and dry, approximately two times per week.

An interview was completed with the Manager of Programs and Development (MPD) and it was confirmed that at the time of the identified issues, resident #010 did not receive sufficient changes to remain clean, dry and comfortable. (583)

Please note: this non-compliance was issued as a result of complaint log #022916 -17, #024451-17 and 026705-17. (583)

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 and ensuring that residents who require continence care products have sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.

WN #10: 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 :

The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, the behavioural triggers for the resident were identified where possible; strategies were developed and implemented to respond to the behaviours where possible; and that action taken to respond to the resident was taken including reassessments and interventions and responses to the interventions were documented.

Resident #010's electronic and paper records were reviewed over a three month period. The resident's care requirements and preferences were reviewed related to a specified area.

During interviews conducted with Registered Nursing staff and Personal Support Workers (PSW's) it was revealed that resident #010 had identified responsive behaviours. It was shared by the Registered Nursing staff and the PSW's when interviewed that this contributed to the resident not being kept clean, dry and comfortable.

Over the time period reviewed, no documented strategies were developed or implemented to respond to the residents identified behaviours. Only one new strategy was documented as being developed or implemented over a two year period.

The two quarterly review assessment of resident #010's mood and behaviour patterns were reviewed over the identified time period. Both assessments identified the resident continued to demonstrate the identified responsive

behaviours. No triggers of the identified responsive behaviours, or strategies to respond to the behaviours were documented.

In an interview with the Resident Assessment Instrument (RAI) Coordinator it was confirmed that during the 3 month period reviewed, strategies were not developed and implemented, and interventions were not initiated to respond to resident #010 responsive behaviours.

In an interview with Behavioral Supports Ontario (BSO) staff #123 it was shared that resident #010 had not been followed or assessed by BSO from admission to the time period reviewed, as they had not been referred.

During interviews conducted with Registered Nursing staff and PSW's it was identified the resident had specific triggers for the identified responsive behaviours. In an interview with the RAI coordinator it was confirmed specific behavioural triggers were not identified in the resident's plan of care.

In an interview with the Manager of Programs Development (MPD) and Registered Nurse (RN) #112, it was identified that there was an increase in the resident's behaviours. It was identified that not all episodes of resistance of care, the staff's interventions and the resident's responses to the interventions were documented. In an interview with the MPD, it was confirmed that resident #010 demonstrated a responsive behaviours and that action was not taken to respond to the needs of the resident. (583)

Please note: this non-compliance was issued as a result of complaint log #022916 -17, #024451-17 and 026705-17. [s. 53. (4)] (583)

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 and ensuring that each resident demonstrating responsive behaviours, the behavioural triggers for the resident were identified where possible; strategies were developed and implemented to respond to the behaviours where possible; and that action taken to respond to the resident was taken including reassessments and interventions and responses to the interventions were documented, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

(A3)
The licensee has failed to ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified.

A) On an identified date, a complaint was received at the MOHLTC with concerns that the home had not taken appropriate action in regards to alleged resident abuse. On an identified date and time, Personal Support Worker (PSW) #116 found resident #001 on the floor. Resident #001 was unable to tell staff what had happened.

An Incident note in resident #001's progress notes by Registered Practical Nurse (RPN) #113 documented an assessment and description of visible injury. Resident #001 later developed other areas of injuries. A review of resident #001's

clinical record and interviews completed by the Inspector, revealed that the resident was unable to get out of bed unassisted. As well, at the time of the inspection resident #001 was unable to communicate with the Inspector.

During interview with the SDM they voiced their concern that they had not been informed of the additional injury until a week later.

In May 2018, during interview with the Inspector, PSW #145 confirmed they had completed a specified assessment during resident #001's bath on an identified date, and did not note any additional injury on resident #001.

In May 2018, the Inspector spoke with PSW #124 and they confirmed that when they bathed resident #001 on another identified date, that during their bath they had noticed the additional area of injury on resident #001. When asked by the Inspector if they reported it they stated they were sure they had reported it however, they were unable to confirm to whom they had actually reported it. They then stated that they would have put it in Point Of Care (POC). Point of Care did identify an injury, not a location.

The licensee has failed to ensure that resident #001's substitute decision-maker were promptly notified of serious injury, in accordance with any instructions provided by the person or persons who are to be so notified.

Please note: this non compliance was issued as a result of complaint log #007545 -18 and CIS log # 008062-18. [s. 107. (5)]

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 and ensuring that the resident's SDM, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, to be implemented voluntarily.

Issued on this 16th day of January, 2019 (A3)

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 CATHIE ROBITAILLE (536) - (A3)
Inspection No. / No de l'inspection :	2018_743536_0006 (A3) v1
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	022916-17, 024451-17, 026705-17, 007545-18, 008062-18, 009368-18 (A3)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 10, 2019(A3)
Licensee / Titulaire de permis :	Idlewyld Manor 449 Sanatorium Road, HAMILTON, ON, L9C-2A7
LTC Home / Foyer de SLD :	Idlewyld Manor 449 Sanatorium Road, HAMILTON, ON, L9C-2A7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Janine Mills

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 Idlewyld Manor, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Order # / Ordre no : 001

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

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 the Long Term Care Homes Act (LTCHA) s.19(1).

Specifically the licensee must:

(a) Ensure all residents are protected from abuse by residents #002 and #012.

(b) Ensure that resident #011 and all residents are protected from abuse and neglect by the licensee or staff.

Grounds / Motifs :

(A2)
1. 1. The licensee has failed to protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

For the purpose of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A) On an identified date and time, a Critical Incident System (CIS) Report log #2931-000011-18 was submitted to the Ministry of Health and Long Term Care (MOHLTC) following a call to the After Hours Pager, reporting an incident of alleged resident to resident abuse between resident #011 and #012. In a progress note, it was

documented by Registered Practical Nurse (RPN) #134 that resident #012 was seen hurrying away from resident #011, at which time the RPN went directly to resident #011 to check on the resident. When RPN #134 spoke to the resident #011, they could not recall what happened. An interview was completed with RPN #134 in 2018. It was identified that when the RPN went to resident #011, and observed and interviewed the resident there was a suspicion that abuse potentially could have occurred. RPN #134 shared that they completed an assessment of resident #011, and that staff were notified to provide increased monitoring of resident #011 and #012.

In an interview with RPN #134 in May 2018, they shared they reported the incident to the oncoming shift but, did not report the incident to the Registered Nurse (RN). On an identified date, resident #011 and #012's responsive behaviours as well as the incident that occurred, were discussed at risk management rounds and the Director of Nursing (DON) was present.

A review of the homes documented investigation notes identified that the investigation into the incident began three days later. In an interview with the DON in 2018, it was confirmed the investigation began after review of resident #011 and #012 clinical records of the documented incident.

In an interview with RPN #134 and #135 who worked on the resident's unit on the identified date, it was shared that staff provided increased monitoring of resident #011 and #012 after the incident, and that the need for increased monitoring had been communicated by word of mouth. In an interview with the DON and Manager of Program Development (MPD), it was identified that no changes were made to the resident's plans of care to direct staff. Dementia Observation System (DOS) charting, and one to one staffing for the resident were not initiated until an identified date.

On a specified date, resident #011 and #012's responsive behaviours were discussed at risk management rounds. It was documented in the meeting notes that resident #012 provoked the situation. A referral was faxed to the Specialty Clinics/Outreach/BSO program for resident #012 to be assessed, which identified the reason for the referral as being a risk to others.

During interviews completed with RPN #135 in May 2018, and with RPN #134 in May 2018, it was identified that resident #011's Substitute Decision Maker (SDM) phoned

the home. At this time RPN #135 notified the SDM of the incident that had occurred. RPN #134 revealed they did not notify the SDM at the time of the suspected incident, and confirmed there was no documentation that the SDM was notified.

In interviews completed with registered staff and Personal Support Workers (PSWs) during the course of the inspection, it was shared that staff were separating resident #011 and #012 whose responsive behaviours put resident #011 at risk. Resident #011 and #012's progress notes were reviewed for an identified period of time. A number of incidents were documented that identified situation of potential risk related to behaviours.

On an identified date, it was documented in resident #012's plan of care by RPN #134 that resident #012 was seen approaching resident #011 and the PSW went directly to resident #011 to check on them. In an interview with the DON, in May 2018, it was shared the home did not complete an investigation into the incident that occurred.

A responsive behaviour focused care plan was created for resident #012, which identified interventions that staff were to follow to minimize the risk of potentially harmful actions. It was confirmed that between two identified dates, no interventions were documented as being developed or implemented in resident #012's plan of care to minimize the risk of their responsive behaviours.

A responsive behaviours focused care plan was created for resident #011 on a specified date. The following interventions were put in place for staff to follow:

-constant supervision between resident #011 and #012
- distract resident #011 if possible
-document a summary of each episode. DOS charting

An interview was completed with the RPN/Documentation Coordinator #130, in May 2018. It was revealed that there was no constant supervision or one to one staff monitoring in place for resident #011 or #012, between two identified dates. The "patient observation records" were reviewed and it was identified DOS charting was completed for a period of seven days on identified dates, for resident #011 and #012 then discontinued. DOS charting was not completed again. It was confirmed by RPN/Documentation Coordinator #130, the intervention was not implemented.

In an interview with Behavioural Supports Ontario (BSO) staff #123, in May 2018, it was shared that they were not following resident #011 as the resident had not been referred. It was shared they received a referral for resident #012 after the incident. It was confirmed BSO was not asked to develop interventions to reduce the risk of potentially harmful interactions between resident #011 and #012.

An annual care conference was held for resident #011 on a specified date. The "resident care conference-interdisciplinary review" for resident #011 was reviewed with RPN #130. The form was incomplete and only identified the medical review from the physician. In an interview with RPN #130 it was shared that a care conference took place. It was also revealed that behaviours were not discussed and confirmed that outcomes and actions were not documented.

In an interview with the Resident Assessment Instrument (RAI) Coordinator in May 2018. Resident #011's and #012's last quarterly assessments, were reviewed. Section E, mood and behaviour patterns were reviewed, and neither resident was coded as having the specified behaviours. The behavioural symptoms Resident Assessment Protocol (RAP) was reviewed, and the RAI Coordinator confirmed that neither resident's specific responsive behaviours were identified nor were interventions to manage the behaviours.

On an identified date in 2018, resident #011's and #012's electronic and paper records were reviewed with the DON and MPD for identified dates. The definition of neglect O. Reg 79/10 s. 5 was read to the DON and the MPD. The DON confirmed that the information reviewed demonstrated a pattern of inaction that jeopardized the well-being of resident #011. The licensee failed to protect the resident in spite of a history and potential risk related to specified behaviours. (583)

PLEASE NOTE: The above noted non-compliance was found during Inspection #2018_561583_0008 related to Critical Incident Inspection (CIS) log #009396-18.

B) i) A complaint was submitted to the MOHLTC ACTIONline on an identified date of an allegation of potential staff to resident abuse towards resident #010.

During the inspection, resident #010 was not able to be interviewed. An interview was completed with the Substitute Decision Makers who shared on an identified date

resident #010 identified an incident occurred and shared an allegation of staff to resident abuse.

In a progress note documented on the day of the incident, RPN #110 identified resident #010 shared an incident of alleged staff to resident abuse and provided resident #010's SDM information on how to contact management staff in relation to the concerns.

In a progress note the following day, RN #112, received a call from resident #010's SDM at which time they again shared concerns related to the alleged incident of staff to resident abuse and it was documented that they listened to all of the SDM's concerns, and reassured them they would be investigated and addressed.

Two additional progress notes followed where the resident identified ongoing concerns related to the incident that occurred.

An interview was completed with RN #112. It was confirmed that they spoke to resident #010's SDM on the day following the incident and that they were told about an allegation of possible staff to resident abuse. RN #112 confirmed that there was no documentation that they spoke to the resident, or assessed the resident after the complaint was received. RN #112 confirmed that there was no documentation that the alleged incident was reported to management, and they could not recall if this incident was reported. In interviews with the Administrator and the DON, it was confirmed that the home did not have any documentation of an investigation related to the alleged incident of abuse that occurred and that it was not reported to the Director. (583)

B) ii) A complaint was submitted to the MOHLTC ACTIONline on an identified date of an allegation of potential staff to resident neglect/abuse towards resident #010.

During the inspection, resident #010 was not able to be interviewed. An interview was completed with the SMD who shared they spoke to resident #010 on an identified date and time, at which time the resident shared concerns about the condition they were in. The resident shared that PSW #017 had recently provided care but, they were in a condition where they still required care. Resident #010 also shared an allegation of staff to resident abuse.

In an interview by the Inspector with SDM #002, it was shared that they spoke to RN #106 at the time of the alleged incident and shared the residents care concerns and asked the staff to follow up.

In a progress documented a few hours later by RPN #108, it was documented they received a message on the unit phone from resident #010's SDM sharing the SDM's and resident's concerns and identified that no staff had followed up with the resident for several hours. It was documented the RPN went to the resident's room and the resident was found in a condition where they required care. This information was confirmed in interviews with RN #106 and RPN #108.

At the time of this incident, RN #106 was the most responsible person in charge in the home. RN #106 confirmed that they did not report the incident to the DON or Administrator.

In interviews with the Administrator and the DON, it was confirmed that the home did not have any documentation of an investigation related to the alleged incident of abuse/neglect that was alleged on an identified date, and that it had not been reported to the Director.

A pattern of inaction occurred in which two incidents i) alleged staff to resident abuse and ii) alleged staff to resident neglect were not investigated or reported to the Director, when allegations were brought forward by resident #010 and their SDM to registered staff members. The home neglected to look into resident #010's care concerns that jeopardized the health, safety or well-being of resident #010. (583)

B) iii) Resident #010's electronic and paper records were reviewed for a three month time period.

A review of the documentation identified resident #010 shared ongoing concerns over this time period, related to not receiving required care. Five incidents were documented in the progress notes that identified that concerns were observed by staff, or brought forward by the resident or SDM that resident #010 was not receiving the care they required.

During interviews conducted with Registered staff and PSW's, it was shared resident #010 had identified behaviours and the clinical record identified there was a change

in the residents medical condition. In an interview with the management it was shared that the home never tried to identify strategies or interventions to help ensure resident #010's care needs could be met.

In an interview with PSW #138, they shared resident #010 specified care needs were regularly not met. RN #106 and #112 shared the frequency of the residents responsive behaviours increased during this time period and management put in place an intervention that increased the length of time it took for the resident to receive required care. The management confirmed this strategy was in place. Inspector #583 asked when this strategy was put in place but, the home was unable to provide documentation.

Resident #010's plan of care focus related to the identified behaviour, was not revised during the three month period reviewed. The quarterly review assessment of resident #010 completed during this time period, identified the resident continued to demonstrate the identified behaviour, but no triggers or strategies were documented on how to respond. Behavioural Supports Ontario (BSO) was not referred.

It was demonstrated through review of the homes investigation notes, interviews with the SDM's and staff and through a review of resident #010's plan of care, that resident #010 was not protected from neglect.

There was a pattern of inaction as the home did not develop strategies to respond to resident #010's behaviours and required care needs which contributed to the resident not receiving required care and being kept comfortable. (583)

2. The licensee has failed to protect residents from abuse by anyone and that residents are not neglected by the licensee or staff.

For the purpose of the Act and this Regulation, "Physical Abuse" means the use of physical force by a resident that causes physical injury to a resident.

A) On an identified date, a complaint was received at the MOHLTC with concerns that the home had not taken appropriate action in regards to alleged resident abuse. On an identified date and time, Personal Support Worker (PSW) #116 found resident #001 on the floor. Resident #001 was unable to tell staff what had happened. An Incident note in resident #001's progress notes by Registered Practical Nurse (RPN)

#113 documented an assessment and description of visible injury. Resident #001 later developed other areas of injuries. A review of resident #001's clinical record and interviews completed by the Inspector, revealed that the resident was unable to get out of bed unassisted. As well, at the time of the inspection resident #001 was unable to communicate with the Inspector.

During interview with the Inspector, PSW #116 stated that resident #001 was unable to get out of bed on their own. During interview, PSW #116 confirmed with the Inspector that resident #001 was missing their bed sheet when they returned resident #001 to their bed. When PSW #116 was asked if they had seen any resident with a white top sheet, they stated that resident #002 had been seen with a bed sheet. The inspector asked PSW #116 if they did rounds on every resident before completing their shift and they stated yes. The Inspector then asked, when they did rounds did they find any other resident on the home area missing a bed sheet, and PSW #116 stated no.

Investigation notes provided by the home contained minutes from a meeting that the DON had met with one of resident #001's SDM's to discuss the incident. The SDM indicated that they suspected that resident #002 had done this. The home failed to ensure that resident #001 was protected from abuse by anyone. (536)

Please note: this non-compliance was issued as a result of complaint log #007545-18 and CIS log # 008062-18.

B) On an identified date and time, it was documented in the progress incident notes that resident #002 brought specified articles and wrapped it around an identified part of co-resident #003 body. It then stated resident #002 probably thought they had to get dressed. It was also documented that resident #002 was physically aggressive when redirected. The resident was unable to be interviewed by the Inspector.

On an identified date and time, the progress notes of resident #002 stated: Resident #002 walked up to another resident #003. Staff went to check on resident #003 to make sure they were okay. The home failed to ensure that resident #003 was protected from abuse by anyone. (536)

C) On an identified date, one of the SDM's for resident #004 put in a written complaint to the home which was forwarded that same day to the MOHLTC. In the

written complaint they voiced their concern that this was resident to resident abuse caused by resident #002. On a specified date and time, PSW #116 found resident #004 in an identified position in bed. Resident #004 was unable to tell staff what had happened. A review of resident #004's clinical record and interviews completed by the Inspector revealed, that the resident was unable to reposition themselves in bed.

During interview with the Inspector, PSW #116 and #124 both stated that resident #004 previously been found in this position, that there were aware of. Interview with PSW #116 revealed, that they had seen the resident approximately 6 to 10 minutes earlier. (536)

Please note: this non-compliance was issued as a result of complaint log #009368-18.

D) On an identified date and time, the progress notes by RPN #113 for resident #002 stated: stated there had been an incident between resident #002 and #005 that put resident #002 at risk. Staff attended, gave redirection to resident #002 attended to resident #005. Resident #005 was unable to communicate with the Inspector.

The home failed to ensure that resident #005 was protected from abuse by anyone. (536)

E) On and identified date and time, the progress notes for resident #002 stated: Staff having to sit near resident's room to monitor resident's whereabouts as they were seen putting resident #003 resident #004 at specified risk. Redirection given to resident #002. Resident became upset with redirects then cooperates. Resident #003 and resident #004 were unable to communicate with the Inspector.

During interview with the Inspector, PSW #126 was asked how they came about this incident happening. The PSW stated that resident #002 was roaming around, and we couldn't see them so we checked on everyone. Staff #126 then stated they walked around and saw resident #003 and #004 and rectified what had occurred.

The home failed to ensure that residents' #003 and #004 were protected from abuse or neglect by anyone.

The severity of this issue was determined to be a level 3 as there was actual harm to

the resident(s). The scope of the issue was a level 3 as it related to six of six residents reviewed. The home had a level 3 history of ongoing non-compliance with this section of the Act that included:

-Voluntary plan of correction (VPC) issued February 8, 2016 (2015_240506_0030) (536)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2018

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

Order # / Ordre no : 002

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

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 the Long Care Homes Act(LTCHA) s. 23 (1).

Specifically the licensee must:

(a) Ensure charge staff and management staff receive training on recognition of abuse and neglect.

(b) Ensure that all alleged, suspected or witnessed incidents of abuse and neglect reported to the licensee are immediately investigated and appropriate action taken in response to every such incident.

(c) Ensure staff responsible for initiating the investigation have authority to take immediate action to protect residents.

(d) Ensure those investigating alleged abuse have received training on conducting an investigation.

Grounds / Motifs :

(A2)
1. The licensee has failed to ensure that (a)every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that was reported to the licensee, was immediately investigated (i)abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff and (b) appropriate action is taken in response to every such incident.

The home's policy titled: "Resident Abuse", policy number: EP-09-01-01, stated: "Idlewyld Manor will take immediate action in response to any alleged, suspected or witnessed incident of abuse within the Manor. All allegations of abuse will be investigated thoroughly, documented and reported. Supervisor/Manager/Charge Nurse Actions include, but are not limited to: Taking corrective action when abuse has occurred, or where there exists a strong suspicion, but no conclusive proof, that abuse has occurred. Intervening and following up on the incident, in accordance with Ministry policies and applicable laws; ongoing monitoring of any situation where abuse is suspected."

A) On an identified date, it was suspected that resident #011 may have been abused by resident #012. An interview was completed with RPN #134 on a specified date, and it was confirmed that it was suspected that an incident of abuse may have occurred at this time.

The incident occurred on a specified date and time, a review of the home's documented investigation notes identified their investigation began three days later. A monitoring intervention was put in place to monitor resident #011 a number of days later. Documentation to monitor the residents using the homes "patient observation record" was not initiated until a specified number of days later for resident #012, and resident #011. Prior to these dates a monitoring process had not been put in place.

In May 2018, resident #011 and #012's clinical records were reviewed with the DON and Manager of Programs Development (MPD). It was identified that there were known responsive behaviours prior to this incident and there had been previous incidents between the two residents that put resident #011 at risk. After review of the clinical records, the home's investigation note and interviews conducted with the staff it was identified the home did not take immediate action to investigate the incident of suspected abuse or appropriate action taken in response to every such incident involving resident #011. (583)

PLEASE NOTE: This evidence of non-compliance related to the above noted non-compliance was found during Inspection #2018_561583_0008 related to Critical Incident Inspection (CIS) log #009396-18. (583)

B) On an identified date and time, PSW #116 found resident #004's in an identified position in bed. Resident #004 was unable to tell staff what had happened. A review of resident #004's clinical record and interviews completed by the Inspector, revealed that the resident was unable to reposition themselves in bed.

The DON when interviewed in May 2018, confirmed that a formal investigation had not been completed. After review of the clinical records, the home's investigation note and interviews conducted with the staff, it was identified the home did not take immediate action to investigate the incident of suspected resident abuse or take appropriate action taken in response to every such incident involving resident #004. (536)

Please note: this non compliance was issued as a result of complaint log #009368-18 .

C) On another specified date and time, PSW #116 found resident #001 on the floor. Resident #001 was unable to tell staff what had happened. An Incident note in resident #001's progress notes by Registered Practical Nurse (RPN) #113 documented an assessment and description of visible injury. Resident #001 later developed other areas of injury. A review of resident #001's clinical record and interviews completed by the Inspector, revealed that the resident was unable to get out of bed unassisted.

In May 2018, the DON confirmed that staff interviews and a formal investigation were not started until fourteen days after the alleged incident. After review of the clinical records, the home's investigation note and interviews conducted with the staff, it was identified the home did not take immediate action to investigate the incident of suspected resident abuse or take appropriate action in response to every such incident involving resident #001. (536)

Please note: this non compliance was issued as a result of complaint log #007545-18 and CIS log # 008062-18.

D) A complaint was submitted to the MOHLTC ACTIONline on an identified date documenting an allegation of potential staff to resident neglect/abuse towards resident #010.

During the inspection, resident #010 was not able to be interviewed. An interview was completed with the SMD who shared they spoke to resident #010 on an identified date and time, at which time the resident shared concerns about the condition they were in. The resident shared that PSW #017 had recently provided care but, they were in a condition where they still required care. Resident #010 also shared an allegation of staff to resident abuse.

In an interview by the Inspector with SDM #002, it was shared that they spoke to RN #106 at the time of the alleged incident and shared the residents care concerns and asked the staff to follow up. In a progress note documented a few hours later by RPN #108, it was documented they received a message on the unit phone from resident #010's SDM sharing the SDM's and resident's concerns and identified that

no staff had followed up with the resident for several hours. It was documented the RPN went to the resident's room and the resident was found in a condition where they required care.

At the time of this incident, RN #106 was the most responsible person in charge in the home. RN #106 confirmed that they did not report the incident to the DON or Administrator.

During interviews with the Administrator and DON, it was confirmed that the home did not have any documentation of an investigation related to the alleged incident of abuse/neglect that occurred on the identified date. (583)

Please note: this non-compliance was issued as a result of complaint log #022916-17, #024451-17 and 026705-17.

E) A complaint was submitted to the MOHLTC ACTIONline on an identified date of an allegation of potential staff to resident abuse towards resident #010.

During the inspection, resident #010 was not able to be interviewed. An interview was completed with the Substitute Decision Makers who identified on an identified date resident #010 identified an incident occurred and shared an allegation of alleged staff to resident abuse.

In a progress note documented on the day of the incident, RPN #110 identified resident #010 shared an incident of alleged staff to resident abuse and provided resident #020's SDM information on how to contact management staff in relation to the concerns.

In a progress note the following day, RN #112, received a call from resident #010's SDM at which time they again shared concerns related to the alleged incident of staff to resident abuse and it was documented that they listened to all of the SDM's concerns, and reassured them they would be investigated and addressed. Two additional progress notes followed where the resident identified ongoing concerns related to the incident that occurred.

An interview was completed with RN #112. It was confirmed that they spoke to resident #010's SDM on the day following the incident, and that an allegation of

abuse was reported. During the interview, RN #112 confirmed that there was no documentation that they spoke to the resident or assessed the resident after the complaint was received. RN #112 confirmed that there was no documentation that the alleged incident was reported to management, and they could not recall if this incident was reported. During interviews with the Administrator and Director of Nursing (DON), it was confirmed that the home did not have any documentation of an investigation related to the alleged incident of abuse that occurred on the identified date. (583)

Please note: this non-compliance was issued as a result of complaint log #022916-17, #024451-17 and 026705-17.

The licensee has failed to ensure that every alleged or suspected incident of abuse of resident #011, #010, #004 and #001 by anyone that the licensee knows of, or that was reported to the licensee, was immediately investigated (i)abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff and (b) appropriate action is taken in response to every such incident. [s. 23. (1)]

The severity of this issue was determined to be a level (2) as there was minimal harm or potential for harm to the resident(s). The scope of the issue was a level (2) as it related to four out of six residents reviewed. The home had a level (2) history of previously unrelated non-compliance. (536)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 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 :

LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Order / Ordre :

The licensee must be compliant with the Long Term Care Homes Act (LTCHA) s. 76 (4) , s. 76 (7) 1.3.

Specifically the licensee must:

(a) Ensure that all staff in the home including agency staff if utilized have received training on the duty under section s.24 to make mandatory reports; annually. The licensee must ensure that all staff in the home who provide direct care to residents have received training on behaviour management and abuse recognition and prevention annually.

(b)All staff will be trained on mandatory reporting by October 26, 2018.

(c) All staff who provide direct care to residents will be trained on behaviour management and abuse recognition and prevention by October 26, 2018.

(d) A record will be kept of this training, including the person who is responsible for providing the training, staff who participated. The record will identify the total number of all staff in the home and a total number of all staff who provide direct care in the home.

(e) A record will be kept of the content of the training that was provided by the home.

Grounds / Motifs :

(A3)
Ground #1 has been removed.

(A3)
2. The licensee has failed to ensure that all staff at the home received training as required by the Act or the Regulations specifically s. 76 (4), and s. 76 (7) 1 and 3.

A) The licensee failed to ensure that all staff in the home received training under s. 76, subsection (2) 4, the duty under section 24 to make mandatory reports received retraining at times and intervals provided for in the regulations. In accordance with O. Reg. 79/10, s. 219. (1), the licensee was required to retrain all staff in the home annually for the purpose of 76(4) of the Act.

During the course of the inspection it was identified in accordance to O. Reg. LTCHA, s. 24 (1) where persons who had reasonable grounds to suspect the following:

1. Improper or incompetent treatment or care of a resident that resulted in risk of harm to the resident or
2. Abuse of a resident by anyone or neglect of a resident by staff that resulted in risk of harm to the resident

The suspicion and information upon which it was based on was not reported to the Director.

In May 2018, training records of the education session which included training on the duty under section 24 to report were requested from the Administrator and Director of Nursing(DON) for all staff who completed training in 2017. A spreadsheet was provided and the documentation showed that 274 out of 305 (90 percent) of all staff were trained on "CO7 - resident abuse". During the inspection it was identified that the total of 305 staff in 2017 may not have been accurate so the home gathered more detailed information from their "My Trainer" records.

"My Trainer" records were provided and it was documented that 250 out of 257 (97 percent) all staff were trained on "CO7 - resident abuse".

In an interview with the Administrator and Director of Nursing (DON) it was confirmed

that all staff in the home did not complete annual retraining related to the duty under section 24 to make mandatory reports. (583)

B) The licensee failed to ensure that all staff who provide direct care to residents, as a condition of continuing to have contact with residents, receive training in 1. Abuse recognition and prevention and 3. Behaviour management, at intervals provided for in the regulations. In accordance with O. Reg. 79/10, s. 221. (2) 1., the licensee was required to retrain all direct care staff in the home annually.

In May 2018, training records were requested from the Administrator and DOC. A spreadsheet was provided and the documentation showed that 235 out of 255 (92 percent) direct care staff were trained on "CO7 – resident abuse" and 241 out of 258 (93 percent) direct care staff were trained on "CO5 – managing behaviours". In addition to these numbers 2 out of 16 (12 percent) of Administration staff were not trained. In interviews with the home they were not able to determine which of these staff if any, provided direct care. During the inspection it was identified the total number of direct care staff varied for each identified area of required training and may not have been accurate so the home gathered more detailed information from their "My Trainer" records.

"My Trainer" records were provided and it was documented that 190 out of 194 (98 percent) direct care staff were trained on "CO7 – resident abuse" and "CO5 – managing behaviours".

In an interview with the Administrator and DON it was confirmed that all direct care staff in the home did not complete annual retraining on abuse recognition and prevention or behaviour management.

When the "My Trainer" records were reviewed it was identified that there were no administration staff included in the totals. The home was unable to provide these records. In an interview with the DON in May 2018, it was shared that the "nursing" section included any administration staff that were Registered Nurses (RN's) or Registered Practical Nurses (RPN).

A review of the "My Trainer" nursing records showed that 180 out of 184 (98 percent) nurses had been trained and a list of the four nurses not trained were identified. During interviews in May 2018, two of four nurses were unable to confirm that they

had received the training and could not provide documentation to the Inspector that it had been completed.

In May 2018, the Administrator shared that the designated lead for training in the home left the role. At the time of the inspection it was shared the home was in the process of changing the system in which education was provided to staff. At the time of the inspection, there was not a training process in place for any staff who had not complete their annual retaining requirements and no annual re-training had been completed for 2018. During the course of the inspection the total number of all staff and direct care who completed training in 2017 could not be confirmed. (583) [s. 76.]

The severity of this issue was determined to be a level 2 as there was potential for actual harm. The scope of the issue was a level 3 as it related to three out of three required areas for mandatory training. The home had a level 3 compliance history of ongoing non-compliance with this section of the Act that included:

-Written Notification (WN)-September 23, 2016 (2016_343585_0013) (536)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2018(A1)

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. 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.

Order / Ordre :

(A3)
The licensee must be compliant with the O. Reg. 79/10, s. 54.

Specifically the licensee shall ensure steps are taken to minimize the risk of altercations and potentially harmful interactions for resident #002, and between resident #011 and #012.

(a) The licensee shall conduct interdisciplinary assessments to determine factors that trigger altercations and implement interventions to ensure the safety of all residents in the home from the verbal and physical aggression demonstrated by resident #002.

(b) The licensee shall conduct interdisciplinary assessments and implement interventions for residents #011 and #012 in regards to responsive behaviours.

(c) The licensee shall ensure that the plan of care for each resident is updated to include clear direction to staff with regards to identified interventions.

Grounds / Motifs :

(A3)
1. The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents including, (b) identifying and implementing interventions.

A) A Critical Incident System (CIS) Report log #2931-000011-18 was submitted following a call to the After Hours Pager reporting an incident of alleged resident to resident abuse between resident #011 and #012. The RPN went directly to resident #011 to check on the resident. When RPN #134 spoke to the resident #011, they could not recall what happened. An interview was completed with RPN #134 in May 2018. It was identified that when the RPN went to resident #011 and observed and interviewed the resident, there was a suspicion that abuse potentially could have occurred. RPN #134 shared that they completed an assessment of resident #011, and that staff were notified to provide increased monitoring of resident #011 and #012.

A Registered Nurse completed a Referral Form for resident #012 which identified the reason for the referral as being a risk to others.

In interviews completed with Registered staff and Personal Support Workers (PSWs) during the course of the inspection, it was shared that staff were separating resident #011 and #012 when they were found together prior to this incident, as there was a history and potential for responsive behaviours which put resident #011 at risk. Resident #011 and #012's progress notes were reviewed and the following incidents were identified.

During review of resident #011 and #012's clinical records it was identified in seven different progress notes that resident #011 was observed trying to have contact with resident #012.

In May 2018, resident #011's and #012's electronic and paper records were reviewed with the Director of Nursing (DON) and Manager of Programs Development(MPD). A responsive behaviours focused care plan was created for resident #012, which identified interventions that staff were to follow to minimize the risk of potentially harmful actions. It was confirmed that between two specified dates, no interventions were documented as being developed or implemented in resident #012's plan of

care to minimize risk related to their responsive behaviours.

A responsive behaviours focused care plan was created for resident #011, and was not revised until an identified date.

An interview was completed with the RPN/Documentation Coordinator #130, in May 2018. It was identified that there were not interventions in place between two identified dates. The "patient observation records" were reviewed and it was identified that DOS charting was completed for a seven day period, for resident #011 and #012 then discontinued. DOS charting was not completed again.

In an interview with Behavioural Supports Ontario (BSO) staff #123, in May 2018, it was shared that they were not following resident #011 as they had not been referred. It was shared they received a referral for resident #012 after the incident. It was confirmed BSO was not asked to develop interventions to reduce the risk of potentially harmful interactions between resident #011 and #012.

An annual care conference was held for resident #011. The "resident care conference – interdisciplinary review" documentation was viewed with RPN #130. It was shared that responsive behaviours were not discussed, RPN #130 confirmed that the SDM was not in attendance.

In an interview with the Resident Assessment Instrument (RAI) Coordinator in May 2018. Resident #011's and #012's last quarterly assessments, were reviewed. Section E, mood and behaviour patterns were reviewed, and neither resident was coded as having the specified behaviours. The behavioural symptoms Resident Assessment Protocol (RAP) was reviewed, and the RAI Coordinator confirmed that neither resident's specific responsive behaviours were identified nor were interventions to manage the behaviours.

The requirements of O.Reg. 79/10, s. 54(b) were read to the Director of Nursing (DON) and Manager of Programs Development(MPD). The DON confirmed that steps were not taken to identify and implement interventions, to minimize the risk of potentially harmful interactions between resident #011 and #012. (583)

PLEASE NOTE: The above noted non-compliance was found during Inspection

#2018_561583_0008 related to Critical Incident Inspection (CIS) log #009396-18.

B) Resident #002 was admitted to the home on an identified date. The resident at that time had Behavioural Support Ontario(BSO) transition services in place to assist with the resident's admission into the home. The BSO services continued following the resident's admission due to resident #002's behaviours.

A review of resident #002's progress notes was completed for the four months following the residents admission. A total of 15 different behaviours were documented in resident #002's progress notes as observed behaviours. The progress notes identified a total of 120 different incidents occurred in a four month period.

On a specified date, the BSO support staff identified strategies to help redirect resident #002 when needed. As specified it included seven different strategies.

BSO then implemented another strategy. The inspector interviewed direct care staff #114, #117, #127, #142, #143 and #144, and only fifty percent of staff were aware of this newest intervention. Four of six staff interviewed, were not aware of the various BSO interventions that had been put into place.

During review of resident #002's care plan the Inspector identified that the BSO strategies to help redirect resident #002 were not included in their care plan. In May 2018, the DON and the MPD both confirmed that the care plan for resident #002, did not include any of the BSO strategies that had been implemented from the specified dates. The home has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents including, implementing interventions. (536)

Please note: this non-compliance was issued as a result of complaint log #007545-18 and CIS log # 008062-18.

The severity of this issue was determined to be a level (2) as there was there was a potential for actual harm. The scope of the issue was a level (2) as it related to three of six residents reviewed. The home had a level (3) history of ongoing noncompliance with this section of the Reg. that included:

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

-Voluntary Plan of Correction (VPC)-September 23, 2016 (2016_343585_0013) (536)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 31, 2018

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Order / Ordre :

The licensee must be compliant with the O. Reg. 79/10, s. 98.

Specifically the licensee shall ensure the appropriate police force is immediately notified of any alleged, suspected or witnessed incident(s) of abuse or neglect of a resident that the licensee suspects constitutes a criminal offense.

Grounds / Motifs :

(A2)
1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long term care home to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offense.

The home's policy titled: "Resident Abuse", policy number: EP-09-01-01, last revised: December 12, 2016, stated: "Police Notification – The appropriate police force will be immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that may constitute a criminal offense."

A) On an identified date, it was suspected that resident #011 may have been abused by resident #012. An interview was completed with RPN #134 in May 2018, and it was confirmed abuse was suspected at that time.

In interviews completed with registered staff and PSW's during the course of the

inspection, it was shared that staff were separating resident #011 and #012 when they were found together, as there was a history of potential responsive behaviours which put resident #011 at risk.

The homes investigation records were reviewed with the DON in May 2018. After review of the clinical records, the home's investigation notes and interviews conducted with the staff identified the home did not immediately notify the police of the suspected incident of abuse that may have constituted a criminal offense. The incident occurred, and it was documented in the homes investigation notes that the police were notified three days later. (583)

PLEASE NOTE: This evidence of non-compliance related to the above noted non-compliance was found during Inspection #2018_561583_0008 related to Critical Incident Inspection (CIS) log #009396-18.

B) A complaint was received at the MOHLTC, with concerns that the home had not taken appropriate action in regards to alleged resident abuse. On an identified date, PSW #116 found resident #001 on the floor. Resident #001 was unable to tell staff what had happened.

An Incident note in resident #001's progress notes by Registered Practical Nurse (RPN) #113 documented an assessment and description of visible injury. Resident #001 later developed other areas of injury. A review of resident #001's clinical record and interviews completed by the Inspector, revealed that the resident was unable to get out of bed unassisted.

In May 2018, the DON provided the Inspector with the amended Critical Incident System (CIS) Report which stated that 28 days after the incident they had spoken to the police. In June 2018, the Inspector spoke with the Senior Support Police Officer for the home who confirmed that they had called the home to follow up after the home had not contacted the police. The licensee failed to ensure that the appropriate police force was immediately notified of an alleged incident involving resident #001. (536)

Please note: this non compliance was issued as a result of complaint log #007545-18 and CIS log # 008062-18.

C) A written complaint was received at the Ministry of Health and Long Term Care (MOHLTC). In the written complaint stated this was resident to resident abuse involving resident #002. On a specified date and time, PSW #116 found resident #004 in an identified position in bed. Resident #004 was unable to tell staff what had happened. Interview with PSW #116 revealed, that they had seen the resident earlier, and there were no concerns with resident #004. A review of resident #004's clinical record and interviews completed by the Inspector revealed, that the resident was unable to reposition themselves in bed.

In May 2018, during interview the DON confirmed that the police had not been contacted in regards to the allegation of abuse. The licensee failed to ensure that the appropriate police force was immediately notified of an alleged incident involving resident #004, that the licensee suspects may constitute a potential criminal offense. (536)

Please note: this non compliance was issued as a result of complaint log #009368-18 . [s. 98.]

The severity of this issue was determined to be a level (1) as there is minimal risk. The scope of the issue was a level (3) as it related to three of three residents reviewed. The home had a level (2) history as there was previous noncompliance unrelated. (536)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 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:

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

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 16th day of January, 2019 (A3)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by CATHIE ROBITAILLE (536) - (A3)

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

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