Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 27, 2020	2020_750539_0009	000948-20, 003512-20, 004354-20, 005728-20, 011374-20, 011393-20, 011975-20	Critical Incident System

Licensee/Titulaire de permis

2063415 Ontario Limited as General Partner of 2063415 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Maple Grove Care Community
215 Sunny Meadow Boulevard BRAMPTON ON L6R 3B5

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

VALERIE GOLDRUP (539), SHERRI COOK (633)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 9-12, 15-18, 22-26, 2020.

The following intakes were completed in this inspection:

Log #000948-20\ Critical Incident System (CIS) #2911-000001-20,
Log #003512-20\ CIS #2911-000005-20,
Log #004354-20\ IL-75223-AH/ CIS #2911-000007-20,
Log #005728-20\ IL-75984-AH/ CIS #2911-000009-20,
Log # 011374-20\ IL-78923-AH/ CIS #2911-000015-20,
Log #011393-20\ IL-78941-AH/ CIS #2911-000016-20,
alleged resident to resident abuse.

Log # 011975-20\ CIS #2911-000018-20, alleged staff to resident abuse.

This inspection was completed concurrently with Complaint inspection 2020_750539_0008.

The inspectors toured the home and observed resident care and activities. Clinical records and plans of care for identified residents were reviewed. Also, relevant documents were reviewed including but not limited to the home's documentation and procedures as related to the inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Acting Director of Care (A/DOC), Assistant Directors of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), a Behavioural Support Ontario (BSO) RPN, residents and families.

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

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

- **5 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

O. Reg. 79/10 2(1) defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

On a specified date, resident #001 told the inspector that a staff member hurt them while providing care. They recalled details of the incident and shared that they informed their family member and a staff member after it occurred. The resident said they were afraid to say anything.

Resident #001's family member said they were concerned with the injury. The resident told them the staff member hurt them. The family member said the resident was afraid to speak up.

The day after the incident, an injury was confirmed and the resident complained of pain requiring pain management.

Four staff members said resident #001 was cognitively aware and they could tell the inspector if asked about this incident.

The licensee has failed to protect resident #001 from abuse. [s. 19. (1)]

2. The licensee has failed to protect resident #010 and resident #011 from sexual abuse.

O. Reg. 79/10 2(1) defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A critical incident report (CI) was submitted to the Ministry of Long-Term Care (MLTC). It stated that a staff member witnessed resident #009 in the lounge area, exhibiting sexually inappropriate behaviour towards residents #010 and #011.

Resident #009 was involved in two previous sexual interactions with another resident.

Two staff confirmed the events, and when asked about their understanding of abuse, stated sexual abuse included the observed behaviour.

The licensee has failed to protect resident #010 and resident #011 from sexual abuse. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents complied with any requirements that were provided for in the regulations.

O. Reg. 79/10, s. 97 (1) (2) states that the resident's substitute decision-maker (SDM), if any, and any other person specified by the resident were to be notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse. The SDM was to be notified of the results of the home's investigation, which was required under subsection 23(1) of the Act, immediately upon completion.

A critical incident report (CI) was submitted to the Ministry of Long-Term Care (MLTC) regarding an alleged incident of abuse related to resident #001. The initial and amended CI documented that the SDM was not notified of the home's investigation and the investigation outcome.

The home's policy stated, in part, that the SDM would only be immediately notified if the resident was not capable. The home's policy did not include that the SDM would be notified of the outcome of the home's investigation.

The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents complied with the requirements to notify the SDM. [s. 20. (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 to ensure the policy to promote zero tolerance of abuse and neglect of residents, shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and (h) shall deal with any additional matters as may be provided for in the regulations. 2007, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that 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 was based to the Director; abuse of a resident by anyone that resulted in harm or a risk of harm to the resident.

A CI was submitted the MLTC regarding an alleged incident of abuse, four business days after the incident had occurred.

The home failed to immediately report the suspicion of the alleged abuse and the information upon which it was based to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, to be implemented voluntarily.

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 :

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

Resident #008 and #009 were involved in four interactions. Staff stated that the residents were not able to consent to the interactions and did not recall them after they occurred.

One on one staff was implemented to prevent further interactions between the two residents.

However, on two occasions when the one on one staff was not present, despite being on duty, interactions took place between resident #008 and #009.

Staff confirmed that on two occasions the one on one staff intervention had not been in place when the interactions occurred.

The licensee failed to ensure interventions were in place to minimize the interactions between resident #008 and resident #009. [s. 54. (b)]

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 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, identifying and implementing interventions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker (SDM) was notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse of the resident that had resulted in a physical injury or pain to resident #001. The SDM was also not notified of the results of the home's investigation required under subsection 23 (1) of the Act, immediately upon the completion of the home's investigation.

On a specified date, resident #001 told the inspector that a staff member hurt them while providing care. Documentation confirmed the injury with pain.

On a specified date, a critical incident (CI) report was submitted to the MLTC and later amended after the home's investigation was completed. The CI documented that the resident's SDM was not notified of the home's investigation or the outcome. Staff confirmed that they did not contact the SDM regarding this incident. After the staff was informed by the Inspector of the legislation regarding alleged abuse investigations and SDM notifications, the CI documented that the staff contacted the SDM.

The licensee has failed to ensure that the resident's substitute decision-maker (SDM) was notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse of the resident and the results of the home's investigation. [s. 97.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation, to be implemented voluntarily.

Issued on this 10th day of August, 2020

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

Original report signed by the inspector.