**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

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


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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON  M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON  M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486


**Public Copy/Copie du public**

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| May 20, 2016 | 2016_291194_0011 | 036387-15 | Critical Incident System |

## Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON  L3R 0E8

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

Fieldstone Commons Care Community
1000 Ellesmere Road SCARBOROUGH ON  M1P 5G2

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

CHANTAL LAFRENIERE (194)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): May 09, 10, 11, 12, 13, 16, and 17, 2016**

**The following critical incident logs were completed during the inspection, Log #001595-15, #036387-15, #010304-16 resident to resident sexual abuse, Log # 002350-15, #009785-16, #012950-16 and #014016-16 alleged staff to resident abuse.**

**During the course of the inspection, the inspector(s) spoke with Residents, Administrator, Director of Care (DOC), Assistant Directors of Care (ADOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal support worker (PSW) and Social Worker (SW)**

**also reviewed clinical health records for identified residents, internal abuse investigations, staff educational records, relevant policies and observation of the staff to resident provision of care.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**
- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that "Falls Policy" VII-G-30.00 dated January 2015 was complied with.

Under O.Reg s. 48(1)1 Every licensee of a long-term care home shall ensure that the following interdisciplinary program is developed and implemented in the home:
-A falls prevention and management program to reduce the incidence of falls and the risk of injury.

"Falls Prevention" policy # VII-G-30.00 dated January 2015 directs:

PROCEDURE:
DOC will:
-Determine a communication process by which residents at moderate or high risk for falling are easily identified to the entire care team.

Registered staff or designate will:
-complete the falls risk assessment in the electronic documentation system at the following times:
-within 24 hours of admission or re-admission
- as triggered by the MDS assessment
- a significant change in status
-Upon completion of the detailed Fall Risk assessment, update care plan with associated risk level and interventions.

POST FALL ASSESSMENT:
The registered staff will:
-complete electronic post fall assessment by using the post fall huddle or fall incident report
-update resident's care plan.

Log #012950-16 related to resident #010

Resident #010 was admitted to the home with a history falls, requiring one staff assist with ADL's. Resident #010 is cognitively well and able to direct care.

Review of the clinical health record identifies a falls risk assessment completed on

admission indicating moderate risk for falls. Physio Therapist completed an assessment of resident #010, 6 days after admission indicating a high risk for falls. Resident #010 was found on the floor approximately one month after admission and a "post fall huddle was completed"

Interview with resident #010, PSW #147, #104, #137 and RPN #146 indicated that the interventions in place for falls for resident #010 consisted of; a bed alarm, the bed in the lowest position, floor mat, one full rail and one quarter rail, with hourly checks at night.

Interviews with the ADOC #107 and ADOC #126 were completed and indicated that the plan of care for resident #010 should have identified that resident #010 was at risk for falls and a list of interventions to prevent further falls.

Review of the plan of care for resident #010 does not identify the resident is at risk for falls or provide interventions.

The Falls policy was not complied with when resident #010's plan of care did not identify; resident #010 was at a moderate risk for falls after the falls risk assessment on admission. The plan of care was not updated to identify resident #010 as being at high risk for falls after a physio assessment 6 days after admission. Resident #010 was found on the floor approximately one month post admission and a post fall huddle completed and still the plan of care for resident #010 was not updated to indicate that resident #010 was at risk for fall or provide interventions for prevention of further falls. [s. 8. (1) (a),s. 8. (1) (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 ensuring that the licensee's "Falls Prevention Policy" is complied with related to resident #010, 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. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the licensee written policy that promotes zero tolerance of abuse and neglect was complied with.

- Policy "Prevention of abuse and neglect of a resident " VII-G-10.00, dated January 2015 directs;

-If any employee or volunteer witnesses an incident, or has any knowledge or an incident, that constitutes resident abuse or neglect; all staff are responsible to immediately take these steps
-Stop the abusive situation and intervene immediately if safe for them to do so while ensuring the safety of the resident
-remove resident from the abuse, or it that is not possible remove the abuse from the resident if safe for them to do so while ensuring the safety of the resident.
-Immediately inform the Executive Director (ED) Administrator or Charge Nurse in the home.

The charge nurse will;
-check the resident's condition to assess his/her safety, emotional and physical well being. IF required, immediate medical attention must be sought, either by contacting the attending physician or transferring the resident to a hospital
-Provide support to the staff member reporting, in Immediately report any of the following to the MOHLTC Director ( with ED/Administrator/ or designate if available)
-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.
-Inform POA immediately
-Contact the Executive Director/Administrator or designate (if not in the home) when it is confirmed that the resident is safe and has received appropriate care.
-Document the current resident status on the resident's record and complete a critical incident report.

-Update the care plan as appropriate, ensuring that the direct care staff are made aware of current resident status.

Log #036387-15 related to resident #001 and resident #002 sexual abuse incident.

A Critical Incident Report describes that PSW #120 was passing by the room when it was observed that resident #001 was sexually inappropriate towards resident #002. PSW #120 immediately went to report to RPN #121.

The clinical health record for resident #002 identified a cognitive impairment. Resident #002 was ambulatory without aides, required supervision with eating, bed mobility and extensive assistance with dressing and personal hygiene.

The clinical health record for resident #001 identifies no cognitive impairment, wheelchair dependent but able to manoeuvre without staff assistance, required 1-2 staff for transferring and toileting, required one staff, limited assistance with dressing and personal hygiene.

During an interview with inspector #194, RPN #121 indicated that an attempt to call ADOC #126 was made when informed by PSW #120 of the sexual abuse incident, but was unsuccessful. RPN #121 indicated a second attempt was made to find the ADOC #126, one and half hours later, but was again unsuccessful. RPN # 121 indicated that a third attempt was made half another later, at which time ADOC #126 was informed of the witnessed sexual abuse between resident #001 and resident #002.

ADOC #126 indicated to inspector #194 that during the internal investigation with PSW #120 is was confirmed that PSW #120 did not intervene between resident #001 and #002 because the staff member felt the “priority” was to notify the registered staff.

Review of the licensee’s internal abuse investigation was completed and indicates that PSW #120 did not immediately “stop the abusive situation and intervene immediately”. RPN #121 did not immediately report the witnessed sexual abuse to the Administrator, Director of Care or designate and did not update the care plan. [s. 20. (1)]

2. Log #009785-16 related to resident #007

Policy "Abuse & Neglect - Zero tolerance: Response to suspected or witnessed abuse" Policy # XV-A-10.70, dated January 2015 defines neglect as;

Neglect: In relation to residents, neglect means the failure to provide the resident with the care and assistance required for his or her health, safety or well being and includes inaction or a pattern of inaction that jeopardizes the health an safety of one or more residents. neglect includes but is not limited to:
-The failure to provide a resident with treatment, care services, or assistance
-with holding food and or health services
-Deliberately failing to meet a dependent resident's needs
-failing to respect and adhere to resident's right to make choices about the delivery of care services as outlined on the plan of care.

The plan of care for resident #007 indicated that the resident is a two person assist with mechanical lift for all transfers and required one staff extensive assist with Activities of Daily Living (ADL's). Resident #007 was cognitively well and able to voice needs effectively.

The SDM of resident #007 reported to the home an allegation of staff to resident neglect. SDM reported that on an identified date, PSW #103 and #122 assisted resident #007 back to bed. Resident #007 informed SDM that PSW #103 left the room, but informed resident #007 that the care would be completed shortly. PSW #103 returned two hours later. Resident #007 indicated to SDM being cold, when staff member returned. Resident #007 indicated to SDM that PSW #103 was verbally inappropriate when asked about the delay in care.

An internal investigation into the allegation was completed. The investigation notes indicate that PSW #103 assisted resident #007 from the dining room to the resident's room, transferred the resident to bed with the help of PSW #122. PSW #103 started to provide care for resident #007. PSW #103 was called to assist co-worker and informed resident #007 of returning shortly. The investigation notes indicate that PSW #103 returned to finish the care for resident #007 approximately two hours later.

During an interview with inspector, PSW #122 indicated that she assisted PSW #103 to transfer resident #007 to bed then left the room as resident #007 was a one staff assist with care. PSW #122 indicated that an hour later hearing someone yelling and entered resident #007's room to find the resident very upset, stating her care had not been completed.

During an interview with inspector #194 resident #007 was able to recall the incident but

not the specific details, other that being upset about being cold and care not completed. Resident #007 indicated that two staff put her bed, and PSW #103 went for something and never came back.

Resident #103 initiated care for resident #007 was called away and failed to complete resident #007's care until two hours later. [s. 20. (1)]

3. Log # 002350-15 related to resident #006

Review of the licensee's policy "Abuse and Neglect resident" Policy # V3-010 dated April 2013 in effect at the time of the incident directs:

Sexual Abuse is defined as:
- Any consensual or non consensual touching, behaviours or remarks of a sexual nature or sexual exploitation that is directed to a resident by a licensee or staff member
-Any non -consensual touching, behaviour or remarks or a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member
-Fondling, masturbation, penetration, leering
-Failure to respect a resident's right to privacy
-inappropriate disclosure of sexual preference
-indecent exposure
-exposure to sexually explicit materials

Procedure:
If any employee or volunteer witnesses an incident, or has any knowledge of an incident, that constitutes resident abuse or neglect; all staff are responsible to immediately take these steps;
- stop the abusive situation and intervene immediately if safe for them to do so while ensuring the safety of the resident
-remove the resident from the abuser, or if that is not possible, remove the abuser from the resident if safe for them to do so while ensuring the safety of the resident.
-immediately inform the Director of Administration (DOA) and/or charge nurse in the home.

The plan of care for resident #006 identifies a moderate cognitive impairement, decision making and short term memory deficit due to Dementia. Resident #006 required constant cueing, reminders and reassurance is wheelchair dependent and is total assist X2 staff

with all ADL's.

A critical incident report(CIR)was submitted on an identified date for a staff to resident sexual abuse. The CIR describes that PSW #102 was sexually inappropriately towards resident #006.

Review of the internal investigation, interview with Administrator and PSW involved was completed by the inspector. The investigation and interviews supported that PSW #102 was sexually inappropriately towards resident #006. The licensee's internal investigation also concluded that additional staff members #109, #131, #135 and RPN #130 were present and witnessed the abuse. The licensee reviewed the video tape of the incident and were able to identify all staff involved. The allegations of sexual abuse was forward to the administrator five days after the incident.

PSW #102 did not comply with the licensee's policy, when the staff member was sexually inappropriate towards resident #006. PSW #109, #131, #135 and RPN #130 did not comply with the licensee's abuse policy when they did not stop the sexual abuse or immediately report the sexual abuse. [s. 20. (1)]

4. Log #012950-16 related to resident #010

Policy "Abuse & Neglect - Zero tolerance: Response to suspected or witnessed abuse" Policy # XV-A-10.70, dated January 2015 defines:

Neglect: In relation to residents, neglect means the failure to provide the resident with the care and assistance required for his or her health, safety or well being and includes inaction or a pattern of inaction that jeopardizes the health an safety of one or more residents. neglect includes but is not limited to:
-The failure to provide a resident with treatment, care services, or assistance
-with holding food and or health services
-Deliberately failing to meet a dependent resident's needs
-failing to respect and adhere to resident's right to make choices about the delivery of care services as outlined on the plan of care.

Resident #010 was admitted to the home with a history of a falls. Resident #010 was cognitively well and able to direct care routines.

A critical incident was submitted for abuse/neglect of resident #010 by staff #104 on an

identified date describing that resident #010 informed the RN of having been on the floor for five hours.

Review of the internal investigation, interviews with resident #010, DOC and PSW #104 were completed by inspectors. The evidence supported that PSW #104 did not provided hourly checks for resident #010 on the identified date for five hours.

The inaction (neglect) of the PSW #104 jeopardized the safety of resident #010 on the identified date. Hourly checks were not completed for resident #010 who had fallen out of bed and could not reach the call bell, independently get up or be heard by staff with the bedroom door closed.

PSW #104 failed to comply with the home policy on abuse, where inaction of a staff member is defined as neglect [s. 20. (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 by ensure the licensee's "Prevention of abuse and neglect of a resident" is complied with, to be implemented voluntarily.***

---

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that strategies have been developed and implemented to respond to resident #001's responsive behaviours.

Log #014016-16 related to resident #001

Resident #001 is a cognitively well, ambulates on the unit with a wheelchair, requires one staff assistance with ADL's.

Resident #001 was involved in a sexually inappropriate incident with a female resident in the home, there was no resulting injury.  Resident #001 was monitored by 1:1 (staff to resident) for approximately two weeks, followed by BSO and relocated within the home.

Interviews with PSW #118, #138, #139 and #143, RN #140 and RPN #119 were conducted all staff interviewed described resident #001 as demanding and manipulative. Staff have explained when resident #001 requires care, the resident will pull the call bell, once the bell has been pulled resident #001 expects staff to respond immediately to the request. If staff are unable to provide immediate assistance to resident #001, the resident becomes angry and verbally abusive towards staff at times.

Review of the plan of care for resident #001 was completed and does not indicate that strategies have been developed and implemented to respond to resident #001's responsive behaviours of sexually inappropriate  or demanding behaviour. [s. 53. (4) (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 by ensuring that strategies are developed and implemented to respond to resident #001's sexually inappropriate and demanding behaviours, to be implemented voluntarily.***

---

**Issued on this 26th day of May, 2016**

| Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs |
| --- |
| |

**Original report signed by the inspector.**