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 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**

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


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| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 6, 2017 | 2017_659189_0016 | 015824-17 | Resident Quality Inspection |

## Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

Deerwood Creek Care Community
70 HUMBERLINE DRIVE ETOBICOKE ON M9W 7H3

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

NICOLE RANGER (189), SLAVICA VUCKO (210), THERESA BERDOE-YOUNG (596)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection.**

**This inspection was conducted on the following date(s): July 19, 20, 21, 24, 25, 26, 27, 28, 31, August 1, 2, 3, 4, 8, 9, 10, 11, 14, 15, 16, 17, 18, 21, 22, 23, 24, 2017.**

**The following critical incident reports were inspected concurrently with the Resident Quality Inspection (RQI):**

**Related to alleged staff to resident abuse:**
**Log # 012043-16 , #028342-16, #033349-16**
**Related to alleged resident to resident abuse:**
**Log # 000591-16, # 019979-16, # 000424-17, # 002634-17, # 013773-17, #005030-17, #017132-17**
**Related to fall prevention:**
**Log # 009753-17**
**Related to unknown cause of injury:**
**Log # 006020-17**
**Related to improper care and treatment**
**Log # 014147-16, # 014260-16**
**The following complaint were inspected concurrently with the RQI:**
**#005061-17, related to infection control and prevention, dining and snack services, food production**

**During the course of the inspection, the inspector(s) spoke with Administrator, Interim Director of Care (DOC), Director of Care (DOC), Interim Assistant Director of Care (ADOC), Environmental Service Manager (ESM), Dietary Service Supervisor, Resident Assessment Instrument (RAI) Coordinator, Housekeeping Supervisor, Resident Relations Coordinator, Director of Resident Programs, Director of Support Services, Activation Aide, Maintenance staff, Behavioural Support Ontario (BSO) RPN, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Residents' Council President, Family Council President, residents and family members.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**
**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Falls Prevention**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Residents' Council**
**Responsive Behaviours**
**Snack Observation**

**During the course of this inspection, Non-Compliances were issued.**
- **16 WN(s)**
- **4 VPC(s)**
- **2 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. 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.

Record review of two identified CIS reports submitted to the MOHLTC reporting an incident of resident to resident abuse between resident #019 and resident #020.

Record review of residents #019 and #020's progress notes indicated the same as mentioned above.

Review of resident #019's MDS assessment indicated a CPS score of 3 indicative of moderate cognitive impairment, and resident #020's MDS assessment indicated a CPS score of 4 indicative of moderate/severe cognitive impairment.

After the first physical altercation between resident #019 and resident #020, every 15 minute safety checks were started for resident #020; they were already in place for resident #019 due to wandering the hallways and into other residents' rooms.

Review of resident #019 and resident #020's plans of care included dementia observation system (DOS) monitoring every 15 minutes which started on an identified time period, and every 30 minute monitoring from an identified time period for resident #020.

Review of resident #019's written care plan directed staff to complete every 15 minute safety checks due to responsive behavior with other residents and staff (especially around meal time), and distract him/her from approaching too close to resident #020.

Review of resident #020's written care plan indicated that resident demonstrates responsive behaviour when he/she perceives his/her personal space is invaded and potential of conflict with other residents when they wander near/inside his/her room.

Interview with PSW #144 revealed that he/she was assigned to residents #019 and #020 on an identified date, and both residents were in the dining room for dinner; dinner usually started at 1700 hours. PSW #144 reported that both residents ambulated independently and leave the dining room when they feel like it. They were running late for dinner service and PSW #144 was busy portering residents out of the dining room at

around 1815 hours when a co-worker, PSW #145, called him/her about hearing a loud bang coming from resident #020's room. PSW #144 reported that he/she did not know when residents #019 and #020 left the dining room nor their whereabouts at 1815 when his/her co-worker heard the bang coming from resident #020's room. PSW #144 and PSW # 145 went to resident #020's room and discovered an altercation between resident #020 and resident #019. They attempted to separate the two residents with the assistance of the charge nurse RPN #148.

Interview with RPN #148 revealed that he/she was in the dining room on the identified date, and last saw resident #020 in the dining room around 1800 hours. A resident approached him/her around 1810 hours reporting that resident #019 had wandered into his/her room and he/she redirected the resident out of the resident's room and back to his/her room and returned to the dining room to get the medication cart; RPN #148 was not aware of resident #020's whereabouts at that time. According to RPN #148 sometime later he/she heard PSW #144 and #145 yelling from resident #020's room, and when he/she arrived he/she witnessed an altercation between resident #019 and resident #020. Resident #020 was agitated, upset and yelling and also hit PSW #144 as he/she was trying to separate the two residents. RPN #148 stopped the altercation between resident #019 and resident #020. Resident #020 was transferred to hospital on a Form 1 and resident #019 was transferred to hospital for assessment of his/her injuries.

According to the interim DOC, resident #019 and #020 had a previous physical altercation on an identified date as reflected in the CIS submitted by the home, and resident #019's written care plan directed staff to distract resident #019 from approaching too close to resident #020. On the identified date, resident #019 wandered into resident #020's room and a altercation ensued where resident #019 sustained injuries and was transferred to hospital for further assessment. The interim DOC confirmed that staff could have taken more steps to minimize the risk of altercations between resident #019 and resident #020. [s. 54. (b)]

2. On an identified date, the home submitted a Critical Incident System Report (CIS), reporting an allegation of resident to resident abuse. The CIS report stated resident #003 and resident #038 were in the dining room, when resident #038 approached resident #003's table to speak to him/her, when resident #003 suddenly grabbed resident #038's identified body area.

The home also submitted a CIS on an identified date, reporting an incident that occurred

between resident #003 and resident #037. The CIS report stated that resident #037 was found on the floor, after he/she was walking in the hallway and resident #003 attempted to grab him/her, where he/she moved away and fell to the floor.

Record review of resident #003's progress notes revealed 5 identified dates where resident #003 demonstrate responsive behaviour with resident #005, #006, #007, #037 and resident #038.

Throughout review of the progress notes from an identified time period, it was noted that resident #003 had made several attempts to inappropriately touch the staff and verbally state inappropriate comments to the staff.

Interview with RN #110, RPN #111 and BSO RPN #141 revealed that the home had identified resident #003 will attempt to touch co residents and staff when left alone in the dining room and in the hallway. The staff stated that the resident is unpredictable and will attempt to touch staff and co residents at any time. The BSO RPN #141 stated that the staff have been instructed to supervise the resident to and from the dining room to avoid leaving him/her alone in the hallway and the dining room as he/she will attempt to grab others.

PSW #140 stated that on an identified date, resident #003 and resident #038 were in the dining room for breakfast. PSW #140 stated that although he/she was in the dining room at the time when resident #003 grabbed resident #038's identified body area, he/she did not witness the incident as he/she was assisting other residents into the dining room. PSW #140 reported to the inspector that he/she is aware that resident #003 should not enter into the dining room first or left unsupervised as he/she will attempt to touch other residents.

PSW #170 stated that he/she is aware that resident #003 will grab other residents when in the hallway and required close monitoring. However, PSW #170 had left resident #003 in the hallway without supervision as he/she needed to check on another resident on his/her assignment when an identified incident happened. PSW #170 reported to the inspector that when he/she came out of the room and found resident #038 on the floor, resident #003 was laughing about the incident.

RPN #111 stated that he/she is aware that resident #003 will grab other residents and attempt to touch when in the hallway and required close monitoring. However, RPN #111 reported that on an identified date, resident #003 was left in the hallway, when he/she

suddenly grabbed resident #007's identified body area as he/she approached the PSW who was serving the nourishment. RPN #111 stated that he/she instructed the staff that the resident should not be left alone in the hallway.

PSW #162 stated that he/she is aware that resident #003 will grab other residents when in the hallway and required close monitoring. However, PSW #162 reported that on an identified date, he/she was located in the nursing station and resident #003 was left in the hallway, when suddenly he/she grabbed resident #006's identified body area as he/she passed by.

Interviews with RN #110, RPN #111, BSO RPN #141 stated that providing close supervision with one to one staff had been the most efficient in reducing and preventing the number of interactions between resident #003 and other residents.

Interview with the interim DOC stated that the home had identified that resident #003 needed one to one staff to closely monitor resident #003 in order to prevent him/her from touching co - residents, and that the resident should not be left unattended in the dining room or in the hallway. The interim DOC confirmed that for the five identified incidents that resident #003 touched other residents, one to one staff was initiated on two occasions. A review with the incidents with the interim DOC confirmed that steps were not taken to manage resident #003's responsive behavior to minimize the risk of altercations and potentially harmful interactions between residents.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.
The home failed to take appropriate actions to manage resident #003, resident #019 and resident #020's responsive behavior to minimize the risk of altercations and potentially harmful interactions between residents.

The scope of the non-compliance is a pattern. [s. 54. (b)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

**Findings/Faits saillants :**

1. The licensee has failed to ensure resident #005, resident #006, resident #007, resident #019, resident #037 and resident #038 were protected from abuse by anyone and not neglected by the licensee or staff.

Record review of two identified CIS reports submitted to the MOHLTC reporting an incident of resident to resident abuse between resident #019 and resident #020.

Record review of residents #019 and #020's progress notes indicated the same as mentioned above.

Review of resident #019's MDS assessment indicated a CPS score of 3 indicative of moderate cognitive impairment, and resident #020's MDS assessment indicated a CPS score of 4 indicative of moderate/severe cognitive impairment.

After the first physical altercation between resident #019 and resident #020, every 15 minute safety checks were started for resident #020; they were already in place for resident #019 due to wandering the hallways and into other residents' rooms.

Review of resident #019 and resident #020's plans of care included dementia observation system (DOS) monitoring every 15 minutes which started on an identified time period, and every 30 minute monitoring from an identified time period for resident #020.

Review of resident #019's written care plan directed staff to complete every 15 minute safety checks due to responsive behavior with other residents and staff (especially around meal time), and distract him/her from approaching too close to resident #020.

Review of resident #020's written care plan indicated that resident demonstrates responsive behaviour when he/she perceives his/her personal space is invaded and potential of conflict with other residents when they wander near/inside his/her room.

Interview with PSW #144 revealed that he/she was assigned to residents #019 and #020 on an identified date, and both residents were in the dining room for dinner; dinner usually started at 1700 hours. PSW #144 reported that both residents ambulated

independently and leave the dining room when they feel like it. They were running late for dinner service and PSW #144 was busy portering residents out of the dining room at around 1815 hours when a co-worker, PSW #145, called him/her about hearing a loud bang coming from resident #020's room. PSW #144 reported that he/she did not know when residents #019 and #020 left the dining room nor their whereabouts at 1815 when his/her co-worker heard the bang coming from resident #020's room. PSW #144 and PSW # 145 went to resident #020's room and discovered an altercation between resident #020 and resident #019. They attempted to separate the two residents with the assistance of the charge nurse RPN #148.

Interview with RPN #148 revealed that he/she was in the dining room on the identified date, and last saw resident #020 in the dining room around 1800 hours. A resident approached him/her around 1810 hours reporting that resident #019 had wandered into his/her room and he/she redirected the resident out of the resident's room and back to his/her room and returned to the dining room to get the medication cart; RPN #148 was not aware of resident #020's whereabouts at that time. According to RPN #148 sometime later he/she heard PSW #144 and #145 yelling from resident #020's room, and when he/she arrived he/she witnessed an altercation between resident #019 and resident #020. Resident #020 was agitated, upset and yelling and also hit PSW #144 as he/she was trying to separate the two residents. RPN #148 stopped the altercation between resident #019 and resident #020. Resident #020 was transferred to hospital on a Form 1 and resident #019 was transferred to hospital for assessment of his/her injuries.

According to the interim DOC, resident #019 and #020 had a previous physical altercation on an identified date as reflected in the CIS submitted by the home, and resident #019's written care plan directed staff to distract resident #019 from approaching too close to resident #020. On the identified date, resident #019 wandered into resident #020's room and a altercation ensued where resident #019 sustained injuries and was transferred to hospital for further assessment. The interim DOC confirmed that staff could have taken more steps to minimize the risk of altercations between resident #019 and resident #020. [s. 54. (b)]

2. On an identified date, the home submitted a Critical Incident System Report (CIS), reporting an allegation of resident to resident abuse. The CIS report stated resident #003 and resident #038 were in the dining room, when resident #038 approached resident #003's table to speak to him/her, when resident #003 suddenly grabbed resident #038's identified body area.

The home also submitted a CIS on an identified date, reporting an incident that occurred between resident #003 and resident #037. The CIS report stated that resident #037 was found on the floor, after he/she was walking in the hallway and resident #003 attempted to grab him/her, where he/she moved away and fell to the floor.

Record review of resident #003's progress notes revealed 5 identified dates where resident #003 demonstrate responsive behaviour with resident #005, #006, #007, #037 and resident #038.

Throughout review of the progress notes from an identified time period, it was noted that resident #003 had made several attempts to inappropriately touch the staff and verbally state inappropriate comments to the staff.

Interview with RN #110, RPN #111 and BSO RPN #141 revealed that the home had identified resident #003 will attempt to touch co residents and staff when left alone in the dining room and in the hallway. The staff stated that the resident is unpredictable and will attempt to touch staff and co residents at any time. The BSO RPN #141 stated that the staff have been instructed to supervise the resident to and from the dining room to avoid leaving him/her alone in the hallway and the dining room as he/she will attempt to grab others.

PSW #140 stated that on an identified date, resident #003 and resident #038 were in the dining room for breakfast. PSW #140 stated that although he/she was in the dining room at the time when resident #003 grabbed resident #038's identified body area, he/she did not witness the incident as he/she was assisting other residents into the dining room. PSW #140 reported to the inspector that he/she is aware that resident #003 should not enter into the dining room first or left unsupervised as he/she will attempt to touch other residents.

PSW #170 stated that he/she is aware that resident #003 will grab other residents when in the hallway and required close monitoring. However, PSW #170 had left resident #003 in the hallway without supervision as he/she needed to check on another resident on his/her assignment when an identified incident happened. PSW #170 reported to the inspector that when he/she came out of the room and found resident #038 on the floor, resident #003 was laughing about the incident.

RPN #111 stated that he/she is aware that resident #003 will grab other residents and

attempt to touch when in the hallway and required close monitoring. However, RPN #111 reported that on an identified date, resident #003 was left in the hallway, when he/she suddenly grabbed resident #007's identified body area as he/she approached the PSW who was serving the nourishment. RPN #111 stated that he/she instructed the staff that the resident should not be left alone in the hallway.

PSW #162 stated that he/she is aware that resident #003 will grab other residents when in the hallway and required close monitoring. However, PSW #162 reported that on an identified date, he/she was located in the nursing station and resident #003 was left in the hallway, when suddenly he/she grabbed resident #006's identified body area as he/she passed by.

Interviews with RN #110, RPN #111, BSO RPN #141 stated that providing close supervision with one to one staff had been the most efficient in reducing and preventing the number of interactions between resident #003 and other residents.

Interview with the interim DOC stated that the home had identified that resident #003 needed one to one staff to closely monitor resident #003 in order to prevent him/her from touching co - residents, and that the resident should not be left unattended in the dining room or in the hallway. The interim DOC confirmed that for the five identified incidents that resident #003 touched other residents, one to one staff was initiated on two occasions. A review with the incidents with the interim DOC confirmed that steps were not taken to manage resident #003's responsive behavior to minimize the risk of altercations and potentially harmful interactions between residents.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual harm experienced by six residents. The scope of the non-compliance is a pattern. A review of the Compliance History revealed the following non-compliances related to LTCHA, 2007 s. 19. In October 2014, the home was issued a Voluntary Plan of Correction for failing to comply with LTCHA2007, s. 19 in that the home did not protect a resident from abuse within report 2014_306510_0024. [s. 19.]

***Additional Required Actions:***

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

**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

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

**s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**s. 6. (9) The licensee shall ensure that the following are documented:**
**1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

On an identified date, the home submitted a Critical Incident System Report (CIS) , reporting an allegation of resident to resident abuse. The CIS report that resident #003 was in the hallway and started to move towards resident #006 who was in the hallway and grabbed at resident #006.

The home also submitted a CIS reporting an allegation of resident to resident abuse. The CIS report that resident #005 reported to the Registered Dietitian (RD) that resident #003 touched him/her on an identified date as he/she was leaving the dining room.

A review of the resident's written plan of care for two identified dates did not reveal the resident's history of touching other residents for the two identified incidents, and did not include interventions to manage the resident's inappropriate behaviour towards other residents.

Interview with the BSO RPN #141 stated the staff were reminded that before and after meals when traffic is heavy to escort resident #003 out of the dining room to avoid close proximity to other residents and try to clear the hallway before he/she comes out of the dining room to minimize the chance of him/her touching others, and that this interventions should be on the written care plan. The BSO RPN #141 confirmed that this intervention was not on the care plan until a later date, when he/she initiated it on the care plan.

Interview with the interim DOC stated the home's expectation was to include all responsive behaviour and interventions in the resident's written plan of care. The interim DOC confirmed that the resident's written plan of care did not set out the planned care for the resident. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Record review of CIS revealed the home submitted the report to the MOHLTC on an identified date reporting that resident #012 sustained a fall with injury on an identified date. The resident was transferred to the hospital.
Record review of resident #012's falls incident-post fall huddle indicated the same as mentioned above.
Record review of resident's care plan and kardex revealed moderate risk for falls and directed PSWs to pin call bell close to resident's pillow if in bed, or to lazy boy chair if sitting in chair.

The inspector observed resident #012 laying in bed with the call bell hanging behind the bed and inaccessible, with no clip.

Interview with PSW #101 revealed that resident #012 was moderate risk for falls and the call bell should have been clipped to the resident's pillow and accessible when the inspector observed the resident laying in bed. The PSW stated that the clip had broken off of the call bell, he/she did not notice it until shown by the inspector, and will report it immediately to be repaired. Interview with PSW #102 stated that the resident was at risk for falls and should always have the call bell clipped to the pillow, as indicated in the care plan. [s. 6. (7)]

3. Record review of the CIS which was submitted to the MOHLTC on an identified date,

reporting that after breakfast around 0930 hours, resident #019 and #020 were seen in the hallway by housekeeping supervisor #147 in an altercation. Another CIS report was submitted to the MOHLTC on an identified date reporting that after dinner around 1815 hours, resident #019 wandered into resident #020's room, and when staff attended they witnessed resident #020 in an altercation with resident #019. Resident #019 sustained an injury

Review of resident #020's plan of care included dementia observation system (DOS) monitoring every 15 minutes which started on an identified date, after the above mentioned altercation with resident #019.

Record review of resident #020's DOS assessment tool revealed no documentation on the evening shift of an identified date.

Interview with PSW #144 revealed that he/she did not remember if he/she monitored resident #020's responsive behaviours every 15 minutes on an identified, evening shift, and he/she did not document on the resident's DOS assessment tool.

Interviews with BSO staff #141 and the interim DOC revealed that the home's expectation is that DOS monitoring is started after every resident to resident altercation or new behaviour is identified, and PSWs are expected to complete it on every shift. [s. 6. (7)]

4. On an identified date, the home submitted a Critical Incident System (CIS) reporting an allegation of resident to resident abuse. The CIS stated that resident #003 suddenly grabbed resident #007 when the PSW staff delivered nourishment to the resident.

On an identified date, the home submitted a CIS report reporting an allegation of resident to resident abuse.
The CIS report stated resident #003 and resident #038 were in the dining room, when resident #038 approached resident #003's table to speak to him/her, when resident #003 suddenly grabbed resident #038.

The home also submitted a CIS on an identified date, reporting an incident that occurred between resident #003 and resident #037 on an identified date. The CIS report stated that resident #037 was found on the floor, after he/she was walking in the hallway and resident #003 attempted to grab him/her, where he/she moved away and fell to the floor.

Review of resident #003's written plan of care revealed that resident #004 has responsive behaviours that includes remarks and actions towards staff and other residents and inappropriate touching towards staff and other residents. Further review of the written plan of care revealed staff are to be physically present to assist/supervise resident #003 to and back from dining room to avoid the resident self propelling alone around in the hallway as resident #003 has a tendency to scream, grab others while in the hallway.

RPN #111 stated that he/she is aware that resident #003 will grab other residents and attempt to touch when in the hallway and required close monitoring. However, RPN #111 reported that on an identified date, resident #003 was left in the hallway, when he/she suddenly grabbed resident #007 as he/she approached the PSW who were serving the nourishment. RPN #111 stated that he/she instructed the staff that the resident should not be left alone in the hallway.

PSW #170 stated that he/she is aware that resident #003 will grab other residents when in the hallway and required close monitoring. However, PSW #170 had left resident #003 in the hallway without supervision as he/she needed to check on another resident on his/her assignment when an identified incident happened. PSW #170 reported to the inspector that when he/she came out of the room and found resident #038 on the floor, resident #003 was laughing about the incident.

PSW #140 stated that on an identified date, resident #003 and resident #038 were in the dining room for breakfast. PSW #140 stated that although he/she was in the dining room at the time when resident #003 grabbed resident #038, he/she did not witness the incident as he/she was assisting other residents into the dining room. PSW #140 reported to the inspector that he/she is aware that resident #003 should not enter into the dining room first or left unsupervised as he/she will attempt to touch other residents.

Interview with the interim DOC confirmed that the resident should not be left unattended in the dining room or in the hallway as he/she will attempt to touch other residents. The DOC confirmed that the care set out in the plan of care was not provided to resident #003 as specified in the plan. [s. 6. (7)]

5. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Record review of CIS report submitted to the MOHLTC on an identified date, reported

that after breakfast around 0930 hours, resident #019 and #020 were seen in the hallway by housekeeping supervisor #147 in an altercation. Another CIS report was submitted to the MOHLTC on an identified date, reporting after dinner around 1815 hours resident #019 wandered into resident #020's room, and when staff attended they witnessed resident #020 in an altercation with resident #019. Resident #019 sustained an injury.

Review of residents #019 and #020's plans of care included dementia observation system (DOS) monitoring every 15 minutes which started on an identified date, after the above mentioned altercation between the two residents. Subsequently DOS monitoring every 30 minutes was started on an identified date, for resident #020.

Record review of resident #019 and #20's DOS assessment tool revealed no documentation on the day shift on an identifieddate and no documentation for resident #20 on an identified date during the evening shift.

Interview with PSW #155 revealed that he/she monitored residents #019 and #020 for responsive behaviours every 15 minutes on an identified date, day shift, but did not document on the residents' DOS assessment tools.

Interview with PSW #144 revealed that he/she monitored resident #020 for responsive behaviors every 30 minutes on an identified date, evening shift but missed documenting on the resident's DOS assessment tool.

Interviews with BSO staff #141 and the interim DOC revealed that the home's expectation is that DOS monitoring is started after every resident to resident altercation or new behaviour is identified, and PSWs are expected to complete it on every shift. [s. 6. (9) 1.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to ensure that the provision of the care set out in the plan of care is documented, and to ensure that there is a written plan of care for each resident that sets out the planned care for the resident, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails**

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

**s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,**
**(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).**
**(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).**
**(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that where bed rails were used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

On an identified date, during stage 1 of the RQI, the inspector conducted a family interview with resident #001 and his/her family member in the resident's room. The inspector observed a mark on the resident's identified body area. The inspector inquired with the resident's family member about the mark , when the family member reported to the inspector that he/she was informed by the staff when he/she arrived at the home in the morning, that the resident was found by the staff against the side rail. The inspector observed that the resident's mattress was a therapeutic air surface, with a side bed rail applied to the centre of the bed.

Record review revealed that on an identified date, physician orders was received for PASD (side rails) while in bed due to air mattress for bed mobility and positioning. Record review of the Restraints/PASD assessment on an identified date, revealed the date for the bed entrapment audit was not completed on the assessment form. Interview with RN #115 revealed that he/she completed the restraint/PASD assessment form, but confirmed that the bed entrapment audit was not completed at the time of the assessment. RN #115 reported that the home's practice is to send a requisition to the maintenance staff in the computer to complete a bed entrapment assessment once there is a modifications or change to the bed system.

Record review of homes bed entrapment inspection sheet provided to the inspector by the ESM, revealed that the inspector was unable to find the entrapment assessment that was conducted for resident #001's bed when the side rails were applied. Interview and review of bed entrapment inspection sheet with the ESM and maintenance staff #168, confirmed that the bed entrapment assessment was not completed for resident #001 when his/her side rail was applied to his/her bed. The maintenance staff #168 conducted the bed entrapment assessment on an identified date, the same day after discussion with the inspector.

Interview with the interim DOC confirmed that resident #001's bed system was not evaluated when there was a change to the resident's bed [s. 15. (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 to ensure that where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.***

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**WN #5: 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 :**

1. The licensee has failed to ensure that the resident who requires continence care products had sufficient changes to remain clean, dry and comfortable.

During an interview with resident #002, the resident reported to the inspector, that on an identified date, he/she required assistance to be changed and pulled the call bell to request assistance. Resident #002 reported that two PSWs came into the room and did not assist to change his/her incontinent product and told him/her that he/she needed to wait until his/her assigned PSW came back to the floor. The resident reported that he/she waited for one hour before he/she was changed.

Interview with PSW #119 revealed that he/she was assigned to provide care for the resident on the day shift on the identified date. PSW #119 reported that he/she left the unit at 1:00pm to attend a mandatory inservice on the main floor. PSW #119 revealed that he/she returned back to the unit at 1:50pm and started to provide nourishments to the residents. PSW #119 reported that as he/she got into resident #002's room, the resident reported that he/she needed to be changed, and that he/she requested to be changed previously by the staff but he/she did not receive the assistance. PSW #119 reported that he/she changed the resident's incontinent product around 2:15pm.

Interview with PSW #124 reported that he/she heard resident #002's call bell after lunch around 1:15pm, and he/she went into resident #002's room, where the resident report to him/her that he/she needed assistance to be changed. PSW #124 reported that he/she informed resident #002 that he/she is assisting another resident at this time but will return back to assist him/her when he/she is finished. PSW #124 reported that he/she did not return back to assist resident #002 with his/her continence change.

Interview with PSW #101 reported that he/she heard resident #002's call bell ringing around 1:30pm, and he/she went into resident #002's room, where the resident reported that he/she needed assistance to be changed. PSW #101 also stated to the resident that he/she was assisting another resident and then left the room. PSW #101 reported that he/she did not return back to assist resident #002 with his/her continence change.

Interview with Interim DOC revealed that an investigation was conducted and confirmed that the resident #002 did not receive assistance to remain clean, dry and comfortable. [s. 51. (2) (g)]

***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 who requires continence care products have sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.***

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**WN #6: 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 failed to ensure the behavioural triggers have been identified for the resident demonstrating responsive behaviours (where possible).

A critical incident report (CIS) was submitted to MOHLTC on an identified date, in relation to an alleged abuse involving resident #025 and resident #022.

According to the CIS, on an identified date, at 1845 hours resident #025 yelled for help from his/her room. When PSW #158 arrived in the room, resident #025 was on the floor fully dressed and resident #022 was in his/her wheelchair with his/her pants pulled down past his/her hip resting on the upper thigh. Interview with PSW #158 revealed resident #022 had a history of being able to pull his/her pants down. This was described in the written plan of care.

A review of the clinical record revealed resident #025 was admitted in the home on an identified date. A review of the Community Care Access Centre (CCAC) admission assessment documents from an identified date, revealed the resident had behavioural symptoms such as socially inappropriate responsive behaviours . The behavioural symptoms have become worse or are less well tolerated by family as compared to 90 days ago.

A review of resident #025's written plan of care on an identified date, revealed a behaviour problem related to restlessness when in bed or attempting to get up from chair without waiting for assistance. Staff to check the resident hourly for his/her whereabouts. The care plan did not identify a socially disruptive inappropriate behaviour, nor interventions for it.

A review of the progress notes revealed on an identified date, the physician documented that registered staff RPN #159 advised him/her that resident #025 demonstrates inappropriate responsive behaviour on a frequent basis. The Psychogeriatrician to assess the resident and discuss treatment with BSO lead. The progress note on an identified date, revealed the BSO lead discussed with the physician in relation to resident #025's inappropriate behavior, Charge nurse to remind staff to monitor resident and distract him/her to private room when showing signs of socially inappropriate behavior.

Interview with PSW #158 revealed he/she has seen resident #025 demonstrating responsive behaviour and he/she has reported it to the nurse. Staff further stated that the resident has tried to touch staff or made socially inappropriate comments when providing personal care such as shower. PSW #158 was not able to define when and how frequently this has happened and if the resident has exhibited this or similar socially inappropriate behavior with other staff.

A review of the flow sheets indicated on five identified dates, resident #025 exhibited socially inappropriate disruptive behavior but there were no progress notes to define the behavior.

Interview with BSO lead RPN #141 revealed unawareness that resident #025 was admitted with a history of socially inappropriate disruptive behaviour, he/she has never received a referral from staff in relation to this behaviour and has never requested support from the Psychogeriatric Resource Consultant (PRC).

During interviews with RPN # 159, BSO Lead RPN #141, and PSW #158, they were not able to identify the triggers of the socially inappropriate behaviour of resident, the frequency and the interventions. [s. 53. (4) (a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible, to be implemented voluntarily.***

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**WN #7: 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 failed to 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.

A Critical Incident Report (CIS) was submitted to MOHLTC on an identified date regarding an allegation of resident to resident abuse.

According to the CIS report, on an identified date, at 1845 hours, resident #025 yelled out for help from his/her room. PSW #158 entered the room and found resident #025 on the floor beside his/her wheelchair fully dressed and resident #022 in his/her room sitting in his/her wheelchair with his/her pants and incontinent product pulled down past his/her hip resting on his/her upper thigh.

A review of the Prevention of Abuse and Neglect Policy of a Resident, Policy #VII-G-10.00, from January 2015, revealed the organization has a zero tolerance policy for resident abuse and neglect. All employees, volunteers, agency staff, private duty caregivers, contracted service providers, residents and families, are required to immediately report any suspected or known incident of abuse or neglect to the Director of MOHLTC and Executive Director/Administrator or designate in charge of the home.

Interview with the home administrator confirmed the alleged abuse was not reported to MOHLTC immediately and was reported to the Ministry two days after the incident because the management of the home was not informed immediately and when they investigated they did not confirm abuse. [s. 20. (1)]

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**WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act**

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

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported was immediately investigated.

Record review of CIS report submitted to the Ministry on an identified date reporting an allegation of staff to resident abuse The CIS indicated that resident #011 was hurt while being repositioned in bed.

Record review of resident #011's progress notes revealed the resident reported to PSW #143 that on an identified date, a PSW held his/her hand tightly, and when the PSW #143 asked how it felt the resident responded that his/her hand was ok and no pain.

Interview with PSW #143 revealed resident #011 complained on an identified date, that the previous day a staff squeezed his/her hand during care. PSW #143 stated he/she immediately reported the resident's allegation to RN #136.

Interview with RN #136 stated that on the identified date, a PSW reported that resident #011 stated that a staff squeezed his/her hand the previous day during care. RN #136 stated that he/she went to assess the resident and there were no complaints of pain to his/her hand, however the resident's allegation was reported to the oncoming shift and at the evening nurse meeting attended by the ADOC or DOC.

Record review of the home's investigation notes revealed the home did not investigate resident #011's allegations of staff to resident abuse immediately. The resident was interviewed by the home's resident relations coordinator six days later regarding the allegation. The CIS was submitted to the MOHLTC and mentioned that resident was assessed and had a bruise on the identified hand, and a picture of the bruise was taken. The investigation notes did not include interviews of staff who worked when the abuse was alleged to have happened.

Interview with the interim ADOC revealed that the home did not fully investigate resident #011's allegation of abuse reported on the identified date. The interim DOC and DOC did not learn about the allegation until six days later, and somehow missed interviewing the PSWs assigned to the resident and other staff who may have assisted with the resident's care on an identified date. Interim DOC further reported that the home will amend the CIS and thoroughly complete the investigation to include interviews with staff who worked on the date mentioned above, that the resident alleged the abuse occurred. [s. 23. (1) (a)]

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**WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

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

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

Record review of CIS submitted to the MOHLTC on an identified date, reported that resident #011 was hurt when being positioned in bed resulting in a bruise on the identified hand.

Record review of resident #011's progress notes and interview with RN #136 revealed that staff reported to RN #136 that on an identified date, a PSW held his/her hand so tight that it almost broke. RN #136 stated that he/she immediately assessed the resident who had no injuries or pain, and documented; the resident denied any concerns. During an interview with RN #136 he/she reported that he/she was aware of the requirements to report to the Ministry, however, he/she reported the resident's allegations to the oncoming shift and the information was also shared at the daily nurses meeting at 1530 hours attended by other registered staff and the ADOC and/or DOC.

Interview with PSW #143 reported he/she informed RN #136 about resident #011's allegation of staff to resident abuse right away on the identified date when the resident reported it.

According to the interim DOC, he/she and the DOC at that time were not aware of resident #011's allegations of abuse , and the CI was not submitted to the MOHLTC until four days after, when the interim DOC became aware of the resident's allegations. [s. 24. (1)]

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**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing**

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

**s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).**

**Findings/Faits saillants :**

1. The licensee had failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

During stage 1 of the Resident Quality Inspection (RQI), resident #002 reported to the inspector in an interview that he/she did not receive his/her scheduled showers on two occasions in an identified month. The resident reported that on an identified date, he/she did not receive his/her scheduled shower, however he/she was offered a shower later on that day but he/she refused. The resident reported that the second day that he/she did not receive her his/showers on an identified date, the unit was short staff.

Record review revealed that resident #002 has a CPS of 0 which indicates intact decision making. Record review revealed that resident #002 is scheduled to receive showers on two identified evenings. Review of the POC documentation revealed that on an identified date, PSW # 152 coded the bathing as not applicable. Interview with PSW # 152 revealed that he/she was assigned to care for the resident on the evening shift on the identified date. PSW # 152 reported that he/she arrived to the home at 4:00pm as he/she was called in to work as the unit was short staff. PSW #152 reported because there was only 2 PSW working on the evening shift instead of the regular schedule of 3 PSW on evening shift, the PSW provided care to the residents, but he/she did not give resident #002 his/her shower that day.

Interview with the Interim DOC revealed that he/she interviewed PSW #152 related to the missed showers, however PSW # 152 informed him/her that he/she provided a bed bath. The inspector and the Interim DOC followed up and spoke to the resident again, where the resident confirmed that he/she did not receive a bed bath nor shower on the identified date. The interim DOC confirmed that resident #002 did not receive his/her showers. [s. 33. (1)]

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**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning**

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

**s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the planned menu items are offered and available at each meal and snack.

During an observation of the snack cart related to a complaint received at the MOHLTC for snack services, the inspector observed on on an identified date of the identified floor snack cart orange juice, coffee, tea and tropical juice on the cart. A review of the Snack delivery Report for the identified date, indicated 125 ml chocolate milk should be on the snack cart.

Interview with PSW #114 who was offering snacks to residents confirmed that chocolate milk was not offered to residents because it was not sent from kitchen on the snack cart. Interview with Dietary Services Supervisor (DSS) Staff # 126 confirmed that the chocolate milk that was written on the snack delivery report was not available for that day and the menu was not updated. [s. 71. (4)]

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**WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information**

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

**s. 79. (3) The required information for the purposes of subsections (1) and (2) is,**
**(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)**
**(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)**
**(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)**
**(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)**
**(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)**
**(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)**
**(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)**
**(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)**
**(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)**
**(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)**
**(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)**
**(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)**
**(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)**
**(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)**
**(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)**
**(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)**
**(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that copies of the inspection reports for the past two year were posted in the home.

During the initial tour of the home on an identified date, the inspector observed that the following inspection report was not posted in the home: 2015_378116_0021 dated December 2, 2015. During an interview with the Interim Director of Care (DOC), he/she found the missing report in the management office and posted the inspection report in the home immediately after it was brought to the DOC's attention. [s. 79. (3) (k)]

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**WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping**

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

**s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,**
**(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:**
**(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,**
**(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and**
**(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that as part of the organized program of housekeeping, procedures were developed and implemented in accordance with manufacturer's specifications, using at a minimum a low level disinfectant in accordance with evidence-based practices and, if there are none, with prevailing practices, for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

On an identified date, the inspector observed resident #001's wheelchair to be visibly soiled. While the inspector was conducting the observation, resident #001’s family member was present in the room and reported to the inspector that the wheelchair was noted to be visibly soiled. The inspector observed resident #001's wheelchair for a period of two days during which the wheelchair continued to be in the same manner and visibly soiled.

The inspector reviewed the wheelchair cleaning schedule for the resident. The wheelchair for resident #001 was scheduled to be cleaned every Friday, and the next scheduled cleaning was on an identified date.

Interview with RN #131 revealed that the wheelchairs are cleaned by the night staff as per schedule and documented on the “wheelchair cleaning schedule” binder which is located in the nursing station. The inspector requested the documentation for resident #001’s prior cleaning schedule, however RN #131 reported that he/she could not find the binder with the documentation for the wheelchair cleaning.

Interview with the Interim DOC, revealed that he/she confirmed that the staff are unable to find the documentation for the residents’ prior wheelchair cleaning, and confirmed that resident #001’s family member reported that resident #001 wheelchair was visibly soiled for a few days, and that it did not appear to be cleaned by the staff. [s. 87. (2) (b)]

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**WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation**
**Every licensee of a long-term care home shall ensure,**
**(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;**
**(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;**
**(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;**
**(d) that the changes and improvements under clause (b) are promptly implemented; and**
**(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a written record of everything provided for in the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents, including the date, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented was promptly prepared.

Record review and interview with the interim DOC revealed that the home's annual evaluation of the prevention of abuse and neglect program for 2016 did not include the date that it was completed. The interim DOC stated that it was completed in January/February 2017. [s. 99. (e)]

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**WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions**

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

**s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,**
**(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).**
**(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).**
**(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, corrective action was taken as necessary, and a written record was kept of everything required under clauses (a) and (b).

Record review of the home's Medication Errors 2016/2017 report and the home's medication incident tracking form/root cause analysis for 2016 indicated a total of 31 medication errors in 2016. Review of the home's medication incident report binder for 2016 with the DOC revealed 38 medication incident reports.

Interview with the DOC revealed that seven medication errors were not reflected in the home's analysis for 2016, and were missed. [s. 135. (2)]

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**WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

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

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

During the initial tour of the home the inspector observed the following:

-Identified unit shower room - Dirty gloves on top of the sink counter and incontinent stool in the toilet. Interview and observation with RPN # 160 confirmed that the dirty gloves should not be left on the counter and the PSW staff are to clean the shower room after use.
- Identified unit shower room – Matted hair left on top of the sink counter. Interview and observation by RPN #111 confirmed that the matted hair should not be left on the sink counter and that PSW staff are to clean the shower room after use.

Interview with the Interim DOC confirmed that the staff did not participate in the infection prevention and control program. [s. 229. (4)]

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**Issued on this 30th day of October, 2017**

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

**Original report signed by the inspector.**

Ontario

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

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

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

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

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

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

## Public Copy/Copie du public

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|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | NICOLE RANGER (189), SLAVICA VUCKO (210), THERESA BERDOE-YOUNG (596) |
| **Inspection No. / No de l'inspection :** | 2017_659189_0016 |
| **Log No. / No de registre :** | 015824-17 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Oct 6, 2017 |
| **Licensee / Titulaire de permis :** | 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP<br>302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8 |
| **LTC Home / Foyer de SLD :** | Deerwood Creek Care Community<br>70 HUMBERLINE DRIVE, ETOBICOKE, ON, M9W-7H3 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Lora Monaco |

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

**Ministére 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

To 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

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 :**

The licensee shall prepare and submit a plan to ensure steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents by identifying and implementing interventions.

The plan shall include, but not limited to the following:

Ensure that resident #003, resident #019, resident #020, and all residents of the home demonstrating responsive behaviors have interventions identified and implemented to minimize potentially harmful interactions between residents.

Ensure that residents demonstrating physically responsive behaviors are identified with strategies to direct staff in the management of the behaviors in each resident's plan of care.

Ensure the importance in monitoring resident #003 and all residents with responsive behaviours to minimize potentially harmful interactions between residents.

Ensure regular evaluation of the effectiveness of the steps taken to mitigate the triggers for responsive behaviours.

Provide education to all staff that enables them to recognize potential triggers and factors of responsive behaviors demonstrated by residents.

The licensee shall maintain a record of re-training provided including dates, times, attendees, trainers and material taught.

The Plan is to submitted by email to nicole.ranger@ontario.ca by October 20, 2017.

**Grounds / Motifs :**

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

On an identified date, the home submitted a Critical Incident System Report (CIS), reporting an allegation of resident to resident abuse. The CIS report stated resident #003 and resident #038 were in the dining room, when resident #038 approached resident #003's table to speak to him/her, when resident #003

suddenly grabbed resident #038's identified body area.

The home also submitted a CIS on an identified date, reporting an incident that occurred between resident #003 and resident #037. The CIS report stated that resident #037 was found on the floor, after he/she was walking in the hallway and resident #003 attempted to grab him/her, where he/she moved away and fell to the floor.

Record review of resident #003's progress notes revealed 5 identified dates where resident #003 demonstrate responsive behaviour with resident #005, #006, #007, #037 and resident #038.

Throughout review of the progress notes from an identified time period, it was noted that resident #003 had made several attempts to inappropriately touch the staff and verbally state inappropriate comments to the staff.

Interview with RN #110, RPN #111 and BSO RPN #141 revealed that the home had identified resident #003 will attempt to touch co residents and staff when left alone in the dining room and in the hallway. The staff stated that the resident is unpredictable and will attempt to touch staff and co residents at any time. The BSO RPN #141 stated that the staff have been instructed to supervise the resident to and from the dining room to avoid leaving him/her alone in the hallway and the dining room as he/she will attempt to grab others.

PSW #140 stated that on an identified date, resident #003 and resident #038 were in the dining room for breakfast. PSW #140 stated that although he/she was in the dining room at the time when resident #003 grabbed resident #038's identified body area, he/she did not witness the incident as he/she was assisting other residents into the dining room. PSW #140 reported to the inspector that he/she is aware that resident #003 should not enter into the dining room first or left unsupervised as he/she will attempt to touch other residents.

PSW #170 stated that he/she is aware that resident #003 will grab other residents when in the hallway and required close monitoring. However, PSW #170 had left resident #003 in the hallway without supervision as he/she needed to check on another resident on his/her assignment when an identified incident happened. PSW #170 reported to the inspector that when he/she came out of the room and found resident #038 on the floor, resident #003 was laughing about the incident.

RPN #111 stated that he/she is aware that resident #003 will grab other residents and attempt to touch when in the hallway and required close monitoring. However, RPN #111 reported that on an identified date, resident #003 was left in the hallway, when he/she suddenly grabbed resident #007's identified body area as he/she approached the PSW who was serving the nourishment. RPN #111 stated that he/she instructed the staff that the resident should not be left alone in the hallway.

PSW #162 stated that he/she is aware that resident #003 will grab other residents when in the hallway and required close monitoring. However, PSW #162 reported that on an identified date, he/she was located in the nursing station and resident #003 was left in the hallway, when suddenly he/she grabbed resident #006's identified body area as he/she passed by.

Interviews with RN #110, RPN #111, BSO RPN #141 stated that providing close supervision with one to one staff had been the most efficient in reducing and preventing the number of interactions between resident #003 and other residents.

Interview with the interim DOC stated that the home had identified that resident #003 needed one to one staff to closely monitor resident #003 in order to prevent him/her from touching co - residents, and that the resident should not be left unattended in the dining room or in the hallway. The interim DOC confirmed that for the five identified incidents that resident #003 touched other residents, one to one staff was initiated on two occasions. A review with the incidents with the interim DOC confirmed that steps were not taken to manage resident #003's responsive behavior to minimize the risk of altercations and potentially harmful interactions between residents. (189)

2. Record review of two identified CIS reports submitted to the MOHLTC reporting an incident of resident to resident abuse between resident #019 and resident #020.

Record review of residents #019 and #020's progress notes indicated the same as mentioned above.

Review of resident #019's MDS assessment indicated a CPS score of 3 indicative of moderate cognitive impairment, and resident #020's MDS

assessment indicated a CPS score of 4 indicative of moderate/severe cognitive impairment.

After the first physical altercation between resident #019 and resident #020, every 15 minute safety checks were started for resident #020; they were already in place for resident #019 due to wandering the hallways and into other residents ' rooms.

Review of resident #019 and resident #020's plans of care included dementia observation system (DOS) monitoring every 15 minutes which started on an identified time period, and every 30 minute monitoring from an identified time period for resident #020.

Review of resident #019's written care plan directed staff to complete every 15 minute safety checks due to responsive behavior with other residents and staff (especially around meal time), and distract him/her from approaching too close to resident #020.

Review of resident #020's written care plan indicated that resident demonstrates responsive behaviour when he/she perceives his/her personal space is invaded and potential of conflict with other residents when they wander near/inside his/her room.

Interview with PSW #144 revealed that he/she was assigned to residents #019 and #020 on an identified date, and both residents were in the dining room for dinner; dinner usually started at 1700 hours. PSW #144 reported that both residents ambulated independently and leave the dining room when they feel like it. They were running late for dinner service and PSW #144 was busy portering residents out of the dining room at around 1815 hours when a co-worker, PSW #145, called him/her about hearing a loud bang coming from resident #020's room. PSW #144 reported that he/she did not know when residents #019 and #020 left the dining room nor their whereabouts at 1815 when his/her co-worker heard the bang coming from resident #020's room. PSW #144 and PSW # 145 went to resident #020's room and discovered an altercation between resident #020 and resident #019. They attempted to separate the two residents with the assistance of the charge nurse RPN #148.

Interview with RPN #148 revealed that he/she was in the dining room on the identified date, and last saw resident #020 in the dining room around 1800

hours. A resident approached him/her around 1810 hours reporting that resident #019 had wandered into his/her room and he/she redirected the resident out of the resident's room and back to his/her room and returned to the dining room to get the medication cart; RPN #148 was not aware of resident #020's whereabouts at that time. According to RPN #148 sometime later he/she heard PSW #144 and #145 yelling from resident #020's room, and when he/she arrived he/she witnessed an altercation between resident #019 and resident #020. Resident #020 was agitated, upset and yelling and also hit PSW #144 as he/she was trying to separate the two residents. RPN #148 stopped the altercation between resident #019 and resident #020. Resident #020 was transferred to hospital on a Form 1 and resident #019 was transferred to hospital for assessment of his/her injuries.

According to the interim DOC, resident #019 and #020 had a previous physical altercation on an identified date as reflected in the CIS submitted by the home, and resident #019's written care plan directed staff to distract resident #019 from approaching too close to resident #020. On the identified date, resident #019 wandered into resident #020's room and a altercation ensued where resident #019 sustained injuries and was transferred to hospital for further assessment. The interim DOC confirmed that staff could have taken more steps to minimize the risk of altercations between resident #019 and resident #020.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.
The home failed to take appropriate actions to manage resident #003, resident #019 and resident #020's responsive behavior to minimize the risk of altercations and potentially harmful interactions between residents.

The scope of the non-compliance is a pattern. (596)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Dec 08, 2017

**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. 19. Duty to protect

**Order / Ordre :**

The licensee shall do the following: to ensure that residents are protected from abuse by resident #003 and resident #020 including during resident to resident altercations.

**Grounds / Motifs :**

1. The licensee has failed to ensure resident #005, resident #006, resident #007, resident #019, resident #037 and resident #038 were protected from abuse by anyone and not neglected by the licensee or staff.

1. The licensee has failed to ensure resident #005, resident #006, resident #007, resident #019, resident #037 and resident #038 were protected from abuse by anyone and not neglected by the licensee or staff.

Record review of two identified CIS reports submitted to the MOHLTC reporting an incident of resident to resident abuse between resident #019 and resident #020.

Record review of residents #019 and #020's progress notes indicated the same as mentioned above.

Review of resident #019's MDS assessment indicated a CPS score of 3 indicative of moderate cognitive impairment, and resident #020's MDS assessment indicated a CPS score of 4 indicative of moderate/severe cognitive impairment.

After the first physical altercation between resident #019 and resident #020, every 15 minute safety checks were started for resident #020; they were already in place for resident #019 due to wandering the hallways and into other residents ' rooms.

Review of resident #019 and resident #020's plans of care included dementia observation system (DOS) monitoring every 15 minutes which started on an identified time period, and every 30 minute monitoring from an identified time period for resident #020.

Review of resident #019's written care plan directed staff to complete every 15 minute safety checks due to responsive behavior with other residents and staff (especially around meal time), and distract him/her from approaching too close to resident #020.

Review of resident #020's written care plan indicated that resident demonstrates responsive behaviour when he/she perceives his/her personal space is invaded and potential of conflict with other residents when they wander near/inside his/her room.

Interview with PSW #144 revealed that he/she was assigned to residents #019 and #020 on an identified date, and both residents were in the dining room for dinner; dinner usually started at 1700 hours. PSW #144 reported that both residents ambulated independently and leave the dining room when they feel like it. They were running late for dinner service and PSW #144 was busy portering residents out of the dining room at around 1815 hours when a co-worker, PSW #145, called him/her about hearing a loud bang coming from resident #020's room. PSW #144 reported that he/she did not know when residents #019 and #020 left the dining room nor their whereabouts at 1815 when his/her co-worker heard the bang coming from resident #020's room. PSW #144 and PSW # 145 went to resident #020's room and discovered an altercation between resident #020 and resident #019. They attempted to separate the two residents with the assistance of the charge nurse RPN #148.

Interview with RPN #148 revealed that he/she was in the dining room on the identified date, and last saw resident #020 in the dining room around 1800 hours. A resident approached him/her around 1810 hours reporting that resident #019 had wandered into his/her room and he/she redirected the resident out of the resident's room and back to his/her room and returned to the dining room to get the medication cart; RPN #148 was not aware of resident #020's whereabouts at that time. According to RPN #148 sometime later he/she heard PSW #144 and #145 yelling from resident #020's room, and when he/she arrived he/she witnessed an altercation between resident #019 and resident

#020. Resident #020 was agitated, upset and yelling and also hit PSW #144 as he/she was trying to separate the two residents. RPN #148 stopped the altercation between resident #019 and resident #020. Resident #020 was transferred to hospital on a Form 1 and resident #019 was transferred to hospital for assessment of his/her injuries.

According to the interim DOC, resident #019 and #020 had a previous physical altercation on an identified date as reflected in the CIS submitted by the home, and resident #019's written care plan directed staff to distract resident #019 from approaching too close to resident #020. On the identified date, resident #019 wandered into resident #020's room and a altercation ensued where resident #019 sustained injuries and was transferred to hospital for further assessment. The interim DOC confirmed that staff could have taken more steps to minimize the risk of altercations between resident #019 and resident #020.

2. On an identified date, the home submitted a Critical Incident System Report (CIS), reporting an allegation of resident to resident abuse. The CIS report stated resident #003 and resident #038 were in the dining room, when resident #038 approached resident #003's table to speak to him/her, when resident #003 suddenly grabbed resident #038's identified body area.

The home also submitted a CIS on an identified date, reporting an incident that occurred between resident #003 and resident #037. The CIS report stated that resident #037 was found on the floor, after he/she was walking in the hallway and resident #003 attempted to grab him/her, where he/she moved away and fell to the floor.

Record review of resident #003's progress notes revealed 5 identified dates where resident #003 demonstrate responsive behaviour with resident #005, #006, #007, #037 and resident #038.

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BSO RPN #141 stated that the staff have been instructed to supervise the resident to and from the dining room to avoid leaving him/her alone in the hallway and the dining room as he/she will attempt to grab others.

PSW #140 stated that on an identified date, resident #003 and resident #038 were in the dining room for breakfast. PSW #140 stated that although he/she was in the dining room at the time when resident #003 grabbed resident #038's identified body area, he/she did not witness the incident as he/she was assisting other residents into the dining room. PSW #140 reported to the inspector that he/she is aware that resident #003 should not enter into the dining room first or left unsupervised as he/she will attempt to touch other residents.

PSW #170 stated that he/she is aware that resident #003 will grab other residents when in the hallway and required close monitoring. However, PSW #170 had left resident #003 in the hallway without supervision as he/she needed to check on another resident on his/her assignment when an identified incident happened. PSW #170 reported to the inspector that when he/she came out of the room and found resident #038 on the floor, resident #003 was laughing about the incident.

RPN #111 stated that he/she is aware that resident #003 will grab other residents and attempt to touch when in the hallway and required close monitoring. However, RPN #111 reported that on an identified date, resident #003 was left in the hallway, when he/she suddenly grabbed resident #007's identified body area as he/she approached the PSW who was serving the nourishment. RPN #111 stated that he/she instructed the staff that the resident should not be left alone in the hallway.

PSW #162 stated that he/she is aware that resident #003 will grab other residents when in the hallway and required close monitoring. However, PSW #162 reported that on an identified date, he/she was located in the nursing station and resident #003 was left in the hallway, when suddenly he/she grabbed resident #006's identified body area as he/she passed by.

Interviews with RN #110, RPN #111, BSO RPN #141 stated that providing close supervision with one to one staff had been the most efficient in reducing and preventing the number of interactions between resident #003 and other residents.

Interview with the interim DOC stated that the home had identified that resident #003 needed one to one staff to closely monitor resident #003 in order to prevent him/her from touching co - residents, and that the resident should not be left unattended in the dining room or in the hallway. The interim DOC confirmed that for the five identified incidents that resident #003 touched other residents, one to one staff was initiated on two occasions. A review with the incidents with the interim DOC confirmed that steps were not taken to manage resident #003's responsive behavior to minimize the risk of altercations and potentially harmful interactions between residents.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual harm experienced by six residents. The scope of the non-compliance is a pattern. A review of the Compliance History revealed the following non-compliances related to LTCHA, 2007 s. 19. In October 2014, the home was issued a Voluntary Plan of Correction for failing to comply with LTCHA 2007, s. 19 in that the home did not protect a resident from abuse within report 2014_306510_0024 (189)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Dec 08, 2017

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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)<br>151, rue Bloor Ouest, 9e étage<br>Toronto ON M5S 2T5 | Directeur<br>a/s du coordonnateur/de la coordonnatrice en matière d'appels<br>Direction de l'inspection des foyers de soins de longue durée<br>Ministère de la Santé et des Soins de longue durée<br>1075, rue Bay, 11e étage<br>Toronto ON M5S 2B1<br>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 6th day of October, 2017**

**Signature of Inspector /**
**Signature de l'inspecteur :**

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

**Ministére 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

**Name of Inspector /**
**Nom de l'inspecteur :** NICOLE RANGER

**Service Area Office /**
**Bureau régional de services :** Toronto Service Area Office