Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 31, 2019	2019_725522_0017	019616-19, 019650-19	Critical Incident System

Licensee/Titulaire de permis

Steeves & Rozema Enterprises Limited
265 North Front Street Suite 200 SARNIA ON N7T 7X1

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

Westmount Gardens Long Term Care Home
590 Longworth Road LONDON ON N6K 4X9

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

JULIE LAMPMAN (522)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 1, 4, 5, 6, 7, 8, 12, 13, 14, 20, 21, 22, 25, 2019.

The following intakes were inspected:
Critical Incident System (CIS) report #2878-000032-19/Log #019650-19 related to resident to resident abuse;
CIS #2878-000030-19/Log#019616-19 related to resident neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Resident Care, the Assistant Manager of Resident Care, the Manager of Life Enrichment, the Nurse Practitioner, Registered Nurses (RN), a Behavioural Supports Ontario (BSO) RN, Registered Practical Nurses, the Resident Assessment Instrument Coordinator, Personal Support Workers (PSWs), BSO PSWs, a Social Worker, a Social Service Worker, a Physiotherapist Aide, a Restorative Care Aide, a Housekeeper, a London Police Detective and residents.

The inspector also observed staff to resident and resident to resident interactions, observed the provision of resident care, reviewed resident clinical records, medication incidents, training records, program evaluations and policies and procedures related to the inspection.

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

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

Observation of a resident #007's room noted specific interventions in place to prevent people from entering the resident's room.

In an interview, resident #007 stated they had requested the interventions about a year ago.

A review of resident 007's electronic progress notes indicated that resident #007 requested the interventions.

A review of resident #007's electronic care plan and kardex in Point Click Care (PCC) noted no reference to the use of the interventions for safety.

In an interview, Registered Practical Nurse (RPN) #110 confirmed the use of the interventions were not in resident #007's plan of care or kardex. RPN #110 stated registered staff were responsible to update a resident's care plan and kardex when new

interventions were added.

In an interview, Manager of Resident Care (MRC) #100 stated the use of the interventions should be included in a resident's plan of care.

The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident. [s. 6. (2)]

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

Resident records were reviewed for two residents to expand the scope related to turning and repositioning.

A) Review of resident #010's kardex noted resident #010 was to be turned and repositioned every two hours.

Review of the Documentation Survey report in PCC for resident #010 for a specific time frame noted documentation was absent for turning and repositioning on four shifts.

In an interview, MRC #100 stated turning and repositioning should be documented in Point of Care for a resident.

MRC #100 reviewed the Documentation Survey report with inspector and confirmed the absence of documentation related to turning and repositioning resident #010.

B) Review of resident #011's plan of care noted resident #011 was to be turned and repositioned every two hours.

Review of the Documentation Survey report in PCC noted the absence of documentation that resident #011 was turned and repositioned during specific time frames on a specific date.

In an interview, MRC #100 stated turning and repositioning should be documented in Point of Care for a resident.

MRC #100 reviewed the Documentation Survey report with inspector and confirmed the absence of documentation related to turning and repositioning resident #011.

C) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care (MLTC) related to an incident of suspected abuse involving resident #001 to resident #002.

i) Review of resident #001’s electronic progress notes in PCC noted a Personal Support Worker (PSW) witnessed an incident of suspected abuse involving resident #001 to resident #002.

In an interview, Registered Nurse (RN) #111 stated interventions were currently in place to monitor resident #001.

In an interview, PSW #117 stated there were interventions in place to monitor resident #001 and the PSW was to document the interventions at specific time frames.

Review of resident #001's documentation of interventions over a specific seven day period noted the absence of documentation during specific time frames on five out of seven days.

In an interview, RPN #110 confirmed that charting for resident #001 had not been completed as required and PSWs were to chart at specific time frames for resident #001.

Review of documentation of interventions for resident #001 for a 30 day period noted the absence of documentation for a specific 24 hour period.

ii) Further review of resident #001's progress notes noted two previous incidents with resident #002. After each incident specific interventions were put in place for resident #001.

In an interview, Behavioural Supports Ontario (BSO) PSW stated they were unable to find documentation of the specific interventions for resident #001 that were initiated related to incidents with resident #002.

In an interview, Manager of Resident Care (MRC) #100 confirmed missing documentation for resident #001 on a specific date. MRC #100 stated documentation of the specific interventions should be completed at specific time frames for resident #001.

Inspector reviewed documentation for an specific eight day period that MRC #100 had

given inspector on a specific date. When the documentation was compared to the documentation that had been given to inspector by RPN #110 six days earlier, all the missing documentation had been completed. MRC #100 stated that they had asked staff to complete the missing documentation. When inspector asked how staff could remember what resident #001 was doing weeks after the fact, MRC #100 stated resident #001 was consistent in their behaviour and routine.

The licensee has failed to ensure that the provision of the care set out in the plan of care was documented. [s. 6. (9) 1.]

3. The licensee has failed to ensure that the resident was reassessed, and the plan of care reviewed and revised at least every six months and at any other time when the resident’s care needs changed or care set out in the plan was no longer necessary.

A) CIS was submitted by the home to the Ministry of Long-Term Care regarding staff to resident neglect related to a complaint from resident #009’s family member.

A review of the email complaint noted that resident #009’s family member was concerned that staff were not turning and repositioning resident #009 every two hours and staff had not given resident #009 appropriate treatment as ordered.

i) Review of resident #009's doctor's orders noted resident #009 was ordered a specific treatment intervention and a specific route of medication administration.

Review of resident’s progress notes noted resident #009 had required the specific treatment intervention over the course of 10 days.

In an interview, Registered Practical Nurse (RPN) #123 stated that resident #009 received a specific treatment intervention and a specific route of medication administration.

In an interview, RPN #126 stated resident #009 was receiving a specific treatment intervention and the intervention should be indicated in the resident’s electronic Medication Administration Record (eMAR).

In an interview, Registered Nurse (RN) #128 stated that resident #009 required a specific route for medication administration. RN #128 stated registered staff who processed the doctor's orders were responsible to ensure the orders for specific treatment interventions

were documented on a resident’s eMAR.

Review of resident #009’s eMAR and electronic Treatment Administration Record (eTAR) noted no documentation that resident #009 had a specific treatment intervention and a specific route of medication administration in place as ordered.

In an interview, Manager of Resident Care (MRC) #100 stated that the specific treatment intervention and the specific route of medication administration should be documented on a resident’s eTAR and registered staff should sign that they have administered the interventions. MRC #100 confirmed the specific treatment intervention and the specific route of medication administration were not indicated on resident #009’s eMAR or eTAR.

ii) Review of resident #009’s plan of care noted no documentation in resident #009’s care plan or kardex related to turning and repositioning. Resident #009’s most recent care plan noted resident #009 required no assistance for bed mobility.

Review of resident #009’s electronic clinical record in PCC noted resident #009 required extensive assistance with bed mobility.

A review of resident #009’s electronic progress notes in PCC noted an entry on a specific date, that indicated resident #009’s family member was upset as resident #009 was not repositioned frequently enough. The progress note indicated the Registered Practical Nurse (RPN) reminded staff that resident #009 was to be repositioned every two hours.

In an interview, Personal Support Worker (PSW) #124 stated if a resident needed to be turned and repositioned, they would find that information on Point of Care (POC) tasks for the resident.

In an interview, RPN #122 stated that on a specific date, resident #009’s family member had expressed concern to them that resident #009 had not been repositioned. RPN #122 stated they had entered a note in resident #009’s eMAR for registered staff to remind PSW staff to turn and reposition resident #009. RPN #122 stated they did not enter turning and repositioning in POC tasks for the PSWs.

In an interview, MRC #100 stated that registered staff were responsible to update a resident’s care plan and the Resident Assessment Instrument (RAI) Coordinator was responsible to enter tasks in POC for the PSWs. MRC #100 confirmed that turning and repositioning was not on resident #009’s care plan or kardex. MRC #100 stated staff

should know that the resident would need to be turned every two hours.

In an interview, MRC #100 stated that resident #009 would have had comfort rounds in place and staff would be responsible to check hourly if resident #009 needed to be turned and repositioned. MRC #100 provided inspector with resident #009’s Comfort Care Rounds Log for a specific time frame which staff initialled hourly that they asked the resident if they needed to be repositioned for comfort or prevention of skin breakdown.

B) Review of resident #010's doctor's orders noted resident #010 was ordered specific medication to be administered by a specific route.

Review of resident #010’s progress notes noted that resident #010 required a specific treatment intervention over the course of several hours. Review of resident #010's eMAR noted no documentation that the specific treatment intervention was administered.

In an interview, Registered Nurse (RN) #128 stated registered staff who processed the doctor's orders were responsible to ensure the orders were documented on a resident’s eMAR.

Review of resident #010’s eMAR and eTAR noted no documentation that the specific route of medication administration for resident #010 had been initiated.

In an interview, MRC #100 stated that registered staff should document the specific route of medication administration on a resident’s eTAR. MRC #100 reviewed resident #010’s eTAR and eMAR and confirmed the specific route of medication administration was not documented on resident #010’s eMAR or eTAR.

C) Resident #011was ordered a specific treatment intervention and a specific route of medication administration.

Review of resident #011’s progress notes noted resident #011 required the specific treatment intervention for four days.

In an interview, Registered Nurse (RN) #128 stated registered staff who processed the orders were responsible to ensure the orders for the specific treatment intervention and specific route of medication administration were documented on a resident’s eMAR.

Review of resident #011’s eMAR and eTAR noted no documentation that resident #011

was ordered a specific treatment intervention and a specific route of medication administration.

In an interview, Manager of Resident Care (MRC) #100 stated that the specific treatment intervention should be documented on a resident's eTAR and registered staff should sign that they have administered the specific treatment intervention.

In an interview, MRC #100 stated that registered staff should document a specific route of medication administration on a resident's eTAR. MRC #100 reviewed resident #011's eTAR and eMAR and confirmed the specific treatment intervention and specific route of medication administration was not documented on resident #010's eMAR or eTAR.

The licensee has failed to ensure that the resident was reassessed, and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary. [s. 6. (10) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 comply with s. 24 (1) 2, in that a person who had reasonable grounds to suspect abuse of a resident, failed to report the alleged abuse immediately to the Director in accordance with s. 24 (1) 2 of the LTCHA.

Pursuant to LTCHA 2007, s. 152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

A) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care (MLTC) related to an incident of suspected abuse involving resident #001 to resident #002.

Review of the CIS report noted a Personal Support Worker (PSW) had a report from another team member that they had witnessed an incident of suspected abuse involving resident #001 to resident #002.

In an interview, Registered Nurse (RN) #111 stated if they suspected or witnessed an incident of abuse of a resident they would report the incident to management right away and then follow management's instructions of what they needed to do.

In an interview, Registered Practical Nurse (RPN) #113 stated if they witnessed a potential abusive interaction between residents they would stop the interaction, remove the resident and sit with resident that was upset. RPN #113 stated they would try to find out what happened from the resident, but some residents could not always tell them. RPN #113 stated they would also talk to the other resident involved. RPN #113 stated they would complete risk management, safety checks on the resident, call families and management and document the incident in a progress note. RPN #113 stated if the Social Worker and RN were in the building, they would call them.

In an interview, PSW #125 stated if they suspected or witnessed an incident of abuse of a resident, they would report it immediately to registered staff.

In an interview, MRC #100 stated if staff witnessed or were informed of an incident of suspected, alleged or witnessed abuse they expected staff to make sure the resident was safe and report the incident immediately. The RPN would report to the RN who would report to the manager or oncall manager. If after hours staff would report to Ministry of Long-Term Care after hours line, submit CIS and notify families depending on

the Cognitive Performance Score (CPS) score of the resident. MRC #100 stated the key was to make sure the resident was safe and the effect it had on the resident was first and foremost. MRC #100 stated the CIS report was submitted either by the MRC or Administrator.

Review of resident #002's electronic progress notes in Point Click Care (PCC) noted two previous incidents of suspected abuse with resident #001.

i) In an interview, Manager of Resident Care (MRC) #100 stated they could not recall the first incident and if it was investigated. MRC #100 stated if there were any signs of distress resident #001 and resident #002 would have been separated. MRC #100 stated they would need to find their notes related to the incident.

MRC #100 reviewed their hand written notes in their notebook with inspector. MRC #100's note did not indicate a date. MRC #100 stated they could not recall how they became aware of the incident, but they did speak to resident #001 about the incident with resident #002.

MRC #100 stated they did not suspect anything had happened which is why they did not submit a CIS report.

In an interview, Administrator #112 reviewed resident #002's progress notes related to the first incident with resident #001. Administrator #112 stated in reviewing resident #002's progress notes the incident could fall under the definition of abuse, but they had not interviewed the staff regarding the incident therefore it was hard to determine. Administrator #112 stated the incident was hard to recall and in reviewing resident #002's progress notes the incident could fall under what should be reported to the MLTC.

ii) In an interview, MRC #100 stated they vaguely remembered the second incident between resident #001 and resident #002 and would need to review their notes.

MRC #100 gave inspector copies from MRC #100's note book related to the second incident. Review of notes with MRC #100 noted two point form lines related to the incident which indicated that resident #002 had safety checks in place and Administrator #112 would call resident #002's Power of Attorney and that resident #001 was being monitored.

MRC #100 stated those were their only notes related to the second incident between resident #001 and resident #002. MRC #100 stated that a CIS report had not been submitted to the MLTC.

In an interview, Administrator #112 stated the second incident between resident #001 and resident #002 could have been considered suspected abuse and should have been reported to the MLTC.

iii) Review of resident #001's electronic progress notes in PCC noted a third incident of suspected abuse towards resident #002.

Review of resident #002's progress notes noted no documentation related to the third incident with resident #001.

In an interview, MRC #100 stated they did not recall the third incident between resident #001 and resident #002. MRC #100 stated they did not have any investigative notes related to the incident but they had noted the incident in their note book. MRC #100 stated they noted there was no documentation in resident #002's progress notes related to the incident.

Review of MRC #100's hand written notes related to the incident between resident #001 and resident #002 noted two point form lines which noted the incident with resident #001 and that there was no documentation in resident #002's progress notes.

In an interview, Administrator #112 stated they were not aware of the third incident between resident #001 and resident #002. Administrator #112 stated the incident would fall under the definition of abuse. Administrator #112 stated it was possible the incident should have been reported to the MLTC.

B) Review of resident #001's electronic progress notes in Point Click Care (PCC) noted an incident of suspected abuse between resident #001 and resident #006.

A review of Long-Term Care Homes.net noted no Critical Incident System reports related to the incident between resident #001 and resident #006.

In an interview, Registered Nurse #111 stated they did not recall the incident between resident #001 and #006. RN #111 stated if an incident of suspected abuse was reported to them, they would follow up immediately and assess the resident for safety. RN #111

stated they would be responsible to report any suspected abuse to management. RN #111 stated management should be aware of the incident between resident #001 and resident #006 as the Resident Care Coordinator was the person who had documented the incident in the resident's progress notes. RN #111 stated after an incident such as what occurred between resident #001 and #006, staff would initiate safety checks for the victim to ensure they were not in any distress and they would also initiate DOS tracking for the aggressor.

In an interview, RPN #123, who worked full time on the home area stated they did not recall the incident between resident #001 and resident #006.

In an interview, MRC #100 stated that they did not recall the incident between resident #001 and resident #006. MRC #100 stated based on resident #006’s progress note it had been reported to the Resident Care Coordinator.

In an interview, Administrator #112 stated they were aware of the incident between resident #001 and resident #006. Administrator #112 stated if the incident happened as was reported then it would be considered abuse and should have been reported to the Ministry of Health and Long-Term Care.

C) Review of resident #001's electronic progress notes in PCC noted an incident of suspected abuse between resident #001 and resident #008.

A review of resident #008’s progress notes noted no documentation related to the incident with resident #001.

In an interview, Registered Practical Nurse (RPN) #104 reviewed resident #001’s progress notes and stated they did not witness the incident between resident #001 and resident #008. RPN #104 stated Physiotherapy Aide (PTA) #119 had reported the incident to them. RPN #104 stated they could not remember the incident and could not recall if resident #008 was in distress after the incident. RPN #104 acknowledged that they had not documented the incident and any follow up with resident #008 in the resident’s progress notes.

In an interview, PTA #119 stated they witnessed the incident of suspected abuse between resident #001 and resident #008. PTA #119 stated they notified the RPN and a Personal Support Worker came and removed resident #008 from the area.

In an interview, MRC #100 stated if staff received a report of suspected, alleged or actual abuse to a resident they would expect staff to ensure the resident was safe and registered staff should report the incident to management immediately. MRC #100 stated the incident would be reported to the Ministry of Long-Term Care and the resident’s family depending on the CPS score of the resident. MRC #100 stated if an incident occurred after hours the registered nurse was responsible to call the after-hours line to report the incident and the Administrator and MRC were responsible to submit the Critical Incident System reports to the Ministry of Long-Term Care.

MRC #100 stated they did not recall the incident between resident #001 and resident #008 and they did not have any notes related to the incident.

In an interview, Administrator #112 stated they did not recall the incident between resident #001 and resident #008 and they did not have any notes related to the incident.

Administrator #112 reviewed resident #001’s progress notes related to the incident. Administrator #112 stated based on the definition of abuse they would consider this an incident of suspected abuse and the incident should have been reported to management.

D) In an interview, Personal Support Worker (PSW) #101 stated there had been an incident of suspected abuse between resident #001 and resident #004.

A review of resident #004’s electronic progress notes noted the MRC was notified of the incident. Review of MRC's documentation in resident #004's progress notes noted they had spoken to resident #004 about the incident and notified resident #004’s Power of Attorney of the incident.

In an interview, Registered Practical Nurse (RPN) #115 stated they were working when the incident between resident #001 and resident #004 occurred. RPN #115 stated a PSW had reported to the RPN that they had witnessed an incident of abuse between resident #001 and resident #004.

In an interview PSW #118 stated they had observed resident #001 and resident #004 together and then resident #004 had come to them visibly upset and shaken.

In an interview, Registered Nurse (RN) #111 stated they recalled the incident between resident #001 and resident #004. RN #111 stated they saw both residents together and had watched them for about five minutes. RN #111 stated at that time they did not

witness any abuse, but RN #111 stated they did witness resident #004 become visibly upset shortly after. RN #111 stated they put safety checks in place for resident #004 due to resident #001’s history as they were unsure if something might have happened.

In an interview, MRC #100 stated they recalled the incident between resident #001 and resident #004 as they had investigated the incident. MRC #100 stated they had no findings related to abuse. MRC #100 stated they did not report the incident to the Ministry of Long-Term Care (MLTC). MRC #100 acknowledged resident #004 was upset after the incident but they did not consider the incident suspected abuse and felt staff had led resident #004 to become upset as they were comforting them at the nurses’ station.

When asked by inspector, MRC #100 acknowledged that staff had reported the incident to them as staff had suspected abuse had occurred.

In an interview, Administrator #112 acknowledged they were aware of the incident between resident #001 and resident #004. Administrator #112 stated they did not feel the incident needed to be reported to the MLTC as the incident was looked into and resident #004 could often be emotionally labile.

E) Review of resident #001's electronic progress notes in PCC noted an incident of suspected abuse between resident #001 and resident #003.

Review of resident #003’s progress notes noted no documentation related to the incident. Further review of resident #003’s progress notes noted several incidents of suspected abuse involving resident #001 over the course of two days. Resident #003's progress notes indicated that resident #003 had not been well during this time and resident #003 had displayed a change in mood after the incidents and indicated they did not want to be near resident #001.

In an interview, Registered Practical Nurse (RPN) #110 stated a staff member had made them aware of the incident between resident #001 and resident #003. RPN #110 stated resident #003 had told them they did not want to be near resident #001.

In an interview, Personal Support Worker (PSW) #120 stated they had witnessed an incident of suspected abuse between resident #001 towards resident #003.

PSW #120 stated they reported the incident to registered staff who assessed resident #003.

In an interview RPN #113 stated that a PSW had reported the incident between resident #001 and resident #003 to them. RPN #113 stated they went straight to resident #003 and called the Registered Nurse (RN). RPN #113 stated they then tried to talk to resident #003 to find out what happened but it was difficult. RPN #113 stated resident #003 seemed fine and did not appear hurt.

In an interview, RN #128 stated they attended resident #003's room after the incident between resident #001 and resident #003. RN #128 stated they were certain they had informed the oncall manager but they were unsure as they did not document the incident and notification of management in resident #003's progress notes.

In an interview, MRC #100 stated they did not remember the incident between resident #001 and resident #003.

Review of MRC #100's hand written notes in MRC #100's notebook for the day after the incident noted a point form line indicating resident #003 had been visibly upset the day after an incident with resident #001 and that resident #003 did not want resident #001 to be near them.

In an interview, Administrator #112 stated they had read the incident in report and they had spoken to resident #001 about the incident. Administrator #112 stated the incident did fit under the definition of suspected abuse and should have been reported to the MLTC.

The licensee has failed to comply with s. 24 (1) 2, in that a person who had reasonable grounds to suspect abuse of a resident, failed to report the alleged abuse immediately to the Director in accordance with s. 24 (1) 2 of the LTCHA. [s. 24. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker and any other person specified by the resident were notified immediately upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident caused distress to the resident that could potentially be detrimental to the resident"s health or well-being.

A) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care (MLTC) related to an incident of suspected abuse involving resident #001 to resident #002.

In an interview, Registered Practical Nurse (RPN) #110 stated if they witnessed or were told of an incident of suspected or alleged abuse of a resident, they would contact a resident’s family. RPN #110 stated it would depend on the situation as management would decide when family would be notified.

In an interview, Registered Practical Nurse #113 stated if they witnessed an interaction of suspected abuse between residents they would call the residents’ families and management.

In an interview, Registered Nurse (RN) #111 stated if they suspected or witnessed an incident of abuse of a resident, they would report the incident to management right away and then follow management’s instructions of what they needed to do.

Review of resident #002’s electronic progress notes in Point Click Care (PCC) noted two previous incidents of suspected abuse involving resident #001.

i) Review of resident #002's progress notes noted the Assistant Manager of Resident Care (AMRC) was notified of the first incident.

Review of resident #002's electronic progress notes noted no documentation that resident #002's substitute decision-maker (SDM) was notified of the incident.

Review of a risk management report noted the incident between resident #001 and resident #002. The risk management report did not indicate that resident #002's SDM was notified of the incident.

In an interview, Manager of Resident Care (MRC) #100 stated they had made a note in their note book that they had contacted resident #002’s SDM regarding the incident. MRC #100 acknowledged that they did not document notification of the SDM in resident #002’s progress notes.

ii) Review of resident #002's progress notes indicated that the registered nurse was notified of the second incident of suspected abuse. Resident #002's progress notes indicated resident #002's POA was contacted two days after the incident of suspected abuse.

In an interview, Administrator #112 stated they had contacted resident #002’s SDM two days after the incident, and documented this in resident #002’s progress notes.

iii) Review of resident #001’s electronic progress notes in PCC noted a third incident of suspected abuse involving resident #001 to resident #002.

Review of resident #002’s progress notes noted no documentation related to the incident of suspected abuse from resident #001 or that resident #002's SDM had been notified of the incident.

In an interview, MRC #100 stated they did not recall the incident between resident #001 and resident #002 but they had noted the incident in their note book.

Review of MRC #100’s hand written notes related to the incident between resident #001 and resident #002 noted two point form lines which noted the incident with resident #001

and that there was no documentation in resident #002's progress notes.

In an interview, Administrator #112 stated they were not aware of the incident between resident #001 and resident #002. Administrator #112 stated resident #002’s SDM should have probably been notified of the incident.

B) Review of resident #001’s electronic progress notes in PCC noted and incident of alleged abuse involving resident #001 to resident #006.

A review of resident #006's progress notes noted no documentation that their SDM was notified of the incident of alleged abuse.

In an interview, Administrator #112 acknowledged that registered staff should have notified resident #006’s SDM and documented this in resident #006’s progress notes.

C) A review of resident #001’s electronic progress notes in PCC noted an incident of suspected abuse involving resident #001 to resident #008.

A review of resident #008’s progress notes noted no documentation related to the incident with resident #001. There was no documentation to support that resident #008’s SDM was notified of the incident.

In an interview, Registered Practical Nurse (RPN) #104 reviewed resident #001’s progress notes and stated they did not witness the incident between resident #001 and resident #008. RPN #104 stated Physiotherapy Aide (PTA) #119 had reported the incident to them. RPN #104 stated they could not remember the incident and could not recall if resident #008 was in distress after the incident. RPN #104 acknowledged that they had not documented the incident and any follow up with resident #008 in the resident’s progress notes.

In an interview, Administrator #112 stated the resident #008's SDM should have been notified of the incident of suspected abuse involving resident #008.

The licensee has failed to ensure that the resident's substitute decision-maker and any other person specified by the resident were notified immediately upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident caused distress to the resident that could potentially be detrimental to the resident"s health or well-being. [s. 97. (1) (a)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care (MLTC) regarding staff to resident neglect related to a complaint from resident #009's family member.

A review of the email complaint noted concerns that staff were not monitoring resident #009 when they were taking their medications as resident #009's family member had found two of resident #009's pills on resident #009's floor.

Review of Silver Fox's Medication Incident Form noted a dose omission occurred for resident #009 and queried that pills were left at resident #009's bedside and dropped. The Medication Incident Form noted that resident #009's family member informed Registered Practical Nurse (RPN) #123 that they had found two of resident #009's pills on resident #009's floor. Resident #009's family member gave the RPN the pills. The Medication Incident Form noted the incident did not reach the resident and there was no harm to the resident. Action was noted that staff were to assist resident #009 with their medication and if the medication was dropped and staff were unable to locate the medication, staff were to make a note so other staff were aware. Staff were to stay with resident #009 to ensure they had swallowed their medication.

In an interview, Manager of Resident Care (MRC) #100 stated they did not know if resident #009 had received or missed their dose of the two medications.

Review of the home's medication incidents for a specific time frame noted the following:

B) Review of Silver Fox's Medication Incident Form noted resident #012 was administered a medication twice instead of once as ordered. There was no harm noted to the resident. Contributing factor was noted as wrong instructions in the electronic Medication Administration Record.

C) Review of Silver Fox's Medication Incident Form noted resident #013's dose of a specific medication had been decreased. Several days later, it was discovered that resident #013 had received three of the lower doses of the medication then continued to receive the previous higher dose. Contributing factor was noted as the order had not been faxed to pharmacy.

In an interview, MRC #100 acknowledged that residents #011 and #012 did not receive their medications as prescribed.

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence.

A) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care (MLTC) related to an incident of suspected abuse involving resident #001 to resident #002.

Review of review of resident #002's electronic progress notes in Point Click Care (PCC) noted a previous incident of suspected abuse involving resident #001.

In an interview, Administrator #112 stated the incident involving resident #001 to resident #002 could be considered abuse. Administrator #112 stated the police were not called regarding this incident.

B) A review of resident #001's electronic progress notes noted an incident of suspected abuse involving resident #001 to resident #003.

In an interview, Administrator #112 stated that the incident between resident #001 and resident #003 could have crossed the threshold and should have been reported to the police.

The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. [s. 98.]

Additional Required Actions:

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

WN #6: 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. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

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 every medication incident involving a resident was reported to the resident's substitute decision-maker.

Review of Silver Fox's Pharmacy Medication Incident Form noted resident #013's dose of a specific medication had been decreased. Several days later, it was discovered that resident #013 had received three of the lower doses of the medication then continued to receive the previous higher dose.

Further review of the Medication Incident form noted resident/POA had a check mark that they were notified but there was no documentation under name, date and time to indicate who was notified and when they were notified. Review of resident #013's progress notes noted no documented evidence that resident #013's POA was notified of the medication incident.

In an interview, Manager of Resident Care #100 confirmed that there was no documentation to support that resident #013's POA was notified on the medication

incident form and resident #013's progress notes. MRC #100 stated resident #013's spouse was in every day to visit so they should have been aware.

The licensee has failed to ensure that every medication incident involving a resident was reported to the resident's substitute decision-maker. [s. 135. (1)]

2. The licensee has failed to ensure that all medication incidents were documented, corrective action was taken as necessary and a written record was kept of everything.

Review of S&R's "Medication Incident" policy RCM 17-09 with a revision date of January 16, 2019, noted in part:

"Category C - I Medication Incidents – Error that reaches the resident (harm or no harm):

Documentation of the medication incident of any actions or interventions implemented will be recorded on the medication incident form, and in the resident's chart on PCC. Include in the charting what medication was given/omitted and physician notified, interventions required, and outcomes for the resident.

All incident reports will be reviewed and analyzed by the MRC/designate. The MRC designate will investigate each incident considering the context of the medication incident and the practice of the nurse(s) involved to determine the education, individual assistance and potential performance management.

The MRC/designate will implement a follow up plan with corrective action which may include medication system process review, seeking individual assistance, participating in in-service education or pursuing more formal continuing education."

A) Review of Silver Fox's Medication Incident Form noted a dose omission occurred for resident #009 and queried that pills were left at resident #009's bedside and dropped. The Medication Incident Form noted that resident #009's family member informed Registered Practical Nurse (RPN) #123 that they had found two of resident #009's pills on the floor in resident #009's room. Resident #009's family member gave RPN #123 the pills.

Review of resident #009's electronic Medication Administration Record (eMAR) noted resident #009 received the two medications daily at 0800 hours. The two medications had been discontinued on a specific date and then restarted four days later.

In an interview, RPN #123 stated that resident #009's family member had informed them that they had found the pills on the floor in resident #009's room and gave the pills to RPN #123. RPN #123 stated they did not ask the family member exactly where they had found the pills. RPN #123 stated they had entered a note for registered staff to watch resident #009 take their pills.

In an interview, MRC #100 stated they did not know if resident #009 had received or missed their dose of the two medications. When asked by inspector, MRC #100 stated they did not follow up with resident #009's family member about where they had located the pills. MRC #100 stated they did not speak to any of the registered staff on previous shifts to determine what had happened. MRC #100 stated there would have been no way to know how long the pills had been on the floor.

MRC #100 stated they had reviewed with registered staff at huddle that staff were to stay with resident #009 to ensure they had swallowed their pills.

B) Review of Silver Fox's Medication Incident Form noted resident #012 was administered a medication twice instead of once as ordered.

In an interview, RPN #123 stated that when new medication orders were received two nurses would complete separate checks of the orders against the eMAR to ensure they were correct in the eMAR. RPN #123 stated they would not necessarily enter a medication incident in a resident's progress notes unless there was harm to the resident. RPN #123 stated if the medication incident reached the resident but there was no harm they would not enter the medication incident into the resident's progress notes, they would only complete a medication incident form.

Review of resident #012's physician's orders noted an order for a specific medication to be administered to resident #012 one time only. Further review of the physician's orders noted the eMAR verification was checked and signed by two separate registered staff.

Review of resident #012's eMAR noted the specific medication was to be given every shift for one day. The medication was signed as given on two shifts on a specific date.

Review of resident #012's electronic progress notes in Point Click Care (PCC) noted no documentation related to the medication incident.

In an interview, MRC #100 stated they had spoken with the RN who had given the first dose of the medication and determined that the Registered Nurse had signed the eMAR but had not entered the administration of the drug in resident #012’s progress note as was the home’s practice. MRC #100 stated they had also spoken to the RN who had written the order for resident #012 and entered it in the eMAR. MRC #100 stated they could not recall which staff member had administered the second dose of medication and reviewed the signatures on resident #012’s eMAR. MRC #100 stated they had not spoken to the RPN who administered the second dose of medication as they were following what was in the eMAR. When asked by inspector, MRC #100 stated they did not know which nurses had completed the first and second check of the orders against the eMAR and questioned why inspector had asked who the staff were. When inspector indicated that registered staff were to check the order against the eMAR to ensure the eMAR was correct. MRC #100 stated they were not sure why the error was not caught during the checks.

When asked by inspector if medication incidents should be documented in a resident’s progress notes, MRC #100 stated “yes and no.” MRC #100 stated a medication incident with dilaudid would absolutely need to be documented in the resident’s progress note, but something on the pharmacy end that did not reach the resident they would look at that as situational.

C) Review of Silver Fox's Medication Incident Form noted resident #013’s dose of a specific medication had been decreased. Several days later, it was discovered that resident #013 had received three of the lower doses of the medication then continued to receive the previous higher dose. Contributing factor was noted as the order had not been faxed to pharmacy. An improvement strategy was noted as, “reviewed placing sticker on med strip at huddle.”

In an interview, RPN #123 stated if a medication order was changed or discontinued the registered staff that processed the order would fax the order to pharmacy and put a change sticker on the resident’s medication strip.

Review of Silver Fox Pharmacy LTC Prescriber’s Order Form for resident #013 noted a telephone order was received to change resident #013’s medication to a lower dose. The order noted initials that pharmacy was faxed. There were no initials beside “change sticker.”

Review of resident #013’s eMAR noted the higher dose of the specific medication had

been discontinued on a specific date. The lower dose of the specific medication had been started the following day and registered staff had signed that they had administered the lower dosage of medication for nine days.

Review of resident #013's electronic progress notes in Point Click Care noted no documentation related to the medication incident.

In an interview, MRC #100 stated resident #013's order for the specific medication was changed over a weekend therefore the pharmacy satellite had sent three lower doses of the specific medication. MRC #100 stated that once the three doses were finished registered staff continued to give the higher dose of the specific medication as a change sticker was not on resident #013's medication strip. MRC #100 stated they were unsure if pharmacy had not received the new order or the new order had not been faxed. MRC #100 stated they did not know who the staff member was who was responsible to fax the order to pharmacy. MRC #100 stated they had not spoken with any of the registered staff who were involved in the medication incident. MRC #100 stated they had spoken to all registered staff during huddle regarding placing a change sticker on medication strips when orders were changed.

MRC #100 stated they did not keep notes related to investigating medication incidents, such as interviews with staff, they only documented on the Medication Incident Form.

In an interview, Administrator #112 stated when a medication incident occurred, they would expect that the medication incident was reviewed with registered staff involved, corrective action was assigned, and the staff were monitored by the MRC or Assistant MRC.

Administrator #112 stated as part of investigating the medication incident they would expect that follow up would be completed with the registered staff who worked previous shifts prior to resident #009's medication being found on the floor by resident #009's family member.

Administrator #112 stated that they would expect that follow up be completed with the registered staff who completed the checks for resident #012's medication. Administrator #112 stated that for medication incidents, discussion and follow up with staff should take place and should be documented as part of the medication incident report.

The licensee has failed to ensure that all medication incidents were documented,

corrective action was taken as necessary and a written record was kept of everything. [s. 135. (2)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to protect residents from abuse by anyone.

A) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care (MLTC) related to an incident of suspected abuse involving resident #001 to resident #002.

Review of the CIS report noted a Personal Support Worker (PSW) had a report from another team member that they had witnessed an incident of suspected abuse involving resident #001 to resident #002.

In an interview, Restorative Care Aide (RCA) #103 stated they witnessed the incident of suspected abuse between resident #001 and resident #002. RCA #103 stated they did not think what they witnessed was appropriate and went to get the Behavioural Supports Ontario (BSO) PSW.

In an interview, BSO PSW #101 stated they were informed of the incident from RCA #104 and went straight to resident #002. BSO PSW #101 stated resident #002 was physically shaking.

In an interview, Social Worker (SW) #109 stated they had sat with resident #002 after the

incident with resident #001. SW #109 stated they had seen resident #002 the previous day and resident #002 had been happy and giggling. SW #109 stated when they sat with resident #002 after the incident, resident #002 had completely shut down, was very shaky and was distressed.

In an interview, Assistant Manager of Resident Care (AMRC) #114 stated they were contacted by the Registered Practical Nurse (RPN) on the floor regarding the incident. AMRC #114 stated they had met with police and reviewed video footage during the time of the incident. AMRC #114 stated based on the video footage there was not enough time for anything to have occurred between the residents.

In an interview, Administrator #112 stated they had reviewed the video footage of the incident, looked at the evidence and based on the fact that resident #002 was distressed by the incident they determined the incident had crossed the threshold for reporting and submitted the CIS.

Review of resident #002’s electronic progress notes in Point Click Care (PCC) noted two previous incidents of suspected abuse involving resident #001.

i) Review of resident #002's progress notes indicated that the AMRC was notified of the first incident of suspected abuse and interventions were put in place for resident #002.

Review of resident #002’s hard copy chart noted safety checks were initiated for resident #002 after the incident.

In an interview, Manager of Resident Care (MRC) #100 stated they could not recall the incident and if it was investigated. MRC #100 stated they would need to find their notes related to the incident.

MRC #100 stated that they had spoken to resident #001 regarding the incident with resident #002.

In an interview, Administrator #112 reviewed resident #002’s progress notes related to the first incident of suspected abuse Administrator #112 stated in reviewing resident #002’s progress notes the incident could fall under the definition of abuse, but they had not interviewed the staff regarding the incident therefore it was hard to determine.

ii) Review of resident #002’s progress notes indicated the RN was notified of the second

incident of suspected abuse and resident #002 was assessed and started on safety checks. The progress note indicated that management had been informed of the incident.

In an interview, MRC #100 stated they vaguely remembered the incident between resident #001 and resident #002 and would need to review their notes.

MRC #100 gave inspector copies from MRC #100’s note book related to the second incident. Review of notes with MRC noted two point form lines related to the incident which indicated that resident #002 had safety checks in place and Administrator #112 would call resident #002's Power of Attorney and that resident #001 was being monitored.

MRC #100 stated those were their only notes related to the incident between resident #001 and resident #002.

In an interview, Administrator #112 stated the incident between resident #001 and resident #002 could have been considered suspected abuse.

iii) Review of resident #001’s electronic progress notes in PCC noted a third incident of suspected abuse towards resident #002.

Review of resident #002’s progress notes noted no documentation related to the third incident with resident #001.

In an interview, MRC #100 stated they did not recall the incident between resident #001 and resident #002. MRC #100 stated they did not have any investigative notes related to the incident but they had noted the incident in their note book. MRC #100 stated they noted there was no documentation in resident #002’s progress notes related to the incident.

Review of MRC #100’s hand written notes related to the incident between resident #001 and resident #002 noted two point form lines which noted the incident with resident #001 and that there was no documentation in resident #002's progress notes.

In an interview, Administrator #112 stated they were not aware of the incident between resident #001 and resident #002. Administrator #112 stated the incident would fall under the definition of abuse. Administrator #112 stated it was possible the incident should

have been reported to the MLTC.

In an interview, Social Service Worker (SSW) #107 stated they had completed a review on resident #002 related to their interactions with resident #001.

SSW #107 stated specific interventions were in place to protect resident #002 after the incident with resident #001. Inspector had observed the specific interventions in place.

SSW #107 stated the specific interventions had not been entered into resident #002's care plan. SSW #107 stated they had sent the review and their recommendations to Administrator #112.

Review of SSW #107's hand written notes for the review noted no mention of the third incident between resident #001 and resident #002.

Review of an email sent to Administrator #112 from SSW #107 noted SSW #107 stated they had reviewed resident #002's interactions with resident #001 and their conclusion was to continue to monitor the interactions from moment to moment and safety checks for resident #002 if needed. SSW #107 stated their recommendation was to have a conversation with resident #001 regarding their behaviour toward resident #002.

In an interview, Registered Nurse (RN) #111 stated there were specific interventions put in place for resident #002.

A review of resident #002's electronic care plan and kardex on Point Click Care (PCC) noted no reference to the specific interventions for resident #002. Further review noted no reference to interventions related to interactions with resident #001 and that the residents were to be monitored.

In an interview, Registered Practical Nurse (RPN) #104 stated that registered staff were responsible to update a resident's care plan. RPN #104 stated resident #002 had specific interventions in place to prevent interactions with resident #001.

RPN #104 reviewed resident #002's care plan and kardex with inspector and confirmed that the specific interventions were not included in resident #002's care plan or kardex. RPN #104 stated there was no focus or interventions for resident #002 related to interactions with resident #001.

In an interview, Manager of Resident Care (MRC) #100 stated the use of a specific intervention should be included in a resident’s plan of care.

In an interview, Administrator #112 stated that after SSW #107's review the interventions related to interactions with resident #001 should have been entered into resident #002’s care plan.

The licensee failed to protect resident #002 from resident #001. Resident #001 had been abusive towards resident #002 on several occasions during which resident #002 showed signs of distress.

Staff failed to document the third incident with resident #001 in resident #002’s progress notes, therefore this incident was not taken into account when SSW #107 completed a review for resident #002. Staff also failed to note in resident #002’s care plan interventions related to interactions with resident #001.

B) Review of resident #001's electronic progress notes in PCC noted an incident of suspected abuse involving resident #001 to resident #003.

A review of resident #001’s electronic progress notes noted staff witnessed the incident of suspected abuse and notified the Registered Practical Nurse.

Review of resident #003’s progress notes noted no documentation related to the incident. Further review of resident #003’s progress notes noted several incidents of suspected abuse involving resident #001 over the course of two days. Resident #003's progress notes indicated that resident #003 had not been well during this time and resident #003 had displayed a change in mood after the incidents and indicated they did not want to be near resident #001.

In an interview, Registered Practical Nurse (RPN) #110 stated a staff member had made them aware of the incident between resident #001 and resident #003. RPN #110 stated resident #003 had told them they did not want to be near resident #001.

In an interview, Personal Support Worker (PSW) #120 stated they had witnessed an incident of suspected abuse between resident #001 towards resident #003.

PSW #120 stated they reported the incident to registered staff who assessed resident #003.

In an interview, RPN #113 stated that a PSW had reported the incident between resident #001 and resident #003 to them. RPN #113 stated they went straight to resident #003 and called the Registered Nurse (RN). RPN #113 stated they then tried to talk to resident #003 to find out what happened but it was difficult. RPN #113 stated resident #003 seemed fine and did not appear hurt.

Observation of resident #003's room noted specific interventions in place for resident #003.

Review of resident #003’s care plan and kardex noted no reference to the use of the specific interventions or any interventions related to interactions with resident #001.

In an interview, Social Service Worker #107 stated they had also completed a review on resident #003 related to their interactions with resident #001.

SSW #107 stated resident #003 might not be able to verbalize how they felt, but if they were distressed resident #003 could let someone know.

Review of SSW #107's review with SSW #107, noted that SSW #107 had not referenced the incident between resident #001 and resident #003. SSW #107 stated they had reviewed documented interactions between resident #001 and resident #003 in resident #003’s progress notes and then crossed referenced resident #001’s progress notes. SSW #107 stated since the incident was not documented in resident #003’s progress notes they were not aware of the incident and did not include it in their review.

SSW #107 stated interventions had not been entered into resident #003’s care plan. SSW #107 stated they had sent their review and their recommendations to Administrator #112.

Review of SSW #107's email sent to Administrator #112 noted SSW #107 stated they had reviewed resident #003’s interactions with resident #001 and their conclusion was to continue to monitor the interactions from moment to moment and safety checks if needed.

In an interview, RPN #104 reviewed resident #003’s care plan and kardex with inspector and confirmed that the use of a specific intervention was not included in resident #003’s care plan or kardex. RPN #104 stated there was no focus or interventions for resident

#003 related to interactions with resident #001.

In an interview, Personal Support Worker #120 stated they had witnessed the incident between resident #001 and resident #003. PSW #120 stated originally they were told that they were to monitor the residents and then they were told resident #001 was not allowed near resident #003.

In an interview, MRC #100 stated the use of a specific intervention should be included in a resident’s plan of care. MRC #100 stated they did not remember the incident between resident #001 and resident #003.

Review of MRC #100’s hand written notes in MRC #100's notebook for the day after the incident noted a point form line indicating resident #003 had been visibly upset the day after an incident with resident #001 and that resident #003 did not want resident #001 to be near them.

In an interview, Administrator #112 stated that after SSW #107's review the interventions related to interactions with resident #001 should have been entered into resident #003’s care plan. Administrator #112 stated they had read about the incident between resident #001 and resident #003 in report and they had spoken to resident #001 about the incident. Administrator #112 stated the incident did fit under the definition of suspected abuse.

The licensee failed to protect resident #003 from resident #001 when staff failed to recognize signs of possible distress in resident #003. Staff failed to recognize that during this time resident #003 had been unwell. After interactions with resident #001, resident #003 had stated they did not like resident #001, had been avoiding resident #001, had been observed crying and showed a flat affect.

Staff failed to document the incident with resident #001 in resident #003’s progress notes, therefore this incident was not taken into account when SSW #107 completed a review for resident #003. Staff also failed to note in resident #003’s care plan interventions related to interactions with resident #001.

C) Review of resident #001’s electronic progress notes in PCC noted an incident of suspected abuse involving resident #001 to resident #006.

In an interview, RPN #123, who worked full time on the home area, stated they did not

recall the incident between resident #001 and resident #006.

In an interview, MRC #100 stated that they did not recall the incident between resident #001 and resident #006. MRC #100 stated based on resident #006’s progress note it had been reported to the Resident Care Coordinator who no longer worked at the home.

In an interview, Administrator #112 stated they were aware of the incident between resident #001 and resident #006. Administrator #112 stated if the incident happened as was reported, then based on the definition of abuse, it would be considered abuse and should have been reported to the Ministry of Health and Long-Term Care.

D) Review of resident #001's electronic progress notes in PCC noted an incident of suspected abuse involving resident #001 to resident #008.

A review of resident #008’s progress notes noted no documentation related to the incident with resident #001.

In an interview, Registered Practical Nurse (RPN) #104 reviewed resident #001’s progress notes and stated they did not witness the incident between resident #001 and resident #008. RPN #104 stated Physiotherapy Aide (PTA) #119 had reported the incident to them. RPN #104 stated they could not remember the incident and could not recall if resident #008 was in distress after the incident. RPN #104 acknowledged that they had not documented the incident and any follow up with resident #008 in the resident’s progress notes.

In an interview, PTA #119 stated the witnessed the incident between resident #001 and resident #008. PTA #119 stated they notified the RPN and a PSW came and removed resident #008.

In an interview, MRC #100 stated they did not recall the incident between resident #001 and resident #008 and they did not have any notes related to the incident.

In an interview, Administrator #112 stated they did not recall the incident between resident #001 and resident #008 and they did not have any notes related to the incident.

Administrator #112 reviewed resident #001’s progress notes related to the incident. Administrator #112 stated based on the definition of abuse they would consider this an incident of suspected abuse.

E) In an interview, Registered Practical Nurse (RPN) #113 stated if they witnessed an interaction of suspected abuse between residents they would stop the interaction, remove the resident and sit with resident that was upset. RPN #113 stated they would try to find out what happened from the resident, but some residents could not always tell them. RPN #113 stated they would also talk to the other resident involved. RPN #113 stated they would complete risk management, safety checks on the resident, call families and management and document the incident in a progress note. RPN #113 stated if the Social Worker and RN were in the building, they would call them.

During the course of the inspection, several staff expressed concern that they did not know what they could and could not do regarding incidents with resident #001, and how to protect other residents from unwanted interactions.

In several interviews, staff members indicated resident #001 had previous incidents with several residents in the home area, including resident #002, #003, #004 and #005.

In an interview, PSW #105 stated they worked with resident #001 and they were told they were not to let resident #001 go into any residents' rooms. PSW #105 stated they were not aware that resident #001 had incidents with other residents on the home area, just resident #002. PSW #105 stated they were made aware of a resident's care needs through other staff and by reviewing a resident's electronic care plan on Point of Care.

Further review of resident #001's electronic progress notes in PCC noted incidents of suspected abuse with resident #008, resident #003, resident #004 and four incidents with resident #002. Two separate incidents of suspected abuse were documented in resident #001's progress notes but the notes did not indicate the residents involved.

A review of resident #001's electronic care plan and kardex on PCC noted no documentation related to resident #001's behaviour and that resident #001 was not to go into other residents' rooms.

In an interview, Social Service Worker (SSW) #107 stated they had completed a review for resident #002 and resident #003 related to their interactions with resident #001. SSW #107 stated that had made recommendations to the Administrator. SSW #107 stated their recommendation was to have a conversation with resident #001 regarding their interactions with resident #002 and resident #003. SSW #107 stated to continue to monitor resident #001's interactions with resident #002 and resident #003 and to

complete safety checks if needed.

In an interview, Registered Practical Nurse (RPN) #104 reviewed resident #001’s care plan and kardex with inspector and confirmed there were no interventions related to resident #001's behaviours or that resident #001 was not to have contact with resident #002 or resident #003.

In an interview, MRC #100 stated resident #001’s behaviours and interventions should be included in resident #001’s plan of care, in particular that resident #001 was not to have contact with resident #002 and resident #003.

In an interview, Administrator #112 stated that after SSW #107's review the interventions related to resident #001’s interactions with resident #002 and resident #003 should have been entered into resident #001’s care plan.

The licensee failed to protect residents from resident #001 by not including interventions related to resident #001’s behaviours in resident #001’s care plan. Staff failed to document specific incidents of suspected abuse in both residents’ progress notes, specifically for resident #002, resident #003 and resident #008.

The licensee has failed to protect residents from abuse by anyone. [s. 19.]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

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 knew of, or that was reported was immediately investigated.

A) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care (MLTC) related to an incident of suspected abuse involving resident #001 to resident #002.

Review of review of resident #002’s electronic progress notes in Point Click Care (PCC) noted previous incidents of suspected abuse involving resident #001 to resident #002.

i) Review of resident #002’s progress notes indicated the RN was notified of the incident of suspected abuse and resident #002 was assessed and started on safety checks. The progress note indicated that management had been informed of the incident.

In an interview, Manager of Resident Care (MRC) #100 stated they vaguely remembered the incident between resident #001 and resident #002 and would need to review their notes.

MRC #100 gave inspector copies from MRC #100’s note book related to the second incident. Review of notes with MRC noted two point form lines related to the incident which indicated that resident #002 had safety checks in place and Administrator #112

would call resident #002's Power of Attorney and that resident #001 was being monitored.

MRC #100 stated they did not have any investigation notes, and those were their only notes related to the incident between resident #001 and resident #002.

MRC #100 stated they did not speak with the staff members who witnessed the incident or the residents involved.

In an interview, Administrator #112 stated they did not investigate the incident between resident #001 and resident #002. Administrator #112 reviewed their notebook and stated the Manger of Life Enrichment (MLE) met with resident #001 regarding the incident. Administrator #112 asked MLE #130 to come to the Administrator’s office.

MLE #130 spoke with Administrator #112 in the presence of inspector and stated they met with resident #001. MLE #130 stated resident #001 stated they were having a good day and asked MLE #130 to leave as they were watching TV.

Administrator #112 confirmed there was no investigation or follow up with resident #001 and resident #002 after the incident. Administrator #112 stated the incident between resident #001 and resident #002 should have been investigated.

ii) Review of resident #001’s electronic progress notes in PCC noted a Personal Support Worker (PSW) witnessed another incident of suspected abuse involving resident #001 to resident #002.

Review of resident #002’s progress notes noted no documentation related to the above incident with resident #001.

In an interview, MRC #100 stated they did not recall the incident between resident #001 and resident #002. MRC #100 stated they did not have any investigative notes related to the incident, but they had noted the incident in their note book. MRC #100 stated they noted there was no documentation in resident #002’s progress notes related to the incident.

Review of MRC #100’s hand written notes related to the incident between resident #001 and resident #002 noted two point form lines which noted the incident with resident #001 and that there was no documentation in resident #002's progress notes.

In an interview, Administrator #112 stated they were not aware of the incident between resident #001 and resident #002. Administrator #112 stated the incident should have been investigated.

B) A review of resident #001’s electronic progress notes noted staff had witnessed and incident of suspected abuse involving resident #001 to resident #003 and notified the Registered Practical Nurse.

Review of resident #003’s progress notes noted no documentation related to the incident.

In an interview, Registered Nurse #128 stated they attended resident #003’s room after the incident between resident #001 and resident #003. RN #128 stated they would report an incident to management, and they would investigate and determine if the incident was abuse. RN #128 stated they were certain they had informed the oncall manager, but they were unsure as they did not document the incident and notification of management in resident #003’s progress notes.

In an interview, MRC #100 stated they did not remember the incident between resident #001 and resident #003.

Review of MRC #100’s hand written notes in MRC #100's notebook for the day after the incident noted a point form line indicating resident #003 had been visibly upset the day after an incident with resident #001 and that resident #003 did not want resident #001 to be near them.

In an interview, Administrator #112 stated the incident between resident #001 and resident #003 should have been reported immediately to management. Administrator #112 stated they had read the incident in report and they had spoken to resident #001 about the incident. Administrator #112 stated that the registered nurse on duty should have followed up with the residents and investigated the incident when it occurred.

C) Review of resident #001’s electronic progress notes in Point Click Care (PCC) noted an incident of suspected abuse involving resident #001 to resident #006.

A review of resident #006’s electronic progress notes noted the incident of suspected abuse involving resident #001. Other than the actual incident there was no further

documentation in either resident’s progress notes related to the incident.

In an interview, MRC #100 stated that the did not recall the incident between resident #001 and resident #006. MRC #100 stated based on resident #006’s progress note it had been reported to the Resident Care Coordinator, who no longer worked at the home.

In an interview, Administrator #112 stated they were aware of the incident and acknowledged that the incident had not been investigated. Administrator #112 stated the incident should have been investigated and staff should have followed up directly with resident #006 to find out what had occurred.

D) Review of resident #001's electronic progress notes in PCC noted an incident of suspected abuse involving resident #001 to resident #008.

A review of resident #008’s progress notes noted no documentation related to the incident with resident #001.

In an interview, Registered Practical Nurse (RPN) #104 reviewed resident #001’s progress notes and stated they did not witness the incident between resident #001 and resident #008. RPN #104 stated Physiotherapy Aide (PTA) #119 had reported the incident to them. RPN #104 stated they could not remember the incident and could not recall if resident #008 was in distress after the incident. RPN #104 acknowledged that they had not documented the incident and any follow up with resident #008 in the resident’s progress notes.

In an interview, PTA #119 stated they had witnessed the incident between resident #001 and resident #008. PTA #119 stated they notified the RPN and a PSW came and removed resident #008.

In an interview, MRC #100 stated they did not recall the incident between resident #001 and resident #008 and they did not have any notes related to the incident.

In an interview, Administrator #112 stated they did not recall the incident between resident #001 and resident #008 and they did not have any notes related to the incident. Administrator #112 stated the incident should have been investigated and reported to management.

The licensee has failed to ensure that every alleged, suspected or witnessed incident of

abuse of a resident by anyone, that the licensee knew of, or that was reported was immediately investigated.

2. The licensee has failed to ensure that appropriate action was taken in response to every incident of alleged, suspected or witnessed incident of abuse of a resident by anyone.

Review of a specific S&R policy created October 27, 2016, noted in part:

"When there is an incident between residents and one or both residents are cognitively impaired (CPS of 2 or greater):
Immediate: Assess the emotional response to the interaction.

Ongoing: Continue to monitor the residents for emotional responses and safety.

-Separate both residents immediately
-Complete a physical assessment and the relevant risk management
-Initiate behaviour/safety tracking for a minimum of 72 hours
-Notify management and SDM
-Update care plan for both residents
-Initiate referral to internal BSO/SW/Chaplain as available in the home
-Consider referral to physician for review at the next visit (as required)."

In an interview, RN #111 stated if an incident of suspected abuse was reported to them, they would follow up immediately and assess the resident for safety. RN #111 stated staff would initiate safety checks for the victim to ensure they were not in any distress and they would also initiate Dementia Observation System (DOS) tracking for the aggressor.

In an interview, Behavioural Supports Ontario Registered Nurse (BSO RN) #129 stated that they reviewed all resident DOS tracking and safety checks. BSO RN #129 stated they would make a copy of the DOS charting and if the resident was on BSO the document would be filed in BSO files and if the resident was not on BSO the document would go to the floor to be filed in the resident's chart.

A) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care (MLTC) related to an incident of suspected abuse involving resident #001 to resident #002.

Review of resident #002's electronic progress notes in Point Click Care (PCC) noted previous incidents with resident #001 as follows:

i) Review of resident #002's progress notes indicated that the AMRC was notified of the first incident of suspected abuse and interventions were put in place for resident #002.

Review of resident #002’s hard copy chart noted safety checks were initiated for resident #002 after the incident.

Review of resident #002's electronic progress notes noted no evidence of a physical assessment of resident #002 after the incident.

In an interview, BSO Personal Support Worker (PSW) #106 stated they had checked the BSO files for resident #001 and could not locate DOS tracking for resident #001 related to the above incidents.

In an interview, MRC #100 stated registered staff should have completed a physical assessment of resident #002 after the incident. MRC #100 stated there should be a record of DOS charting for resident #001 related to the incident.

ii) Review of resident #002’s progress notes indicated the RN was notified of the second incident of suspected abuse and resident #002 was assessed and started on safety checks. The progress note indicated that management had been informed of the incident.

A review of resident #002's hard copy chart noted no documented Dementia Observation System (DOS) safety checks initiated after the incident.

In an interview, BSO PSW #106 confirmed that they could not locate DOS safety checks that were initiated for resident #002 after the incident.

In an interview, BSO PSW #106 stated they had checked the BSO files for resident #001 and could not locate DOS tracking for resident #001 related to the incident.

In an interview, MRC #100 stated DOS tracking and safety checks should be documented and filed for resident #001 and resident #002.

B) Review of resident #001's electronic progress notes in PCC noted an incident of suspected abuse involving resident #001 to resident #003.

A review of resident #001’s electronic progress notes noted staff witnessed the incident of suspected abuse and notified the Registered Practical Nurse (RPN).

Review of resident #003’s progress notes noted no documentation of assessments or follow up with resident #003 related to the incident. There was one progress note for resident #003 from the time of the incident which noted that resident #003 stated they were not happy that resident #001 would come into their room.

There was no documentation in resident #001’s progress notes that registered staff followed up with resident #001 after the incident.

In an interview, RPN #113 stated that a PSW had reported the incident between resident #001 and resident #003 to them. RPN #113 stated they went straight to resident #003’s room and called the Registered Nurse (RN).

RPN #113 stated they tried to talk to resident #003 to find out what happened but it was difficult. RPN #113 stated resident #003 would have had a skin assessment completed and Dementia Observation System (DOS) safety tracking would have been initiated.

RPN #113 reviewed resident’s electronic progress notes and assessment tab in Point Click Care (PCC) with inspector. RPN #113 confirmed that a skin assessment was not completed on resident #003 and there was no documentation in resident #003’s progress notes related to initiating DOS safety tracking to monitor resident #003’s response to the incident.

RPN #113 reviewed resident #003’s hard copy chart with inspector. RPN #113 confirmed safety checks were not initiated on resident #003 until a day after the incident.

In an interview, RN #128 stated they attended resident #003’s room after the incident between resident #001 and resident #003. RN #128 stated resident #003 would have been started on 72 hour safety checks. RN #128 acknowledged that they had not documented the incident or initiation of safety checks in resident #003’s progress notes.

In an interview, Administrator #111 stated resident #003 should have had a physical assessment after the incident with resident #001. Administrator #111 stated interventions

should have been put in place for resident #003 and those interventions should have been documented.

C) Review of resident #001's electronic progress notes in PCC noted and incident of suspected abuse involving resident #001 to resident #006.

A review of resident #006's electronic progress notes noted documentation of the incident.

There was no further documentation in either resident's electronic progress notes in PCC regarding any follow up with resident #001 or resident #006 related to the incident.

In an interview, RN #111 stated they did not recall the incident between resident #001 and #006. RN #111 stated if an incident of suspected abuse was reported to them, they would follow up immediately and assess the resident for safety. RN #111 stated after an incident such as what occurred between resident #001 and #006, staff would initiate safety checks for the victim to ensure they were not in any distress and they would also initiate Dementia Observation System (DOS) tracking for the aggressor. RN #111 reviewed resident #006's hard copy chart and noted that there were no documented DOS safety checks. RN #111 stated BSO staff review all DOS charting and safety checks and they may have the safety checks for the residents in their files.

In an interview, BSO PSW #106 stated they had reviewed the BSO files and were unable to find safety checks or DOS tracking for either resident related to the incident.

In an interview, MRC #100 stated when there was an incident of suspected, alleged or actual abuse involving a resident the key was making sure the resident was safe and the effect it had on the resident was first and foremost. MRC #100 stated DOS tracking and safety checks should be completed for residents when there was any sort of altercation or incident between residents.

In an interview, Administrator #112 stated resident #006 should have been assessed and safety checks should have been initiated after the incident with resident #001 to determine if resident #006 was in any distress after the incident.

D) Review of resident #001's electronic progress notes in PCC noted an incident of suspected abuse involving resident #001 to resident #008.

A review of resident #008's progress notes noted no documentation related to the incident with resident #001 or any follow up with resident #008.

In an interview, Registered Practical Nurse (RPN) #104 reviewed resident #001's progress notes and stated they did not witness the incident between resident #001 and resident #008. RPN #104 stated Physiotherapy Aide (PTA) #119 had reported the incident to them. RPN #104 stated they could not remember the incident and could not recall if resident #008 was in distress after the incident. RPN #104 acknowledged that they had not documented the incident and any follow up with resident #008 in the resident's progress notes. RPN #104 stated after such an incident resident #008 would have had safety checks. RPN #104 reviewed resident #002's hard copy chart and acknowledged that there were no documented safety checks initiated after the incident with resident #001.

In an interview, MRC #100 stated when there was an incident of suspected, alleged or actual abuse involving a resident the key was making sure the resident was safe and the effect it had on the resident was first and foremost.

In an interview, Administrator #112 stated resident #008 should have been assessed and had safety checks initiated after the incident with resident #001 to determine if resident #008 was in any distress after the incident.

The licensee has failed to ensure that appropriate action was taken in response to every incident of alleged, suspected or witnessed incident of abuse of a resident by anyone. [s. 23. (1)]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure where the Act or Regulations required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

A) Ontario Regulation 79/10 s. 55 (a) states, “Every licensee of a long-term care home shall ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident’s behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care (MLTC) related to an incident of suspected abuse involving resident #001 to resident #002.

Review of S&R’s policy “Responsive Behaviour Program” RCM 10-05-00 with a revision date of May 27, 2019, defined responsive behaviours as “behaviours that often indicate an unmet need in a person, whether cognitive, physical, emotional, social, environmental or other…”

The policy stated in part:

“The RTM will complete a clinical assessment when a responsive behaviour occurs to identify the causes, such as medication related or chemically or physiologically based, and triggers…or to determine a possible delirium.
Documentation in the progress notes will include, but not be limited to:
Who was involved?

What events lead up to the incident?
What precipitated the incident?
Have any similar incidents occurred in the past?
What measures or procedures have been implemented to prevent a similar incident?”

During the course of the inspection several registered staff members had stated to Inspector #522 that they had been informed that they were no longer to document any specific behaviours in resident #001’s progress notes. Registered staff indicated that they were to complete a Customer/Team Member Feedback form and submit the form to the Assistant Manager of Resident Care (AMRC) who would review the form and determine whether the information should be documented in resident #001’s progress notes.

In an interview, Assistant Manager of Resident Care (AMRC) #114 stated they had directed staff to submit the Customer/Team Member Feedback form. AMRC #114 stated the documentation related to an incident was forever in the resident’s chart and it should only be objective information. AMRC #114 stated they thought staff had subjective interpretation of specific incidents which involved resident #001 so staff had been asked to complete a concern form and management would follow up. Staff were asked to chart that an incident occurred between two residents and that a concern form had been completed. AMRC #114 stated that way management could review the incident and that way there was objective information documented in the resident’s chart.

Review of resident #001’s electronic progress notes in Point Click Care (PCC) noted on a specific date that a concern/complaint form had been filed with the AMRC regarding an incident involving resident #001.

There was no further documentation in resident #001’s progress notes that indicated what the incident was related to or what resident was involved.

In an interview, Registered Practical Nurse (RPN) #113 stated they had entered the progress note for resident #001 and had submitted the concern/complaint form to the AMRC. RPN #113 stated they had witnessed an incident of suspected abuse involving resident #001 and resident #005.

A review of resident #005’s electronic progress notes in PCC noted an incident where resident #001 was inappropriate with resident #005.

Review of resident #001’s electronic progress notes noted no documentation related to

the incident with resident #005.

In an interview, Manager of Resident Care #100 stated when there was an incident involving two residents the incident should be documented in both resident's charts.

In an interview, Administrator #112 stated that some registered staff had been charting subjectively in resident #001's chart. Administrator #112 stated that any incidents between two residents should be documented in both resident's progress notes. Administrator #112 stated they expected staff to complete an objective account of what had occurred.

B) Ontario Regulation 79/10 s.228 (1) states, "Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements: There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review."

Review of S&R's "Risk Management Document" policy CQI 05-01 with a last review date of August 7, 2015, noted in part:

Risk management is "an integral part of quality improvement and is a process by which risks that have or may cause harm are identified, assessed, managed and evaluated."

"Every team member is responsible for risk management. Risk Management involves identification of risks, risk mitigation strategies, resident safety and education of both residents and employees."

Review of specific S&R policy noted in part, staff were to assess a resident's emotional response to a specific interaction. If there was evidence of abuse or staff were unsure of a resident's response, staff were to complete the relevant risk management.

In an interview, Registered Practical Nurse (RPN) #113 stated when there was an incident of alleged, suspected or witnessed abuse or neglect they would complete risk management in Point Click Care (PCC).

Review of resident #001's electronic progress notes in PCC noted incidents of witnessed or suspected abuse involving resident #008, resident #006, resident #003, resident #004, and four incidents involving resident #002.

Review of Risk Management in PCC noted the one incident between resident #001 and resident #002 was the only documented incident in risk management.

In an interview, RPN #113 confirmed that there was no risk management entered for resident #001 for the incidents. RPN #113 stated they did not enter risk management for those incidents, and it was possible staff were not to enter risk management for those specific incidents.

In an interview, RPN #104 confirmed that the most recent incident between resident #001 and resident #002 had not been entered into risk management. RPN #104 searched resident #001 in risk management and confirmed there were no entries for resident #001 other than one incident involving resident #002.

In an interview, Manager of Resident Care #100 stated that the home did not enter resident abuse or neglect in risk management.

In an interview, Administrator #112 reviewed the home's risk management in PCC. Administrator #112 stated there was a category under risk management for specific behaviour and staff should have documented any specific incidents, including the above incidents involving resident #001, in risk management.

The licensee has failed to ensure where the Act or Regulations required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure where the Act or Regulations requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, that the policy is complied with, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's written record was kept up to date at all times.

A) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care (MLTC) related to an incident of suspected abuse involving resident #001 to resident #002.

A review of resident #001's electronic progress notes in Point Click Care (PCC) noted on a specific date staff witnessed an incident of suspected abuse involving resident #001 to resident #002.

There was no documentation in resident #002's electronic progress notes related to the specific incident with resident #001.

In an interview, Administrator #112 reviewed resident #002's progress notes and stated that the incident between resident #001 and resident #002 should have been documented in resident #002's progress notes.

B) Review of resident #001's electronic progress notes in PCC noted an incident of suspected abuse involving resident #001 to resident #003.

A review of resident #001's electronic progress notes noted on a specific date staff witnessed the incident of suspected abuse and notified the Registered Practical Nurse (RPN).

A review of resident #003's electronic progress notes in PCC noted no documentation

related to the specific incident between resident #001 and resident #003.

The only documentation in resident #003's progress notes on the specific date related to resident #001 stated that resident #002 told the RPN that they were not happy that resident #001 would come into their room. The note did not reference why resident #003 had made the statement.

In an interview, Social Service Worker #107 stated they had completed a review on resident #003 related to their interactions with resident #001.

When inspector reviewed SSW #107's review with SSW #107, inspector noted that SSW #107 had not referenced the specific incident between resident #001 and resident #003. SSW #107 stated they had reviewed documented interactions between resident #001 and resident #003 in resident #003's progress notes and then crossed referenced resident #001's progress notes. SSW #107 stated since the specific incident was not documented in resident #003's progress notes they were not aware of the incident and did not include it in the review. SSW #107 stated the incident should have been documented in resident #001 and resident #003's progress notes.

In an interview, Manager of Resident Care (MRC) #100 stated why would staff document in both residents' progress notes if resident #003 had no concerns.

In an interview, Administrator #112 reviewed resident #003's progress notes and stated that the specific incident between resident #001 and #003 should have been documented in resident #003's progress notes.

C) Review of resident #001's electronic progress notes in PCC noted an incident of suspected abuse involving resident #001 to resident #008.

A review of resident #008's progress notes noted no documentation related to the specific incident with resident #001.

In an interview, Administrator #112 reviewed resident #008's progress notes and stated that the specific incident between resident #001 and #008 should have been documented in resident #008's progress notes.

The licensee has failed to ensure that a resident's written record was kept up to date at all times. [s. 231.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident's written record is kept up to date at all times, to be implemented voluntarily.

Issued on this 22nd day of January, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIE LAMPMAN (522)
Inspection No. / No de l'inspection :	2019_725522_0017
Log No. / No de registre :	019616-19, 019650-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 31, 2019
Licensee / Titulaire de permis :	Steeves & Rozema Enterprises Limited 265 North Front Street, Suite 200, SARNIA, ON, N7T-7X1
LTC Home / Foyer de SLD :	Westmount Gardens Long Term Care Home 590 Longworth Road, LONDON, ON, N6K-4X9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Mary Alice Barr

To Steeves & Rozema Enterprises Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident’s care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must comply with s. 6 (10) of LTCHA 2007.

Specifically, the licensee must ensure:

a) The plan of care for specific residents is reviewed and revised to include the use of a specific treatment intervention and specific route of medication administration, if ordered, and turning and repositioning;
b) The plan of care for the use of a specific treatment intervention, specific route of medication administration and turning and repositioning must be implemented.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident was reassessed, and the plan of care reviewed and revised at least every six months and at any other time when the resident’s care needs changed or care set out in the plan was no longer necessary.

A) CIS was submitted by the home to the Ministry of Long-Term Care regarding staff to resident neglect related to a complaint from resident #009’s family member.

A review of the email complaint noted that resident #009’s family member was

concerned that staff were not turning and repositioning resident #009 every two hours and staff had not given resident #009 appropriate treatment as ordered.

i) Review of resident #009's doctor's orders noted resident #009 was ordered a specific treatment intervention and a specific route of medication administration.

Review of resident's progress notes noted resident #009 had required the specific treatment intervention over the course of 10 days.

In an interview, Registered Practical Nurse (RPN) #123 stated that resident #009 received a specific treatment intervention and a specific route of medication administration.

In an interview, RPN #126 stated resident #009 was receiving a specific treatment intervention and the intervention should be indicated in the resident's electronic Medication Administration Record (eMAR).

In an interview, Registered Nurse (RN) #128 stated that resident #009 required a specific route for medication administration. RN #128 stated registered staff who processed the doctor's orders were responsible to ensure the orders for specific treatment interventions were documented on a resident's eMAR.

Review of resident #009's eMAR and electronic Treatment Administration Record (eTAR) noted no documentation that resident #009 had a specific treatment intervention and a specific route of medication administration in place as ordered.

In an interview, Manager of Resident Care (MRC) #100 stated that the specific treatment intervention and the specific route of medication administration should be documented on a resident's eTAR and registered staff should sign that they have administered the interventions. MRC #100 confirmed the specific treatment intervention and the specific route of medication administration were not indicated on resident #009's eMAR or eTAR.

ii) Review of resident #009's plan of care noted no documentation in resident #009's care plan or kardex related to turning and repositioning. Resident #009's most recent care plan noted resident #009 required no assistance for bed

mobility.

Review of resident #009's electronic clinical record in PCC noted resident #009 required extensive assistance with bed mobility.

A review of resident #009's electronic progress notes in PCC noted an entry on a specific date, that indicated resident #009's family member was upset as resident #009 was not repositioned frequently enough. The progress note indicated the Registered Practical Nurse (RPN) reminded staff that resident #009 was to be repositioned every two hours.

In an interview, Personal Support Worker (PSW) #124 stated if a resident needed to be turned and repositioned, they would find that information on Point of Care (POC) tasks for the resident.

In an interview, RPN #122 stated that on a specific date, resident #009's family member had expressed concern to them that resident #009 had not been repositioned. RPN #122 stated they had entered a note in resident #009's eMAR for registered staff to remind PSW staff to turn and reposition resident #009. RPN #122 stated they did not enter turning and repositioning in POC tasks for the PSWs.

In an interview, MRC #100 stated that registered staff were responsible to update a resident's care plan and the Resident Assessment Instrument (RAI) Coordinator was responsible to enter tasks in POC for the PSWs. MRC #100 confirmed that turning and repositioning was not on resident #009's care plan or kardex. MRC #100 stated staff should know that the resident would need to be turned every two hours.

In an interview, MRC #100 stated that resident #009 would have had comfort rounds in place and staff would be responsible to check hourly if resident #009 needed to be turned and repositioned. MRC #100 provided inspector with resident #009's Comfort Care Rounds Log for a specific time frame which staff initialled hourly that they asked the resident if they needed to be repositioned for comfort or prevention of skin breakdown.

B) Review of resident #010's doctor's orders noted resident #010 was ordered

specific medication to be administered by a specific route.

Review of resident #010's progress notes noted that resident #010 required a specific treatment intervention over the course of several hours. Review of resident #010's eMAR noted no documentation that the specific treatment intervention was administered.

In an interview, Registered Nurse (RN) #128 stated registered staff who processed the doctor's orders were responsible to ensure the orders were documented on a resident's eMAR.

Review of resident #010's eMAR and eTAR noted no documentation that the specific route of medication administration for resident #010 had been initiated.

In an interview, MRC #100 stated that registered staff should document the specific route of medication administration on a resident's eTAR. MRC #100 reviewed resident #010's eTAR and eMAR and confirmed the specific route of medication administration was not documented on resident #010's eMAR or eTAR.

C) Resident #011was ordered a specific treatment intervention and a specific route of medication administration.

Review of resident #011's progress notes noted resident #011 required the specific treatment intervention for four days.

In an interview, Registered Nurse (RN) #128 stated registered staff who processed the orders were responsible to ensure the orders for the specific treatment intervention and specific route of medication administration were documented on a resident's eMAR.

Review of resident #011's eMAR and eTAR noted no documentation that resident #011 was ordered a specific treatment intervention and a specific route of medication administration.

In an interview, Manager of Resident Care (MRC) #100 stated that the specific treatment intervention should be documented on a resident's eTAR and

registered staff should sign that they have administered the specific treatment intervention.

In an interview, MRC #100 stated that registered staff should document a specific route of medication administration on a resident's eTAR. MRC #100 reviewed resident #011's eTAR and eMAR and confirmed the specific treatment intervention and specific route of medication administration was not documented on resident #010's eMAR or eTAR.

The licensee has failed to ensure that the resident was reassessed, and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

The severity of this issue was determined to be a level 2 as there was minimal risk to the residents. The scope of the issue was a level 3 as it was widespread. The home had a level 3 history of previous noncompliance with this subsection of the LTCHA 2007, issued as a voluntary plan of correction on December 14, 2018 (2018_563670_0034). (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2020

Order # / No d'ordre : 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. 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. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee must comply with s. 24 (1) of LTCHA 2007.

Specifically, the licensee must ensure:

a) A person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred shall immediately report the suspicion and the information upon which it is based to the Director;
b) All staff, including management, receive training on specific abuse and mandatory reporting requirements to the Director. A record is kept of the training and attendance.

Grounds / Motifs :

1. The licensee has failed to comply with s. 24 (1) 2, in that a person who had reasonable grounds to suspect abuse of a resident, failed to report the alleged abuse immediately to the Director in accordance with s. 24 (1) 2 of the LTCHA.

Pursuant to LTCHA 2007, s. 152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

A) A Critical Incident System (CIS) report was submitted by the home to the

Ministry of Long-Term Care (MLTC) related to an incident of suspected abuse involving resident #001 to resident #002.

Review of the CIS report noted a Personal Support Worker (PSW) had a report from another team member that they had witnessed an incident of suspected abuse involving resident #001 to resident #002.

In an interview, Registered Nurse (RN) #111 stated if they suspected or witnessed an incident of abuse of a resident they would report the incident to management right away and then follow management’s instructions of what they needed to do.

In an interview, Registered Practical Nurse (RPN) #113 stated if they witnessed a potential abusive interaction between residents they would stop the interaction, remove the resident and sit with resident that was upset. RPN #113 stated they would try to find out what happened from the resident, but some residents could not always tell them. RPN #113 stated they would also talk to the other resident involved. RPN #113 stated they would complete risk management, safety checks on the resident, call families and management and document the incident in a progress note. RPN #113 stated if the Social Worker and RN were in the building, they would call them.

In an interview, PSW #125 stated if they suspected or witnessed an incident of abuse of a resident, they would report it immediately to registered staff.

In an interview, MRC #100 stated if staff witnessed or were informed of an incident of suspected, alleged or witnessed abuse they expected staff to make sure the resident was safe and report the incident immediately. The RPN would report to the RN who would report to the manager or oncall manager. If after hours staff would report to Ministry of Long-Term Care after hours line, submit CIS and notify families depending on the Cognitive Performance Score (CPS) score of the resident. MRC #100 stated the key was to make sure the resident was safe and the effect it had on the resident was first and foremost. MRC #100 stated the CIS report was submitted either by the MRC or Administrator.

Review of resident #002’s electronic progress notes in Point Click Care (PCC) noted two previous incidents of suspected abuse with resident #001.

i) In an interview, Manager of Resident Care (MRC) #100 stated they could not recall the first incident and if it was investigated. MRC #100 stated if there were any signs of distress resident #001 and resident #002 would have been separated. MRC #100 stated they would need to find their notes related to the incident.

MRC #100 reviewed their hand written notes in their notebook with inspector. MRC #100's note did not indicate a date. MRC #100 stated they could not recall how they became aware of the incident, but they did speak to resident #001 about the incident with resident #002.

MRC #100 stated they did not suspect anything had happened which is why they did not submit a CIS report.

In an interview, Administrator #112 reviewed resident #002's progress notes related to the first incident with resident #001. Administrator #112 stated in reviewing resident #002's progress notes the incident could fall under the definition of abuse, but they had not interviewed the staff regarding the incident therefore it was hard to determine. Administrator #112 stated the incident was hard to recall and in reviewing resident #002's progress notes the incident could fall under what should be reported to the MLTC.

ii) In an interview, MRC #100 stated they vaguely remembered the second incident between resident #001 and resident #002 and would need to review their notes.

MRC #100 gave inspector copies from MRC #100's note book related to the second incident. Review of notes with MRC #100 noted two point form lines related to the incident which indicated that resident #002 had safety checks in place and Administrator #112 would call resident #002's Power of Attorney and that resident #001 was being monitored.

MRC #100 stated those were their only notes related to the second incident between resident #001 and resident #002. MRC #100 stated that a CIS report had not been submitted to the MLTC.

In an interview, Administrator #112 stated the second incident between resident #001 and resident #002 could have been considered suspected abuse and should have been reported to the MLTC.

iii) Review of resident #001's electronic progress notes in PCC noted a third incident of suspected abuse towards resident #002.

Review of resident #002's progress notes noted no documentation related to the third incident with resident #001.

In an interview, MRC #100 stated they did not recall the third incident between resident #001 and resident #002. MRC #100 stated they did not have any investigative notes related to the incident but they had noted the incident in their note book. MRC #100 stated they noted there was no documentation in resident #002's progress notes related to the incident.

Review of MRC #100's hand written notes related to the incident between resident #001 and resident #002 noted two point form lines which noted the incident with resident #001 and that there was no documentation in resident #002's progress notes.

In an interview, Administrator #112 stated they were not aware of the third incident between resident #001 and resident #002. Administrator #112 stated the incident would fall under the definition of abuse. Administrator #112 stated it was possible the incident should have been reported to the MLTC.

B) Review of resident #001's electronic progress notes in Point Click Care (PCC) noted an incident of suspected abuse between resident #001 and resident #006.

A review of Long-Term Care Homes.net noted no Critical Incident System reports related to the incident between resident #001 and resident #006.

In an interview, Registered Nurse #111 stated they did not recall the incident between resident #001 and #006. RN #111 stated if an incident of suspected abuse was reported to them, they would follow up immediately and assess the resident for safety. RN #111 stated they would be responsible to report any

suspected abuse to management. RN #111 stated management should be aware of the incident between resident #001 and resident #006 as the Resident Care Coordinator was the person who had documented the incident in the resident's progress notes. RN #111 stated after an incident such as what occurred between resident #001 and #006, staff would initiate safety checks for the victim to ensure they were not in any distress and they would also initiate DOS tracking for the aggressor.

In an interview, RPN #123, who worked full time on the home area stated they did not recall the incident between resident #001 and resident #006.

In an interview, MRC #100 stated that they did not recall the incident between resident #001 and resident #006. MRC #100 stated based on resident #006's progress note it had been reported to the Resident Care Coordinator.

In an interview, Administrator #112 stated they were aware of the incident between resident #001 and resident #006. Administrator #112 stated if the incident happened as was reported then it would be considered abuse and should have been reported to the Ministry of Health and Long-Term Care.

C) Review of resident #001's electronic progress notes in PCC noted an incident of suspected abuse between resident #001 and resident #008.

A review of resident #008's progress notes noted no documentation related to the incident with resident #001.

In an interview, Registered Practical Nurse (RPN) #104 reviewed resident #001's progress notes and stated they did not witness the incident between resident #001 and resident #008. RPN #104 stated Physiotherapy Aide (PTA) #119 had reported the incident to them. RPN #104 stated they could not remember the incident and could not recall if resident #008 was in distress after the incident. RPN #104 acknowledged that they had not documented the incident and any follow up with resident #008 in the resident's progress notes.

In an interview, PTA #119 stated they witnessed the incident of suspected abuse between resident #001 and resident #008. PTA #119 stated they notified the RPN and a Personal Support Worker came and removed resident #008 from the

area.

In an interview, MRC #100 stated if staff received a report of suspected, alleged or actual abuse to a resident they would expect staff to ensure the resident was safe and registered staff should report the incident to management immediately. MRC #100 stated the incident would be reported to the Ministry of Long-Term Care and the resident’s family depending on the CPS score of the resident. MRC #100 stated if an incident occurred after hours the registered nurse was responsible to call the after-hours line to report the incident and the Administrator and MRC were responsible to submit the Critical Incident System reports to the Ministry of Long-Term Care.

MRC #100 stated they did not recall the incident between resident #001 and resident #008 and they did not have any notes related to the incident.

In an interview, Administrator #112 stated they did not recall the incident between resident #001 and resident #008 and they did not have any notes related to the incident.

Administrator #112 reviewed resident #001’s progress notes related to the incident. Administrator #112 stated based on the definition of abuse they would consider this an incident of suspected abuse and the incident should have been reported to management.

D) In an interview, Personal Support Worker (PSW) #101 stated there had been an incident of suspected abuse between resident #001 and resident #004.

A review of resident #004’s electronic progress notes noted the MRC was notified of the incident. Review of MRC's documentation in resident #004's progress notes noted they had spoken to resident #004 about the incident and notified resident #004’s Power of Attorney of the incident.

In an interview, Registered Practical Nurse (RPN) #115 stated they were working when the incident between resident #001 and resident #004 occurred. RPN #115 stated a PSW had reported to the RPN that they had witnessed an incident of abuse between resident #001 and resident #004.

In an interview PSW #118 stated they had observed resident #001 and resident #004 together and then resident #004 had come to them visibly upset and shaken.

In an interview, Registered Nurse (RN) #111 stated they recalled the incident between resident #001 and resident #004. RN #111 stated they saw both residents together and had watched them for about five minutes. RN #111 stated at that time they did not witness any abuse, but RN #111 stated they did witness resident #004 become visibly upset shortly after. RN #111 stated they put safety checks in place for resident #004 due to resident #001's history as they were unsure if something might have happened.

In an interview, MRC #100 stated they recalled the incident between resident #001 and resident #004 as they had investigated the incident. MRC #100 stated they had no findings related to abuse. MRC #100 stated they did not report the incident to the Ministry of Long-Term Care (MLTC). MRC #100 acknowledged resident #004 was upset after the incident but they did not consider the incident suspected abuse and felt staff had led resident #004 to become upset as they were comforting them at the nurses' station.

When asked by inspector, MRC #100 acknowledged that staff had reported the incident to them as staff had suspected abuse had occurred.

In an interview, Administrator #112 acknowledged they were aware of the incident between resident #001 and resident #004. Administrator #112 stated they did not feel the incident needed to be reported to the MLTC as the incident was looked into and resident #004 could often be emotionally labile.

E) Review of resident #001's electronic progress notes in PCC noted an incident of suspected abuse between resident #001 and resident #003.

Review of resident #003's progress notes noted no documentation related to the incident. Further review of resident #003's progress notes noted several incidents of suspected abuse involving resident #001 over the course of two days. Resident #003's progress notes indicated that resident #003 had not been well during this time and resident #003 had displayed a change in mood after the incidents and indicated they did not want to be near resident #001.

In an interview, Registered Practical Nurse (RPN) #110 stated a staff member had made them aware of the incident between resident #001 and resident #003. RPN #110 stated resident #003 had told them they did not want to be near resident #001.

In an interview, Personal Support Worker (PSW) #120 stated they had witnessed an incident of suspected abuse between resident #001 towards resident #003.

PSW #120 stated they reported the incident to registered staff who assessed resident #003.

In an interview RPN #113 stated that a PSW had reported the incident between resident #001 and resident #003 to them. RPN #113 stated they went straight to resident #003 and called the Registered Nurse (RN). RPN #113 stated they then tried to talk to resident #003 to find out what happened but it was difficult. RPN #113 stated resident #003 seemed fine and did not appear hurt.

In an interview, RN #128 stated they attended resident #003's room after the incident between resident #001 and resident #003. RN #128 stated they were certain they had informed the oncall manager but they were unsure as they did not document the incident and notification of management in resident #003's progress notes.

In an interview, MRC #100 stated they did not remember the incident between resident #001 and resident #003.

Review of MRC #100's hand written notes in MRC #100's notebook for the day after the incident noted a point form line indicating resident #003 had been visibly upset the day after an incident with resident #001 and that resident #003 did not want resident #001 to be near them.

In an interview, Administrator #112 stated they had read the incident in report and they had spoken to resident #001 about the incident. Administrator #112 stated the incident did fit under the definition of suspected abuse and should have been reported to the MLTC.

The licensee has failed to comply with s. 24 (1) 2, in that a person who had reasonable grounds to suspect abuse of a resident, failed to report the alleged abuse immediately to the Director in accordance with s. 24 (1) 2 of the LTCHA.

The severity of this issue was determined to be a level 1 as there was minimal risk to the residents. The scope of the issue was a level 3 as it was widespread. The home had a level 3 history of previous noncompliance with this subsection of the LTCHA 2007, issued as a voluntary plan of correction on November 26, 2018 (2018_674610_0020). (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2020

Order # / No d'ordre : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Order / Ordre :

The licensee must comply with s. 97 (1) of LTCHA 2007.

Specifically, the licensee must ensure:

a) Any resident's substitute decision-maker and any other person specified by the resident are notified immediately upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident that causes distress to the resident that could potentially be detrimental to the resident"s health or well-being.
b) A documented record must be kept of:
i) Who notified the resident's SDM;
ii) When the SDM was notified;
iii) The outcome of the discussion with the SDM; and
iv) If the SDM is unsatisfied, how the home is addressing the SDM's concerns.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident's substitute decision-maker and any other person specified by the resident were notified immediately upon

becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident caused distress to the resident that could potentially be detrimental to the resident"s health or well-being.

A) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care (MLTC) related to an incident of suspected abuse involving resident #001 to resident #002.

In an interview, Registered Practical Nurse (RPN) #110 stated if they witnessed or were told of an incident of suspected or alleged abuse of a resident, they would contact a resident’s family. RPN #110 stated it would depend on the situation as management would decide when family would be notified.

In an interview, Registered Practical Nurse #113 stated if they witnessed an interaction of suspected abuse between residents they would call the residents’ families and management.

In an interview, Registered Nurse (RN) #111 stated if they suspected or witnessed an incident of abuse of a resident, they would report the incident to management right away and then follow management’s instructions of what they needed to do.

Review of resident #002’s electronic progress notes in Point Click Care (PCC) noted two previous incidents of suspected abuse involving resident #001.

i) Review of resident #002's progress notes noted the Assistant Manager of Resident Care (AMRC) was notified of the first incident.

Review of resident #002's electronic progress notes noted no documentation that resident #002's substitute decision-maker (SDM) was notified of the incident.

Review of a risk management report noted the incident between resident #001 and resident #002. The risk management report did not indicate that resident #002's SDM was notified of the incident.

In an interview, Manager of Resident Care (MRC) #100 stated they had made a

note in their note book that they had contacted resident #002's SDM regarding the incident. MRC #100 acknowledged that they did not document notification of the SDM in resident #002's progress notes.

ii) Review of resident #002's progress notes indicated that the registered nurse was notified of the second incident of suspected abuse. Resident #002's progress notes indicated resident #002's POA was contacted two days after the incident of suspected abuse.

In an interview, Administrator #112 stated they had contacted resident #002's SDM two days after the incident, and documented this in resident #002's progress notes.

iii) Review of resident #001's electronic progress notes in PCC noted a third incident of suspected abuse involving resident #001 to resident #002.

Review of resident #002's progress notes noted no documentation related to the incident of suspected abuse from resident #001 or that resident #002's SDM had been notified of the incident.

In an interview, MRC #100 stated they did not recall the incident between resident #001 and resident #002 but they had noted the incident in their note book.

Review of MRC #100's hand written notes related to the incident between resident #001 and resident #002 noted two point form lines which noted the incident with resident #001 and that there was no documentation in resident #002's progress notes.

In an interview, Administrator #112 stated they were not aware of the incident between resident #001 and resident #002. Administrator #112 stated resident #002's SDM should have probably been notified of the incident.

B) Review of resident #001's electronic progress notes in PCC noted and incident of alleged abuse involving resident #001 to resident #006.

A review of resident #006's progress notes noted no documentation that their

SDM was notified of the incident of alleged abuse.

In an interview, Administrator #112 acknowledged that registered staff should have notified resident #006's SDM and documented this in resident #006's progress notes.

C) A review of resident #001's electronic progress notes in PCC noted an incident of suspected abuse involving resident #001 to resident #008.

A review of resident #008's progress notes noted no documentation related to the incident with resident #001. There was no documentation to support that resident #008's SDM was notified of the incident.

In an interview, Registered Practical Nurse (RPN) #104 reviewed resident #001's progress notes and stated they did not witness the incident between resident #001 and resident #008. RPN #104 stated Physiotherapy Aide (PTA) #119 had reported the incident to them. RPN #104 stated they could not remember the incident and could not recall if resident #008 was in distress after the incident. RPN #104 acknowledged that they had not documented the incident and any follow up with resident #008 in the resident's progress notes.

In an interview, Administrator #112 stated the resident #008's SDM should have been notified of the incident of suspected abuse involving resident #008.

The licensee has failed to ensure that the resident's substitute decision-maker and any other person specified by the resident were notified immediately upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident caused distress to the resident that could potentially be detrimental to the resident"s health or well-being.

The severity of this issue was determined to be a level 1 as there was no risk to the residents. The scope of the issue was a level 3 as it was widespread. The home had a level 2 history of noncompliance with a different subsection of the legislation. (522)

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

Jan 31, 2020

Order # / No d'ordre : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must comply with s. 131 (2) of Ontario Regulation 79/10.

Specifically, the licensee must ensure:
a) Drugs are administered to residents #012, resident #013 and any other resident in accordance with the directions for use specified by the prescriber;
b) Registered staff receive education on processing doctor's orders;
c) Attendance and a record of the education is documented.

Grounds / Motifs :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care (MLTC) regarding staff to resident neglect related to a complaint from resident #009's family member.

A review of the email complaint noted concerns that staff were not monitoring resident #009 when they were taking their medications as resident #009's family member had found two of resident #009's pills on resident #009's floor.

Review of Silver Fox's Medication Incident Form noted a dose omission occurred for resident #009 and queried that pills were left at resident #009's bedside and dropped. The Medication Incident Form noted that resident #009's family member informed Registered Practical Nurse (RPN) #123 that they had found two of resident #009's pills on resident #009's floor. Resident #009's family member gave the RPN the pills. The Medication Incident Form noted the incident did not reach the resident and there was no harm to the resident. Action

was noted that staff were to assist resident #009 with their medication and if the medication was dropped and staff were unable to locate the medication, staff were to make a note so other staff were aware. Staff were to stay with resident #009 to ensure they had swallowed their medication.

In an interview, Manager of Resident Care (MRC) #100 stated they did not know if resident #009 had received or missed their dose of the two medications.

Review of the home's medication incidents for a specific time frame noted the following:

B) Review of Silver Fox's Medication Incident Form noted resident #012 was administered a medication twice instead of once as ordered. There was no harm noted to the resident. Contributing factor was noted as wrong instructions in the electronic Medication Administration Record.

C) Review of Silver Fox's Medication Incident Form noted resident #013's dose of a specific medication had been decreased. Several days later, it was discovered that resident #013 had received three of the lower doses of the medication then continued to receive the previous higher dose. Contributing factor was noted as the order had not been faxed to pharmacy.

In an interview, MRC #100 acknowledged that residents #011 and #012 did not receive their medications as prescribed.

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The severity of this issue was determined to be a level 2 as there was minimal risk to the residents. The scope of the issue was a level 3 as it was widespread. The home had a level 3 history of previous noncompliance with this subsection of Ontario Regulation 79/10 issued as a voluntary plan of correction on November 24, 2017 (2017_262630_0031).
(522)

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Feb 28, 2020

Order # / No d'ordre : 005 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must comply with s. 98 of Ontario Regulation 79/10.

Specifically, the licensee must ensure:

a) The appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence;
b) A record is kept of the notification of the police, including who notified the police, when the police were notified and the outcome.

Grounds / Motifs :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence.

A) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care (MLTC) related to an incident of suspected abuse involving resident #001 to resident #002.

Review of review of resident #002’s electronic progress notes in Point Click Care (PCC) noted a previous incident of suspected abuse involving resident #001.

In an interview, Administrator #112 stated the incident involving resident #001 to resident #002 could be considered abuse. Administrator #112 stated the police were not called regarding this incident.

B) A review of resident #001’s electronic progress notes noted an incident of suspected abuse involving resident #001 to resident #003.

In an interview, Administrator #112 stated that the incident between resident #001 and resident #003 could have crossed the threshold and should have been reported to the police.

The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

The severity of this issue was determined to be a level 2 as there was minimal risk to the residents. The scope of the issue was a level 2 as it was a pattern, involving two out of three residents. The home had a level 2 history of noncompliance with a different subsection of the legislation. (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jan 31, 2020

Order # / No d'ordre : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) corrective action is taken as necessary; and
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Order / Ordre :

The licensee must comply with s. 135 (2) of Ontario Regulation 79/10.

Specifically, the licensee must ensure:

a) All medication incidents are documented;
b) Corrective action is taken as necessary;
c) A written record is kept of everything, including who is responsible for the corrective action and the outcomes of the corrective action.

Grounds / Motifs :

1. The licensee has failed to ensure that all medication incidents were documented, corrective action was taken as necessary and a written record was kept of everything.

Review of S&R's "Medication Incident" policy RCM 17-09 with a revision date of January 16, 2019, noted in part:

“Category C - I Medication Incidents – Error that reaches the resident (harm or no harm):

Documentation of the medication incident of any actions or interventions implemented will be recorded on the medication incident form, and in the

resident's chart on PCC. Include in the charting what medication was given/omitted and physician notified, interventions required, and outcomes for the resident.

All incident reports will be reviewed and analyzed by the MRC/designate. The MRC designate will investigate each incident considering the context of the medication incident and the practice of the nurse(s) involved to determine the education, individual assistance and potential performance management.

The MRC/designate will implement a follow up plan with corrective action which may include medication system process review, seeking individual assistance, participating in in-service education or pursuing more formal continuing education."

A) Review of Silver Fox's Medication Incident Form noted a dose omission occurred for resident #009 and queried that pills were left at resident #009's bedside and dropped. The Medication Incident Form noted that resident #009's family member informed Registered Practical Nurse (RPN) #123 that they had found two of resident #009's pills on the floor in resident #009's room. Resident #009's family member gave RPN #123 the pills.

Review of resident #009's electronic Medication Administration Record (eMAR) noted resident #009 received the two medications daily at 0800 hours. The two medications had been discontinued on a specific date and then restarted four days later.

In an interview, RPN #123 stated that resident #009's family member had informed them that they had found the pills on the floor in resident #009's room and gave the pills to RPN #123. RPN #123 stated they did not ask the family member exactly where they had found the pills. RPN #123 stated they had entered a note for registered staff to watch resident #009 take their pills.

In an interview, MRC #100 stated they did not know if resident #009 had received or missed their dose of the two medications. When asked by inspector, MRC #100 stated they did not follow up with resident #009's family member about where they had located the pills. MRC #100 stated they did not speak to any of the registered staff on previous shifts to determine what had happened.

MRC #100 stated there would have been no way to know how long the pills had been on the floor.

MRC #100 stated they had reviewed with registered staff at huddle that staff were to stay with resident #009 to ensure they had swallowed their pills.

B) Review of Silver Fox's Medication Incident Form noted resident #012 was administered a medication twice instead of once as ordered.

In an interview, RPN #123 stated that when new medication orders were received two nurses would complete separate checks of the orders against the eMAR to ensure they were correct in the eMAR. RPN #123 stated they would not necessarily enter a medication incident in a resident's progress notes unless there was harm to the resident. RPN #123 stated if the medication incident reached the resident but there was no harm they would not enter the medication incident into the resident's progress notes, they would only complete a medication incident form.

Review of resident #012's physician's orders noted an order for a specific medication to be administered to resident #012 one time only. Further review of the physician's orders noted the eMAR verification was checked and signed by two separate registered staff.

Review of resident #012's eMAR noted the specific medication was to be given every shift for one day. The medication was signed as given on two shifts on a specific date.

Review of resident #012's electronic progress notes in Point Click Care (PCC) noted no documentation related to the medication incident.

In an interview, MRC #100 stated they had spoken with the RN who had given the first dose of the medication and determined that the Registered Nurse had signed the eMAR but had not entered the administration of the drug in resident #012's progress note as was the home's practice. MRC #100 stated they had also spoken to the RN who had written the order for resident #012 and entered it in the eMAR. MRC #100 stated they could not recall which staff member had administered the second dose of medication and reviewed the signatures on

resident #012's eMAR. MRC #100 stated they had not spoken to the RPN who administered the second dose of medication as they were following what was in the eMAR. When asked by inspector, MRC #100 stated they did not know which nurses had completed the first and second check of the orders against the eMAR and questioned why inspector had asked who the staff were. When inspector indicated that registered staff were to check the order against the eMAR to ensure the eMAR was correct. MRC #100 stated they were not sure why the error was not caught during the checks.

When asked by inspector if medication incidents should be documented in a resident's progress notes, MRC #100 stated "yes and no." MRC #100 stated a medication incident with dilaudid would absolutely need to be documented in the resident's progress note, but something on the pharmacy end that did not reach the resident they would look at that as situational.

C) Review of Silver Fox's Medication Incident Form noted resident #013's dose of a specific medication had been decreased. Several days later, it was discovered that resident #013 had received three of the lower doses of the medication then continued to receive the previous higher dose. Contributing factor was noted as the order had not been faxed to pharmacy. An improvement strategy was noted as, "reviewed placing sticker on med strip at huddle."

In an interview, RPN #123 stated if a medication order was changed or discontinued the registered staff that processed the order would fax the order to pharmacy and put a change sticker on the resident's medication strip.

Review of Silver Fox Pharmacy LTC Prescriber's Order Form for resident #013 noted a telephone order was received to change resident #013's medication to a lower dose. The order noted initials that pharmacy was faxed. There were no initials beside "change sticker."

Review of resident #013's eMAR noted the higher dose of the specific medication had been discontinued on a specific date. The lower dose of the specific medication had been started the following day and registered staff had signed that they had administered the lower dosage of medication for nine days.

Review of resident #013's electronic progress notes in Point Click Care noted no

documentation related to the medication incident.

In an interview, MRC #100 stated resident #013's order for the specific medication was changed over a weekend therefore the pharmacy satellite had sent three lower doses of the specific medication. MRC #100 stated that once the three doses were finished registered staff continued to give the higher dose of the specific medication as a change sticker was not on resident #013's medication strip. MRC #100 stated they were unsure if pharmacy had not received the new order or the new order had not been faxed. MRC #100 stated they did not know who the staff member was who was responsible to fax the order to pharmacy. MRC #100 stated they had not spoken with any of the registered staff who were involved in the medication incident. MRC #100 stated they had spoken to all registered staff during huddle regarding placing a change sticker on medication strips when orders were changed.

MRC #100 stated they did not keep notes related to investigating medication incidents, such as interviews with staff, they only documented on the Medication Incident Form.

In an interview, Administrator #112 stated when a medication incident occurred, they would expect that the medication incident was reviewed with registered staff involved, corrective action was assigned, and the staff were monitored by the MRC or Assistant MRC.

Administrator #112 stated as part of investigating the medication incident they would expect that follow up would be completed with the registered staff who worked previous shifts prior to resident #009's medication being found on the floor by resident #009's family member.

Administrator #112 stated that they would expect that follow up be completed with the registered staff who completed the checks for resident #012's medication. Administrator #112 stated that for medication incidents, discussion and follow up with staff should take place and should be documented as part of the medication incident report.

The licensee has failed to ensure that all medication incidents were documented, corrective action was taken as necessary and a written record was

kept of everything.

The severity of this issue was determined to be a level 2 as there was minimal risk to the residents. The scope of the issue was a level 3 as it was widespread. The home had a level 3 history of previous noncompliance with this subsection of Ontario Regulation 79/10 issued as a written notification on November 24, 2017 (2017_262630_0031).
(522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2020

Order # / No d'ordre : 007

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 must comply with s. 19 of LTCHA 2007.

Specifically, the licensee must ensure:
a) All residents are protected from abuse;
b) All staff receive training on specific S&R policies;
c) A record is kept of the training and attendance.
c) Resident #002 and resident #003 and any other resident has their care plan updated.

Grounds / Motifs :

1. The licensee has failed to protect residents from abuse by anyone.

A) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care (MLTC) related to an incident of suspected abuse involving resident #001 to resident #002.

Review of the CIS report noted a Personal Support Worker (PSW) had a report from another team member that they had witnessed an incident of suspected abuse involving resident #001 to resident #002.

In an interview, Restorative Care Aide (RCA) #103 stated they witnessed the incident of suspected abuse between resident #001 and resident #002. RCA #103 stated they did not think what they witnessed was appropriate and went to get the Behavioural Supports Ontario (BSO) PSW.

In an interview, BSO PSW #101 stated they were informed of the incident from RCA #104 and went straight to resident #002. BSO PSW #101 stated resident #002 was physically shaking.

In an interview, Social Worker (SW) #109 stated they had sat with resident #002 after the incident with resident #001. SW #109 stated they had seen resident #002 the previous day and resident #002 had been happy and giggling. SW #109 stated when they sat with resident #002 after the incident, resident #002 had completely shut down, was very shaky and was distressed.

In an interview, Assistant Manager of Resident Care (AMRC) #114 stated they were contacted by the Registered Practical Nurse (RPN) on the floor regarding the incident. AMRC #114 stated they had met with police and reviewed video footage during the time of the incident. AMRC #114 stated based on the video footage there was not enough time for anything to have occurred between the residents.

In an interview, Administrator #112 stated they had reviewed the video footage of the incident, looked at the evidence and based on the fact that resident #002 was distressed by the incident they determined the incident had crossed the threshold for reporting and submitted the CIS.

Review of resident #002's electronic progress notes in Point Click Care (PCC) noted two previous incidents of suspected abuse involving resident #001.

i) Review of resident #002's progress notes indicated that the AMRC was notified of the first incident of suspected abuse and interventions were put in place for resident #002.

Review of resident #002's hard copy chart noted safety checks were initiated for resident #002 after the incident.

In an interview, Manager of Resident Care (MRC) #100 stated they could not recall the incident and if it was investigated. MRC #100 stated they would need to find their notes related to the incident.

MRC #100 stated that they had spoken to resident #001 regarding the incident with resident #002.

In an interview, Administrator #112 reviewed resident #002's progress notes related to the first incident of suspected abuse Administrator #112 stated in

reviewing resident #002's progress notes the incident could fall under the definition of abuse, but they had not interviewed the staff regarding the incident therefore it was hard to determine.

ii) Review of resident #002's progress notes indicated the RN was notified of the second incident of suspected abuse and resident #002 was assessed and started on safety checks. The progress note indicated that management had been informed of the incident.

In an interview, MRC #100 stated they vaguely remembered the incident between resident #001 and resident #002 and would need to review their notes.

MRC #100 gave inspector copies from MRC #100's note book related to the second incident. Review of notes with MRC noted two point form lines related to the incident which indicated that resident #002 had safety checks in place and Administrator #112 would call resident #002's Power of Attorney and that resident #001 was being monitored.

MRC #100 stated those were their only notes related to the incident between resident #001 and resident #002.

In an interview, Administrator #112 stated the incident between resident #001 and resident #002 could have been considered suspected abuse.

iii) Review of resident #001's electronic progress notes in PCC noted a third incident of suspected abuse towards resident #002.

Review of resident #002's progress notes noted no documentation related to the third incident with resident #001.

In an interview, MRC #100 stated they did not recall the incident between resident #001 and resident #002. MRC #100 stated they did not have any investigative notes related to the incident but they had noted the incident in their note book. MRC #100 stated they noted there was no documentation in resident #002's progress notes related to the incident.

Review of MRC #100's hand written notes related to the incident between

resident #001 and resident #002 noted two point form lines which noted the incident with resident #001 and that there was no documentation in resident #002's progress notes.

In an interview, Administrator #112 stated they were not aware of the incident between resident #001 and resident #002. Administrator #112 stated the incident would fall under the definition of abuse. Administrator #112 stated it was possible the incident should have been reported to the MLTC.

In an interview, Social Service Worker (SSW) #107 stated they had completed a review on resident #002 related to their interactions with resident #001.

SSW #107 stated specific interventions were in place to protect resident #002 after the incident with resident #001. Inspector had observed the specific interventions in place.

SSW #107 stated the specific interventions had not been entered into resident #002's care plan. SSW #107 stated they had sent the review and their recommendations to Administrator #112.

Review of SSW #107's hand written notes for the review noted no mention of the third incident between resident #001 and resident #002.

Review of an email sent to Administrator #112 from SSW #107 noted SSW #107 stated they had reviewed resident #002's interactions with resident #001 and their conclusion was to continue to monitor the interactions from moment to moment and safety checks for resident #002 if needed. SSW #107 stated their recommendation was to have a conversation with resident #001 regarding their behaviour toward resident #002.

In an interview, Registered Nurse (RN) #111 stated there were specific interventions put in place for resident #002.

A review of resident #002's electronic care plan and kardex on Point Click Care (PCC) noted no reference to the specific interventions for resident #002. Further review noted no reference to interventions related to interactions with resident #001 and that the residents were to be monitored.

In an interview, Registered Practical Nurse (RPN) #104 stated that registered staff were responsible to update a resident's care plan. RPN #104 stated resident #002 had specific interventions in place to prevent interactions with resident #001.

RPN #104 reviewed resident #002's care plan and kardex with inspector and confirmed that the specific interventions were not included in resident #002's care plan or kardex. RPN #104 stated there was no focus or interventions for resident #002 related to interactions with resident #001.

In an interview, Manager of Resident Care (MRC) #100 stated the use of a specific intervention should be included in a resident's plan of care.

In an interview, Administrator #112 stated that after SSW #107's review the interventions related to interactions with resident #001 should have been entered into resident #002's care plan.

The licensee failed to protect resident #002 from resident #001. Resident #001 had been abusive towards resident #002 on several occasions during which resident #002 showed signs of distress.

Staff failed to document the third incident with resident #001 in resident #002's progress notes, therefore this incident was not taken into account when SSW #107 completed a review for resident #002. Staff also failed to note in resident #002's care plan interventions related to interactions with resident #001.

B) Review of resident #001's electronic progress notes in PCC noted an incident of suspected abuse involving resident #001 to resident #003.

A review of resident #001's electronic progress notes noted staff witnessed the incident of suspected abuse and notified the Registered Practical Nurse.

Review of resident #003's progress notes noted no documentation related to the incident. Further review of resident #003's progress notes noted several incidents of suspected abuse involving resident #001 over the course of two days. Resident #003's progress notes indicated that resident #003 had not been

well during this time and resident #003 had displayed a change in mood after the incidents and indicated they did not want to be near resident #001.

In an interview, Registered Practical Nurse (RPN) #110 stated a staff member had made them aware of the incident between resident #001 and resident #003. RPN #110 stated resident #003 had told them they did not want to be near resident #001.

In an interview, Personal Support Worker (PSW) #120 stated they had witnessed an incident of suspected abuse between resident #001 towards resident #003.

PSW #120 stated they reported the incident to registered staff who assessed resident #003.

In an interview, RPN #113 stated that a PSW had reported the incident between resident #001 and resident #003 to them. RPN #113 stated they went straight to resident #003 and called the Registered Nurse (RN). RPN #113 stated they then tried to talk to resident #003 to find out what happened but it was difficult. RPN #113 stated resident #003 seemed fine and did not appear hurt.

Observation of resident #003's room noted specific interventions in place for resident #003.

Review of resident #003's care plan and kardex noted no reference to the use of the specific interventions or any interventions related to interactions with resident #001.

In an interview, Social Service Worker #107 stated they had also completed a review on resident #003 related to their interactions with resident #001.

SSW #107 stated resident #003 might not be able to verbalize how they felt, but if they were distressed resident #003 could let someone know.

Review of SSW #107's review with SSW #107, noted that SSW #107 had not referenced the incident between resident #001 and resident #003. SSW #107 stated they had reviewed documented interactions between resident #001 and

resident #003 in resident #003's progress notes and then crossed referenced resident #001's progress notes. SSW #107 stated since the incident was not documented in resident #003's progress notes they were not aware of the incident and did not include it in their review.

SSW #107 stated interventions had not been entered into resident #003's care plan. SSW #107 stated they had sent their review and their recommendations to Administrator #112.

Review of SSW #107's email sent to Administrator #112 noted SSW #107 stated they had reviewed resident #003's interactions with resident #001 and their conclusion was to continue to monitor the interactions from moment to moment and safety checks if needed.

In an interview, RPN #104 reviewed resident #003's care plan and kardex with inspector and confirmed that the use of a specific intervention was not included in resident #003's care plan or kardex. RPN #104 stated there was no focus or interventions for resident #003 related to interactions with resident #001.

In an interview, Personal Support Worker #120 stated they had witnessed the incident between resident #001 and resident #003. PSW #120 stated originally they were told that they were to monitor the residents and then they were told resident #001 was not allowed near resident #003.

In an interview, MRC #100 stated the use of a specific intervention should be included in a resident's plan of care. MRC #100 stated they did not remember the incident between resident #001 and resident #003.

Review of MRC #100's hand written notes in MRC #100's notebook for the day after the incident noted a point form line indicating resident #003 had been visibly upset the day after an incident with resident #001 and that resident #003 did not want resident #001 to be near them.

In an interview, Administrator #112 stated that after SSW #107's review the interventions related to interactions with resident #001 should have been entered into resident #003's care plan. Administrator #112 stated they had read about the incident between resident #001 and resident #003 in report and they

had spoken to resident #001 about the incident. Administrator #112 stated the incident did fit under the definition of suspected abuse.

The licensee failed to protect resident #003 from resident #001 when staff failed to recognize signs of possible distress in resident #003. Staff failed to recognize that during this time resident #003 had been unwell. After interactions with resident #001, resident #003 had stated they did not like resident #001, had been avoiding resident #001, had been observed crying and showed a flat affect.

Staff failed to document the incident with resident #001 in resident #003’s progress notes, therefore this incident was not taken into account when SSW #107 completed a review for resident #003. Staff also failed to note in resident #003’s care plan interventions related to interactions with resident #001.

C) Review of resident #001’s electronic progress notes in PCC noted an incident of suspected abuse involving resident #001 to resident #006.

In an interview, RPN #123, who worked full time on the home area, stated they did not recall the incident between resident #001 and resident #006.

In an interview, MRC #100 stated that they did not recall the incident between resident #001 and resident #006. MRC #100 stated based on resident #006’s progress note it had been reported to the Resident Care Coordinator who no longer worked at the home.

In an interview, Administrator #112 stated they were aware of the incident between resident #001 and resident #006. Administrator #112 stated if the incident happened as was reported, then based on the definition of abuse, it would be considered abuse and should have been reported to the Ministry of Health and Long-Term Care.

D) Review of resident #001's electronic progress notes in PCC noted an incident of suspected abuse involving resident #001 to resident #008.

A review of resident #008’s progress notes noted no documentation related to the incident with resident #001.

In an interview, Registered Practical Nurse (RPN) #104 reviewed resident #001's progress notes and stated they did not witness the incident between resident #001 and resident #008. RPN #104 stated Physiotherapy Aide (PTA) #119 had reported the incident to them. RPN #104 stated they could not remember the incident and could not recall if resident #008 was in distress after the incident. RPN #104 acknowledged that they had not documented the incident and any follow up with resident #008 in the resident's progress notes.

In an interview, PTA #119 stated the witnessed the incident between resident #001 and resident #008. PTA #119 stated they notified the RPN and a PSW came and removed resident #008.

In an interview, MRC #100 stated they did not recall the incident between resident #001 and resident #008 and they did not have any notes related to the incident.

In an interview, Administrator #112 stated they did not recall the incident between resident #001 and resident #008 and they did not have any notes related to the incident.

Administrator #112 reviewed resident #001's progress notes related to the incident. Administrator #112 stated based on the definition of abuse they would consider this an incident of suspected abuse.

E) In an interview, Registered Practical Nurse (RPN) #113 stated if they witnessed an interaction of suspected abuse between residents they would stop the interaction, remove the resident and sit with resident that was upset. RPN #113 stated they would try to find out what happened from the resident, but some residents could not always tell them. RPN #113 stated they would also talk to the other resident involved. RPN #113 stated they would complete risk management, safety checks on the resident, call families and management and document the incident in a progress note. RPN #113 stated if the Social Worker and RN were in the building, they would call them.

During the course of the inspection, several staff expressed concern that they did not know what they could and could not do regarding incidents with resident

#001, and how to protect other residents from unwanted interactions.

In several interviews, staff members indicated resident #001 had previous incidents with several residents in the home area, including resident #002, #003, #004 and #005.

In an interview, PSW #105 stated they worked with resident #001 and they were told they were not to let resident #001 go into any residents' rooms. PSW #105 stated they were not aware that resident #001 had incidents with other residents on the home area, just resident #002. PSW #105 stated they were made aware of a resident's care needs through other staff and by reviewing a resident's electronic care plan on Point of Care.

Further review of resident #001's electronic progress notes in PCC noted incidents of suspected abuse with resident #008, resident #003, resident #004 and four incidents with resident #002. Two separate incidents of suspected abuse were documented in resident #001's progress notes but the notes did not indicate the residents involved.

A review of resident #001's electronic care plan and kardex on PCC noted no documentation related to resident #001's behaviour and that resident #001 was not to go into other residents' rooms.

In an interview, Social Service Worker (SSW) #107 stated they had completed a review for resident #002 and resident #003 related to their interactions with resident #001. SSW #107 stated that had made recommendations to the Administrator. SSW #107 stated their recommendation was to have a conversation with resident #001 regarding their interactions with resident #002 and resident #003. SSW #107 stated to continue to monitor resident #001's interactions with resident #002 and resident #003 and to complete safety checks if needed.

In an interview, Registered Practical Nurse (RPN) #104 reviewed resident #001's care plan and kardex with inspector and confirmed there were no interventions related to resident #001's behaviours or that resident #001 was not to have contact with resident #002 or resident #003.

In an interview, MRC #100 stated resident #001's behaviours and interventions should be included in resident #001's plan of care, in particular that resident #001 was not to have contact with resident #002 and resident #003.

In an interview, Administrator #112 stated that after SSW #107's review the interventions related to resident #001's interactions with resident #002 and resident #003 should have been entered into resident #001's care plan.

The licensee failed to protect residents from resident #001 by not including interventions related to resident #001's behaviours in resident #001's care plan. Staff failed to document specific incidents of suspected abuse in both residents' progress notes, specifically for resident #002, resident #003 and resident #008.

The licensee has failed to protect residents from abuse by anyone.

The severity of this issue was determined to be a level 3 as there was actual harm and actual risk to residents. The scope of the issue was a level 3 as it was widespread. The home had a level 3 history of previous noncompliance with this subsection of the LTCHA 2007, issued as a voluntary plan of correction on November 26, 2018 (2018_674610_0021). (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2020

Order # / No d'ordre : 008 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must comply with s. 23 (1) of LTCHA 2007.

Specifically, the licensee must ensure:

a) Every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported is immediately investigated.
b) The investigation must be documented, including staff and resident interviews, resident observation, notification of the resident's substitute decision maker, notification of the resident's physician and if applicable, notification of the appropriate police force;
c) All residents are assessed and safety checks put in place to monitor a resident's response to every incident of alleged, suspected or witnessed incident of abuse of a resident by anyone. Documentation must be kept of the resident's assessment and safety checks.

Grounds / Motifs :

1. The licensee has failed to ensure that every alleged, suspected or witnessed

incident of abuse of a resident by anyone, that the licensee knew of, or that was reported was immediately investigated.

A) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care (MLTC) related to an incident of suspected abuse involving resident #001 to resident #002.

Review of review of resident #002's electronic progress notes in Point Click Care (PCC) noted previous incidents of suspected abuse involving resident #001 to resident #002.

i) Review of resident #002's progress notes indicated the RN was notified of the incident of suspected abuse and resident #002 was assessed and started on safety checks. The progress note indicated that management had been informed of the incident.

In an interview, Manager of Resident Care (MRC) #100 stated they vaguely remembered the incident between resident #001 and resident #002 and would need to review their notes.

MRC #100 gave inspector copies from MRC #100's note book related to the second incident. Review of notes with MRC noted two point form lines related to the incident which indicated that resident #002 had safety checks in place and Administrator #112 would call resident #002's Power of Attorney and that resident #001 was being monitored.

MRC #100 stated they did not have any investigation notes, and those were their only notes related to the incident between resident #001 and resident #002.

MRC #100 stated they did not speak with the staff members who witnessed the incident or the residents involved.

In an interview, Administrator #112 stated they did not investigate the incident between resident #001 and resident #002. Administrator #112 reviewed their notebook and stated the Manger of Life Enrichment (MLE) met with resident #001 regarding the incident. Administrator #112 asked MLE #130 to come to the

Administrator's office.

MLE #130 spoke with Administrator #112 in the presence of inspector and stated they met with resident #001. MLE #130 stated resident #001 stated they were having a good day and asked MLE #130 to leave as they were watching TV.

Administrator #112 confirmed there was no investigation or follow up with resident #001 and resident #002 after the incident. Administrator #112 stated the incident between resident #001 and resident #002 should have been investigated.

ii) Review of resident #001's electronic progress notes in PCC noted a Personal Support Worker (PSW) witnessed another incident of suspected abuse involving resident #001 to resident #002.

Review of resident #002's progress notes noted no documentation related to the above incident with resident #001.

In an interview, MRC #100 stated they did not recall the incident between resident #001 and resident #002. MRC #100 stated they did not have any investigative notes related to the incident, but they had noted the incident in their note book. MRC #100 stated they noted there was no documentation in resident #002's progress notes related to the incident.

Review of MRC #100's hand written notes related to the incident between resident #001 and resident #002 noted two point form lines which noted the incident with resident #001 and that there was no documentation in resident #002's progress notes.

In an interview, Administrator #112 stated they were not aware of the incident between resident #001 and resident #002. Administrator #112 stated the incident should have been investigated.

B) A review of resident #001's electronic progress notes noted staff had witnessed and incident of suspected abuse involving resident #001 to resident #003 and notified the Registered Practical Nurse.

Review of resident #003's progress notes noted no documentation related to the incident.

In an interview, Registered Nurse #128 stated they attended resident #003's room after the incident between resident #001 and resident #003. RN #128 stated they would report an incident to management, and they would investigate and determine if the incident was abuse. RN #128 stated they were certain they had informed the oncall manager, but they were unsure as they did not document the incident and notification of management in resident #003's progress notes.

In an interview, MRC #100 stated they did not remember the incident between resident #001 and resident #003.

Review of MRC #100's hand written notes in MRC #100's notebook for the day after the incident noted a point form line indicating resident #003 had been visibly upset the day after an incident with resident #001 and that resident #003 did not want resident #001 to be near them.

In an interview, Administrator #112 stated the incident between resident #001 and resident #003 should have been reported immediately to management. Administrator #112 stated they had read the incident in report and they had spoken to resident #001 about the incident. Administrator #112 stated that the registered nurse on duty should have followed up with the residents and investigated the incident when it occurred.

C) Review of resident #001's electronic progress notes in Point Click Care (PCC) noted an incident of suspected abuse involving resident #001 to resident #006.

A review of resident #006's electronic progress notes noted the incident of suspected abuse involving resident #001. Other than the actual incident there was no further documentation in either resident's progress notes related to the incident.

In an interview, MRC #100 stated that the did not recall the incident between

resident #001 and resident #006. MRC #100 stated based on resident #006's progress note it had been reported to the Resident Care Coordinator, who no longer worked at the home.

In an interview, Administrator #112 stated they were aware of the incident and acknowledged that the incident had not been investigated. Administrator #112 stated the incident should have been investigated and staff should have followed up directly with resident #006 to find out what had occurred.

D) Review of resident #001's electronic progress notes in PCC noted an incident of suspected abuse involving resident #001 to resident #008.

A review of resident #008's progress notes noted no documentation related to the incident with resident #001.

In an interview, Registered Practical Nurse (RPN) #104 reviewed resident #001's progress notes and stated they did not witness the incident between resident #001 and resident #008. RPN #104 stated Physiotherapy Aide (PTA) #119 had reported the incident to them. RPN #104 stated they could not remember the incident and could not recall if resident #008 was in distress after the incident. RPN #104 acknowledged that they had not documented the incident and any follow up with resident #008 in the resident's progress notes.

In an interview, PTA #119 stated they had witnessed the incident between resident #001 and resident #008. PTA #119 stated they notified the RPN and a PSW came and removed resident #008.

In an interview, MRC #100 stated they did not recall the incident between resident #001 and resident #008 and they did not have any notes related to the incident.

In an interview, Administrator #112 stated they did not recall the incident between resident #001 and resident #008 and they did not have any notes related to the incident. Administrator #112 stated the incident should have been investigated and reported to management.

The licensee has failed to ensure that every alleged, suspected or witnessed

incident of abuse of a resident by anyone, that the licensee knew of, or that was reported was immediately investigated.

2. The licensee has failed to ensure that appropriate action was taken in response to every incident of alleged, suspected or witnessed incident of abuse of a resident by anyone.

Review of a specific S&R policy created October 27, 2016, noted in part:

"When there is an incident between residents and one or both residents are cognitively impaired (CPS of 2 or greater):
Immediate: Assess the emotional response to the interaction.

Ongoing: Continue to monitor the residents for emotional responses and safety.

-Separate both residents immediately
-Complete a physical assessment and the relevant risk management
-Initiate behaviour/safety tracking for a minimum of 72 hours
-Notify management and SDM
-Update care plan for both residents
-Initiate referral to internal BSO/SW/Chaplain as available in the home
-Consider referral to physician for review at the next visit (as required)."

In an interview, RN #111 stated if an incident of suspected abuse was reported to them, they would follow up immediately and assess the resident for safety. RN #111 stated staff would initiate safety checks for the victim to ensure they were not in any distress and they would also initiate Dementia Observation System (DOS) tracking for the aggressor.

In an interview, Behavioural Supports Ontario Registered Nurse (BSO RN) #129 stated that they reviewed all resident DOS tracking and safety checks. BSO RN #129 stated they would make a copy of the DOS charting and if the resident was on BSO the document would be filed in BSO files and if the resident was not on BSO the document would go to the floor to be filed in the resident's chart.

A) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care (MLTC) related to an incident of suspected abuse

involving resident #001 to resident #002.

Review of resident #002's electronic progress notes in Point Click Care (PCC) noted previous incidents with resident #001 as follows:

i) Review of resident #002's progress notes indicated that the AMRC was notified of the first incident of suspected abuse and interventions were put in place for resident #002.

Review of resident #002's hard copy chart noted safety checks were initiated for resident #002 after the incident.

Review of resident #002's electronic progress notes noted no evidence of a physical assessment of resident #002 after the incident.

In an interview, BSO Personal Support Worker (PSW) #106 stated they had checked the BSO files for resident #001 and could not locate DOS tracking for resident #001 related to the above incidents.

In an interview, MRC #100 stated registered staff should have completed a physical assessment of resident #002 after the incident. MRC #100 stated there should be a record of DOS charting for resident #001 related to the incident.

ii) Review of resident #002's progress notes indicated the RN was notified of the second incident of suspected abuse and resident #002 was assessed and started on safety checks. The progress note indicated that management had been informed of the incident.

A review of resident #002's hard copy chart noted no documented Dementia Observation System (DOS) safety checks initiated after the incident.

In an interview, BSO PSW #106 confirmed that they could not locate DOS safety checks that were initiated for resident #002 after the incident.

In an interview, BSO PSW #106 stated they had checked the BSO files for resident #001 and could not locate DOS tracking for resident #001 related to the incident.

In an interview, MRC #100 stated DOS tracking and safety checks should be documented and filed for resident #001 and resident #002.

B) Review of resident #001's electronic progress notes in PCC noted an incident of suspected abuse involving resident #001 to resident #003.

A review of resident #001's electronic progress notes noted staff witnessed the incident of suspected abuse and notified the Registered Practical Nurse (RPN).

Review of resident #003's progress notes noted no documentation of assessments or follow up with resident #003 related to the incident. There was one progress note for resident #003 from the time of the incident which noted that resident #003 stated they were not happy that resident #001 would come into their room.

There was no documentation in resident #001's progress notes that registered staff followed up with resident #001 after the incident.

In an interview, RPN #113 stated that a PSW had reported the incident between resident #001 and resident #003 to them. RPN #113 stated they went straight to resident #003's room and called the Registered Nurse (RN).

RPN #113 stated they tried to talk to resident #003 to find out what happened but it was difficult. RPN #113 stated resident #003 would have had a skin assessment completed and Dementia Observation System (DOS) safety tracking would have been initiated.

RPN #113 reviewed resident's electronic progress notes and assessment tab in Point Click Care (PCC) with inspector. RPN #113 confirmed that a skin assessment was not completed on resident #003 and there was no documentation in resident #003's progress notes related to initiating DOS safety tracking to monitor resident #003's response to the incident.

RPN #113 reviewed resident #003's hard copy chart with inspector. RPN #113 confirmed safety checks were not initiated on resident #003 until a day after the incident.

In an interview, RN #128 stated they attended resident #003's room after the incident between resident #001 and resident #003. RN #128 stated resident #003 would have been started on 72 hour safety checks. RN #128 acknowledged that they had not documented the incident or initiation of safety checks in resident #003's progress notes.

In an interview, Administrator #111 stated resident #003 should have had a physical assessment after the incident with resident #001. Administrator #111 stated interventions should have been put in place for resident #003 and those interventions should have been documented.

C) Review of resident #001's electronic progress notes in PCC noted and incident of suspected abuse involving resident #001 to resident #006.

A review of resident #006's electronic progress notes noted documentation of the incident.

There was no further documentation in either resident's electronic progress notes in PCC regarding any follow up with resident #001 or resident #006 related to the incident.

In an interview, RN #111 stated they did not recall the incident between resident #001 and #006. RN #111 stated if an incident of suspected abuse was reported to them, they would follow up immediately and assess the resident for safety. RN #111 stated after an incident such as what occurred between resident #001 and #006, staff would initiate safety checks for the victim to ensure they were not in any distress and they would also initiate Dementia Observation System (DOS) tracking for the aggressor. RN #111 reviewed resident #006's hard copy chart and noted that there were no documented DOS safety checks. RN #111 stated BSO staff review all DOS charting and safety checks and they may have the safety checks for the residents in their files.

In an interview, BSO PSW #106 stated they had reviewed the BSO files and were unable to find safety checks or DOS tracking for either resident related to the incident.

In an interview, MRC #100 stated when there was an incident of suspected, alleged or actual abuse involving a resident the key was making sure the resident was safe and the effect it had on the resident was first and foremost. MRC #100 stated DOS tracking and safety checks should be completed for residents when there was any sort of altercation or incident between residents.

In an interview, Administrator #112 stated resident #006 should have been assessed and safety checks should have been initiated after the incident with resident #001 to determine if resident #006 was in any distress after the incident.

D) Review of resident #001's electronic progress notes in PCC noted an incident of suspected abuse involving resident #001 to resident #008.

A review of resident #008's progress notes noted no documentation related to the incident with resident #001 or any follow up with resident #008.

In an interview, Registered Practical Nurse (RPN) #104 reviewed resident #001's progress notes and stated they did not witness the incident between resident #001 and resident #008. RPN #104 stated Physiotherapy Aide (PTA) #119 had reported the incident to them. RPN #104 stated they could not remember the incident and could not recall if resident #008 was in distress after the incident. RPN #104 acknowledged that they had not documented the incident and any follow up with resident #008 in the resident's progress notes. RPN #104 stated after such an incident resident #008 would have had safety checks. RPN #104 reviewed resident #002's hard copy chart and acknowledged that there were no documented safety checks initiated after the incident with resident #001.

In an interview, MRC #100 stated when there was an incident of suspected, alleged or actual abuse involving a resident the key was making sure the resident was safe and the effect it had on the resident was first and foremost.

In an interview, Administrator #112 stated resident #008 should have been assessed and had safety checks initiated after the incident with resident #001 to determine if resident #008 was in any distress after the incident.

The licensee has failed to ensure that that appropriate action was taken in response to every incident of alleged, suspected or witnessed incident of abuse of a resident by anyone.

The severity of this issue was determined to be a level 3 as there was actual risk to residents. The scope of the issue was a level 3 as it was widespread. The home had a level 3 history of previous noncompliance with this subsection of the LTCHA 2007, issued as a voluntary plan of correction on November 27, 2018 (2018_607523_0029). (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jan 31, 2020

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 Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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

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

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

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

Issued on this 31st day of December, 2019

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Julie Lampman

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