Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 9, 2018	2018_643111_0004	015526-17, 018281-17, 021368-17, 023721-17, 002352-18	Critical Incident System

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

Maplewood
12 Maplewood Avenue Box 249 BRIGHTON ON K0K 1H0

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

LYNDA BROWN (111)

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): February 8, 12 to 16, 2018

The following critical incident reports (CIR) were inspected concurrently during this inspection:
-log # 021368-17, 023721-17, 018281-17, 015526-17 and 002352-18 related to suspected resident to resident verbal/physical abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector observed residents, reviewed the health records of residents, reviewed the licensee's investigations, reviewed Behavioural Support Ontario collaborative meeting minutes and reviewed the following licensee's policies: Prevention of Abuse and Neglect and Responsive Behaviours.

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

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **0 VPC(s)**
- **1 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	Legendé 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 O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

The licensee has failed to ensure steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #001, resident #002, resident #003 and resident #004, by identifying and implementing interventions.

Review of the written plan of care for resident #001 indicated the resident had been admitted to the home with diagnoses that included cognitive impairment. The resident demonstrated specified responsive behaviours towards other residents and staff. Two specified triggers were identified and included a specified resident. Steps taken to minimize altercations included: every 15 minute checks when the resident was demonstrating the responsive behaviour, a specified method of transporting the resident to and from meals and activities, and encourage roommates to perform activities in places that won't disturb the resident.

Review of the written plan of care for resident #002 indicated the resident demonstrated specified responsive behaviours related to cognitive impairment. Steps taken to minimize altercations included: monitor for signs of responsive behaviours; use behaviour tracking sheet to track incidence; every 15 minute checks for aggression towards peers to be implemented as needed; provide diversional activity for 15 minutes if responsive behaviour escalates; distract with refreshments; take to quiet area, remind of inappropriate behaviour is unacceptable; remove from area if demonstrating responsive behaviour with a particular resident; keep both resident #001 and resident #002 away from one another; BSO collaborative meeting to discuss resident's responsive behaviours; 1:1 staffing to be assigned as needed when behaviour becomes a threat to the resident or others.

The Administrator provided a summary of incidents over an eight month period which revealed four critical incidents of witnessed or suspected abuse involving resident #001 that were reported to the Ministry of Health and Long-Term Care, three of which involving resident #001 and resident #002, related to altercations.

Review of the progress notes for resident #002 over the same eight month period indicated there were five additional altercations involving resident #002. All of the altercations occurred while the residents were in a specified area of the home.

Interview with PSW #101 by Inspector #111, indicated resident #001 would demonstrate the specified responsive behaviours in specified situations. The PSW indicated resident

#002 demonstrated specified responsive behaviours mainly towards specified residents and occurred in specified situations. The PSW also indicated the best approach to manage the responsive behaviour. The PSW indicated both resident #001 and #002 did not like one another and staff try to keep them apart. The PSW indicated 1:1 monitoring and every 15 minute checks have been used in the past for both resident #001 and #002.

Interview with RN #108 indicated resident #001 is generally a very quiet resident but can demonstrate responsive behaviours if feels threatened in specified situations. The RN recalled an altercation involving resident #002 and resident #001, the RN was "very concerned" with resident #001 responsive behaviours and contacted the Behavioural Support Transition Unit (BSTU) to assess the resident. The RN indicated an alarming device was put in place for resident #001 to alert staff when the resident left the room. The RN indicated resident #002 is generally easy going but will demonstrate responsive behaviours towards other residents in specified areas and results in an altercation. The RN indicated the residents seating was altered which resolved the responsive behaviours in the dining room. The RN indicated staff are to ensure resident #002 is not left alone in a specified area and confirmed resident #001 disliked resident #002.

Interview with the DOC indicated resident #001 only identified trigger for responsive behaviours was resident #002 who would provoke the resident in a specified area. The DOC indicated strategies used included: both residents placed in rooms in separate halls, alarming device for resident #001, checking resident #001 every 15 minutes, ensuring both residents are kept apart in specified areas at specified times and resident #001 was placed on 1:1 in the past. The DOC indicated resident #001 was also the recipient of an altercation by another resident. The DOC indicated resident #002 has cognitive impairment. The DOC indicated resident #002 will also demonstrate another responsive behaviour that is triggered by hunger so staff try to ensure resident #002 receives snacks when responsive behaviour is noted to reduce possible negative interaction with other residents. The DOC indicated staff attempt to keep resident #002 away from resident #001.

Review of the health records of resident #001 and resident #002 indicated there were ongoing physical altercations and potentially harmful interactions between both residents, which all occurred in a specified area of the home. In addition, there were altercations and potentially harmful altercations between resident #001 and other residents (resident #003 & #004) and resident #002 with other residents (resident #005 & #006). The steps identified for both resident #001 and #002 were not always taken to minimize the risk for

both residents resulting in two actual harmful altercations between resident #001 and #002 and one actual harmful interaction between resident #001 and resident #004. The steps identified for each resident (either 1:1 monitoring or every 15 minute checks) were also not taken until after the altercations occurred. [s. 54. (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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

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

Under LTCHA, 2007, s.20(2) the licensee shall ensure that the policy to promote zero tolerance of abuse and neglect of residents shall:
(c) provide for a program, that complies with the regulations, for preventing abuse and neglect
(e) contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents.

Review of the licensee's policy Zero Tolerance of Abuse and Neglect of Residents (A 6.9) revised June 2015 indicated in cases where a staff member witnesses/suspects/hears about an act of abuse or neglect, once the resident is physically safe, the following steps shall be taken: complete an investigation in accordance with the investigation procedures policy.

Related to Log #015526-17:

Interview with the Administrator indicated the expectation is that all registered staff are to complete the mandatory report checklist for any suspected, alleged or witnessed incidents of resident abuse as per the licensee's investigation procedure policy which ensures the manager on call is notified, family and physician are notified, and an investigation is completed immediately.

A) Review of the progress notes for resident #001 indicated there was a suspected physical abuse between resident #001 and resident #004 documented by RN #111 on a specified date and time. No injuries were noted to either resident at that time but three days later, resident #001 was noted to have an injury to a specified area. There was no documented evidence the mandatory report checklist was completed.
B) Review of the progress notes for resident #002 by RN #108, indicated there was a suspected physical abuse between resident #002 and resident #001 on a specified date and time. No injuries were noted. There was a second suspected physical abuse between resident #002 and resident #006 documented by RN #111 five months later at a specified time. No injuries were noted to either resident. There was no documented evidence the mandatory report checklist was completed for either incident.

Interview with RN #108 indicated any alleged, suspected or witnessed incidents of abuse require a completion of the mandatory report checklist which ensures the incident is reported and investigated. The RN indicated this is the usual practice but this did not occur for the incident that occurred on a specified date.

Interview with the Administrator indicated there was no documented evidence that RN #111 completed the mandatory report checklist for the either of the two incidents that occurred on specified dates involving resident #001 and #004 and involving resident #002 and #006. The Administrator also confirmed RN #108 did not complete the mandatory report checklist for the incident involving resident #001 and resident #002. [s. 20. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) 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; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

The licensee has failed to ensure that procedures and interventions were 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 that minimize the risk of altercations and potentially harmful interactions between and among residents.

Related to log #015526-17, #018281-17, #021368-17, #023721-17 and #002352-18:

Review of the licensee's policy related to responsive behaviours indicated the following three licensee policies were included:

a. Managing Responsive Behaviours (SM 1.4) revised July 2013 indicated:
-when a new or escalated behaviour is identified, the Dementia Observation System (DOS) shall be initiated (as per policy SM 1.9);
-each resident that has been identified to have potential or actual responsive behaviours shall be immediately referred to a physician or other individual specializing in psycho-geriatric medicine;
- a medication map shall be initiated to determine behavioural patterns and appropriate use of psychotropic medications;
-the multidisciplinary team shall review the results of the medication map and DOS charting to determine the most appropriate interventions;
-a crisis care plan shall be developed and integrated with the full plan of care [BAT Tool].

b. Dementia Observation System (DOS) and Intervention Analysis Tool (SM 1.9) revised July 2013 indicated:
-the DOS shall be completed daily every 30 minutes over a 24 hour period for a minimum of 7 days by the PSW or designate. The results of the DOS analyzed for behavioural patterns to determine the need for interventions and development of the care plan to address responsive behaviours;
-if responsive behaviours are identified during the observation period, a Behavioural Assessment Tool (BAT) shall be initiated for further assessment;
-the registered staff shall prepare and initiate an Intervention Analysis Tool (IAT) based on BAT identification and the IAT shall replace the DOS.
C. Use of Whiteboard for Communication (SM 1.12) revised July 2013 indicated:
-the whiteboard shall be displayed in an area of the home restricted from residents, families and visitors;
- when a resident expresses a new responsive behaviour and when there are changes to an existing responsive behaviour, the registered staff or designate shall record the available information on the whiteboard as soon as possible to ensure effective communication is established. Information added to the whiteboard shall be reported at shift to shift report by the registered staff for 3 shifts to promote awareness of new or changed behaviours and resident status.

Review of the clinical records of resident #001, #002, #003, and #004 and review of the home's investigations indicated:
- There were ongoing altercations and potentially harmful interactions which mainly occurred in a specified area.
- There were potentially harmful altercations between resident #001 and three other residents (resident #002, #003 & #004)
- There were altercations or potentially harmful interactions between resident #002 and three other residents (resident #005 & #006) that occurred on five specified dates.
-Five incidents of witnessed and/or suspected physical and/or verbal abuse involving resident #001 three residents (#002, #003 and #004) on five specified dates. Three of those incidents involved resident #001 and resident #002.
-There were two near miss altercations or potentially harmful interactions involving resident #001 (towards resident #004 and resident #002) on two specified dates.
-There was one resident to resident physical and verbal abuse incident that was witnessed between resident #002 and resident #006 (CIR # 2717-000024-17).

Interview with DOC indicated the home does not currently have a white board in place and does not use other monitoring/ assessment tools (i.e. BAT tool, IAT, medication map

or crisis care plan). The DOC indicated the home utilized the DOS tool only. The DOC indicated the home meets monthly to discuss residents with responsive behaviours at the BSO collaborative meetings. The DOC indicated she/he is the Behavioural Support Ontario (BSO) representative and occasionally assisted by RPN #106. The DOC indicated she/he makes referrals to MRT (Mobile Response Team) or BSTU (Behavioural Supports Transition Unit) for residents with responsive behaviours. The DOC indicated both resident #001 and resident #002 have been referred to both MRT and BSTU.

Interview with RPN #106 by Inspector #111 indicated had no awareness of being the assistant BSO representative for the home.

Interview with PSW #101 by Inspector #111, indicated no awareness of any BSO involvement with resident #001 or resident #002.

Interview with RN #108 by Inspector #111, indicated the home does not really have a responsive behaviour program in place. The RN indicated the Mobile Response Team (MRT) comes into the home monthly to assess residents upon request but is not aware that they are assessing resident #001 or #002. The RN indicated was very concerned with a recent incident involving resident #001 responsive behaviour and contacted the Behavioural Support Transition Unit (BSTU).

Review of the health care record for resident #001 indicated the resident was referred to the Speciality Geriatric Psychiatry Outreach Program (SGPOP) after the fourth critical incident. A referral was submitted to the Behavioural Support Transition Unit (BSTU) after the last incident. There was no documented evidence the resident was assessed by the Mobile Response Team (MRT) during that time period.

Review of the health care record for resident #002 indicated the resident had not been referred to the Mobile Response Team (MRT) in two years. The resident was referred to the Speciality Geriatric Psychiatry Outreach Program (SGPOP) after the fifth altercation and the consultation report indicated the responsive behaviours would need to be managed with behavioural strategies as the resident would not respond to pharmacological treatment.

Review of the Behavioural Support Ontario (BSO) collaborative meeting minutes for 2017 indicated the meetings were mainly attended by the Administrator, DOC and the BSO Coordinator (an RN from outside agency). There were meeting minutes only available for

the last five months of 2017. There was no discussion regarding use of other assessment/monitoring tools to be used or review of the DOS tools that were used. A specified meeting in 2017 discussed resident #001 to have possible increased pharmacological interventions and 1:1. There was no discussion related to resident #002. The meeting two months later indicated resident #001 on 1:1 for a specified period of time and resident #002 on every 15 minute checks and review care plan and update. The following month meeting indicated the need to implement medication changes for resident #002. It was not until the fifth month meeting that the additional strategies of an alarming device and to escort the residents to and from meals/activities was discussed. This meeting indicated to phase out use the of 1:1 due to resident #001 having no responsive behaviours. The meeting indicated if resident #002 had a another critical incident, would recommend trial use of a specified medication.

The licensee's policy and procedures to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, were not implemented as: most of the assessments/monitoring tools were not implemented for resident #001 or resident #002, despite having ongoing altercations with each other or other residents. A whiteboard that was to be used for communication to all staff of residents demonstrating responsive behaviours was not implemented, a BSO interdisciplinary team was not in place (only included management and outside agency) and referrals to other specialized psycho-geriatric medicine services (MRT, BSTU and SGPOP) was not utilized until after several altercations had occurred. [s. 55. (a)]

WN #4: 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 :

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

Related to log # 023721-17:

A critical incident report (CIR) was submitted to the Director for a witnessed resident to resident physical abuse incident that occurred on a specified date and time. See details under O.Reg. 79/10, s. 54(a). The CIR indicated the police were notified.

Review of the investigation and interview with the Administrator indicated the police were notified four days later.

2. Related to log # 018281-17:

A critical incident report (CIR) was submitted to the Director for a suspected resident to resident physical abuse incident occurred on a specified date and time. See details under O.Reg. 79/10, s. 54(a). The CIR indicated the police were notified.

Review of the investigation and interview with the Administrator indicated the police were notified two days later.

3. Related to log # 002352-18:

A critical incident report (CIR) was submitted to the Director for a witnessed resident to resident physical abuse incident that occurred on a specified date and time. See details under O.Reg. 79/10, s. 54(a). The CIR indicated the police were notified.

Review of the investigation and interview with the Administrator indicated the police were notified twelve days later. [s. 98.]

Issued on this 10th day of April, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2018_643111_0004
Log No. / No de registre :	015526-17, 018281-17, 021368-17, 023721-17, 002352-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 9, 2018
Licensee / Titulaire de permis :	0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership 2020 Fisher Drive, Suite 1, PETERBOROUGH, ON, K9J-6X6
LTC Home / Foyer de SLD :	Maplewood 12 Maplewood Avenue, Box 249, BRIGHTON, ON, K0K-1H0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Rachel Corkery

To 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership, you are hereby required to comply with the following order(s) by the date (s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee shall be compliant with O.Reg. 79/10, s. 54(b).

The licensee shall prepare, implement and submit a plan to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between resident #001 and resident #002, and between resident #001 and any other resident, and between resident #002 and any other resident. The plan must include, but is not limited to the following:
-review and revise the plan of care for resident #001 and resident #002, and any other residents who demonstrate verbally and physically abusive behaviour, to ensure all triggers and steps taken to manage these behaviours are clearly identified.
-ensure all direct care staff are aware of the responsive behaviours, triggers and strategies to manage the responsive behaviours for resident #001 and resident #002, and any other resident who demonstrates verbally and physically aggressive responsive behaviours,
- how staff will communicate from shift to shift to ensure awareness of responsive behaviours, triggers of the responsive behaviours, and strategies to manage these behaviours.
-all staff to be retrained on all of the licensee's responsive behaviour policies, to ensure all staff are aware of assessment/monitoring tools to be implemented for those residents demonstrating responsive behaviours.

Please submit the the written plan for achieving compliance for inspection 2018_643111_004 to Lynda Brown, LTC Homes Inspector, MOHLTC, by email to: MOHLTCIBCentralE@ontario.ca by April 16, 2018. Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to ensure steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #001, resident #002, resident #003 and resident #004, by identifying and implementing interventions.

Review of the written plan of care for resident #001 indicated the resident had been admitted to the home with diagnoses that included cognitive impairment. The resident demonstrated specified responsive behaviours towards other residents and staff. Two specified triggers were identified and included a specified resident. Steps taken to minimize altercations included: every 15 minute checks when the resident was demonstrating the responsive behaviour,

a specified method of transporting the resident to and from meals and activities, and encourage roommates to perform activities in places that won't disturb the resident.

Review of the written plan of care for resident #002 indicated the resident demonstrated specified responsive behaviours related to cognitive impairment. Steps taken to minimize altercations included: monitor for signs of responsive behaviours; use behaviour tracking sheet to track incidence; every 15 minute checks for aggression towards peers to be implemented as needed; provide diversional activity for 15 minutes if responsive behaviour escalates; distract with refreshments; take to quiet area, remind of inappropriate behaviour is unacceptable; remove from area if demonstrating responsive behaviour with a particular resident; keep both resident #001 and resident #002 away from one another; BSO collaborative meeting to discuss resident's responsive behaviours; 1:1 staffing to be assigned as needed when behaviour becomes a threat to the resident or others.

The Administrator provided a summary of incidents over an eight month period which revealed four critical incidents of witnessed or suspected abuse involving resident #001 that were reported to the Ministry of Health and Long-Term Care, three of which involving resident #001 and resident #002, related to altercations.

Review of the progress notes for resident #002 over the same eight month period indicated there were five additional altercations involving resident #002. All of the altercations occurred while the residents were in a specified area of the home.

Interview with PSW #101 by Inspector #111, indicated resident #001 would demonstrate the specified responsive behaviours in specified situations. The PSW indicated resident #002 demonstrated specified responsive behaviours mainly towards specified residents and occurred in specified situations. The PSW also indicated the best approach to manage the responsive behaviour. The PSW indicated both resident #001 and #002 did not like one another and staff try to keep them apart. The PSW indicated 1:1 monitoring and every 15 minute checks have been used in the past for both resident #001 and #002.

Interview with RN #108 indicated resident #001 is generally a very quiet resident but can demonstrate responsive behaviours if feels threatened in specified situations. The RN recalled an altercation involving resident #002 and resident

#001, the RN was "very concerned" with resident #001 responsive behaviours and contacted the Behavioural Support Transition Unit (BSTU) to assess the resident. The RN indicated an alarming device was put in place for resident #001 to alert staff when the resident left the room. The RN indicated resident #002 is generally easy going but will demonstrate responsive behaviours towards other residents in specified areas and results in an altercation. The RN indicated the residents seating was altered which resolved the responsive behaviours in the dining room. The RN indicated staff are to ensure resident #002 is not left alone in a specified area and confirmed resident #001 disliked resident #002.

Interview with the DOC indicated resident #001 only identified trigger for responsive behaviours was resident #002 who would provoke the resident in a specified area. The DOC indicated strategies used included: both residents placed in rooms in separate halls, alarming device for resident #001, checking resident #001 every 15 minutes, ensuring both residents are kept apart in specified areas at specified times and resident #001 was placed on 1:1 in the past. The DOC indicated resident #001 was also the recipient of an altercation by another resident. The DOC indicated resident #002 has cognitive impairment. The DOC indicated resident #002 will also demonstrate another responsive behaviour that is triggered by hunger so staff try to ensure resident #002 receives snacks when responsive behaviour is noted to reduce possible negative interaction with other residents. The DOC indicated staff attempt to keep resident #002 away from resident #001.

Review of the health records of resident #001 and resident #002 indicated there were ongoing physical altercations and potentially harmful interactions between both residents, which all occurred in a specified area of the home. In addition, there were altercations and potentially harmful altercations between resident #001 and other residents (resident #003 & #004) and resident #002 with other residents (resident #005 & #006). The steps identified for both resident #001 and #002 were not always taken to minimize the risk for both residents resulting in two actual harmful altercations between resident #001 and #002 and one actual harmful interaction between resident #001 and resident #004. The steps identified for each resident (either 1:1 monitoring or every 15 minute checks) were also not taken until after the altercations occurred. [s. 54. (b)]

The severity of this issue was a level 3 as there was actual harm to residents (resident #001 and resident #001), resident #001 was involved in five out of the

six critical incidents that were reported, and three out of the six critical incidents involved resident #001 and resident #002. The scope was level 3 as five out of six critical incidents involved altercations and potentially harmful interactions. Compliance history was a level 4 as there was previous related non-compliance that involved resident #001 and resident #002: Voluntary Plan of Correction (VPC) under O.Reg. 79/10, s.54 (b) was issued on July 4, 2017 (#2017_578672_0011). (111)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
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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 9th day of April, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : LYNDA BROWN

Service Area Office / Bureau régional de services : Central East Service Area Office