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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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jun 17, 2020 | 2020_838760_0008 | 006808-20, 007930-20, 007936-20, 008140-20, 008319-20 | Critical Incident System |

### Licensee/Titulaire de permis

Royal Canadian Legion District 'D' Care Centres
59 Lawson Rd TORONTO ON M1C 2J1

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

Tony Stacey Centre for Veterans' Care
59 Lawson Road TORONTO ON M1C 2J1

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

JACK SHI (760)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): May 22, 2020- on site and May 25, 26, 27, 28, 29, June 1, 2020- off site.**

**Log #006808-20 was related to falls prevention.**
**Log #007930-20 was related to falls prevention.**
**Log #007936-20 was related to falls prevention.**
**Log #008140-20 was related to staff to resident abuse.**
**Log #008319-20 was related to resident to resident abuse.**

**During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Behavioural Supports Ontario Registered Practical Nurse (BSO RPN), Previous Environmental Manager (PEM), General Aide (GA), Recreational Aide (RA), Nurse Managers (NM), Physiotherapist (PT).**

**During the course of inspection, the inspector conducted observations, record reviews and interviews.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**
**Safe and Secure Home**

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

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

**WN #1: The Licensee has failed to comply with 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 failed to ensure that resident #006 was protected from emotional abuse

by resident #005.

In accordance with O.Reg. 79/10, s. 2 (1), "emotional abuse" means any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.

A Critical Incident System (CIS) report was submitted by the home to the Director, indicating resident #005 made a threatening remark about resident #006 in front of a staff member. Resident #006 was not harmed by resident #005 during this incident and resident #005 provided further clinical interventions following this incident.

A record review of the progress notes indicated, resident #005 became upset at recreation aide (RA) #105 after RA #105 brought resident #006 close to them. RA #105 removed resident #006 from resident #005 and attempted to redirect resident #005. At that point, resident #005 made a threatening comment about resident #006. Staff came to intervene and provided clinical interventions to resident #005, following this incident.

A record review of the progress notes also noted that resident #005 had a similar prior interaction with the home's social worker. Staff intervened and redirected resident #005 and the social worker left the area. Furthermore, the progress notes indicated that resident #005 had a potential physical altercation with a co-resident following the incident with resident #006. Staff intervened and was able to deescalate this situation.

RA #105 was interviewed and confirmed the incident occurred as specified.

An interview with DOC #107 confirmed resident #006 was emotionally abused by resident #005.

The home failed to ensure resident #006 was protected from emotional abuse by resident #005. [s. 19. (1)]

2. The licensee failed to ensure resident #004 was protected from physical and verbal abuse by the staff in the home.

In accordance with O.Reg. 79/10, s. 2 (1), "physical abuse" means the use of physical force by anyone other than a resident that causes physical injury or pain. In accordance with O.Reg. 79/10, s. 2 (1), "verbal abuse" means any form of verbal communication of a

threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A CIS report was submitted by the home and indicated an allegation of staff to resident physical abuse that occurred between resident #004 and PSW #115 that resulted in an injury with resident #004.

A record review of the progress notes indicated RPN #113 went into resident #004's room and noticed visible injuries to the resident. Resident #004 alleged PSW #115 had used an object to hit them causing the injury. The nurse manager was informed, and interventions were rendered by RPN #113 to resident #004's injury afterwards.

A record review of the home's investigation notes indicated that a verbal altercation ensued between resident #004 and PSW #115 prior to the incident, where resident #004 was heard by PSW #116 arguing with PSW #115 and PSW #115 was shouting to resident #004. Later, PSW #115 provided assistance to resident #004 and was noted that there was struggle the resident and PSW #115 over an object in the room.

An interview with RPN #113 confirmed the findings that were documented in the progress notes and in the home's investigation. RPN #113 indicated there were previous concerns with PSW #115's approach to other residents on the unit.

DOC #107 confirmed that the allegation of physical and verbal abuse from PSW #115 was substantiated and the interaction that took place between resident #004 and PSW #115 was not appropriate, including the shouting that occurred prior to this incident.

The home failed to ensure resident #004 was protected from verbal and physical abuse by PSW #115. [s. 19. (1)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.**

## Findings/Faits saillants :

1. The licensee failed to ensure that the home is a safe and secure environment for resident #001.

A CIS report was submitted by the home related to a fall that resident #001, which lead to an injury from a radiator in the room.

A record review of the progress notes indicated RPN #109 found resident #001 leaning against the heater. NM #111 was called by RPN #109 and confirmed that resident #001 sustained an injury from the heater. As per the progress notes, interventions and assessments were performed by the registered staff who attended the situation.

An interview with the Previous Environmental Manager (PEM) #100 indicated that there was a heating, ventilation and air conditioning (HVAC) system in the home. PEM #100 indicated the use of radiators in resident's rooms was in addition to the heat already provided by the HVAC system. PEM #100 indicated the home decided to turn off the radiator in resident #001’s room following this incident.

An interview with RPN #109 indicated they would adjust the radiator for resident #001, as per their request. In an interview with RPN #110, they stated that there was no direction related to monitoring the risk for residents that have their beds close to a radiator. RPN #110 stated it would be in their discretion to check residents who are in their bed most of the time and provide the appropriate interventions, if necessary, to move their beds away from the radiator. PT #106 stated in their interview that the nurses should be assessing resident’s environment and the orientation of their beds and how close it was to the radiator, as it is one of the heat sources provided in resident's rooms.

DOC #107 confirmed in their interview that the nursing department does not have any processes in place to monitor the temperature in resident rooms and that this would be the responsibility of the maintenance department. Furthermore, DOC #107 indicated that the home currently does not have a formal process in place to monitor resident beds that are close to a radiator. In the interview with PEM #100, they indicated the home includes the use of radiators to maintain heating in all the resident's rooms.

The home failed to ensure that it was a safe and secure environment for resident #001, when they sustained an injury from the radiator in their room. [s. 5.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.***

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

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

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

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to resident #001.

A CIS report was submitted by the home related to a fall that resident #001, which lead to an injury.

Fall prevention interventions were put in place including an intervention to encourage the resident to use an identified assistive device in one area of the written plan of care whereas in another area of the written plan of care it indicated not to use such an assistive device.

An interview with RPN #109 indicated resident #001 had an assistive device attached to their bed. PT #106 indicated resident #001 used this device to assist with an activity of

daily living. In an interview with RPN #110, they also confirmed the use of this assistive device.

During an interview with DOC #107, they checked resident #001's former room and indicated that there were no assistive devices attached to the bed. DOC #107 questioned the intervention that was in resident #001's written plan of care related to recommending the use of the assistive device in one section and direction not to use the device in another.

The home failed to ensure that resident #001's written plan of care provided clear directions to staff related their fall prevention interventions. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan.

A CIS report was submitted by the home related a fall that resident #002 and resident #003 sustained in their room and was sent to the hospital further treatment.

A record review of the progress notes indicated a PSW saw resident #002 with resident #003 on the unit. They were redirected by the PSW and shortly after, the PSW saw that they fell. Assessments were performed by the registered staff and both residents were sent to the hospital and diagnosed with an injury.

A record review of resident #003's written plan of care indicated the use of assistive devices as part of their fall prevention interventions. The plan of care indicated that resident #003 was identified to be at risk for falls.

An interview with PSW #102 indicated they saw resident #002 and resident #003 together on unit and attempting to leave the home. PSW #102 redirected the two residents and PSW #102 continued with their duties for that morning. Shortly after, PSW #102 heard a noise and attended to both residents' fall.

DOC #107 was interviewed and indicated that staff should have given resident #003 in their assistive device, as per their written plan of care, when they noticed they were with resident #002, prior to their fall. DOC #107 indicated that the home did not provide the care set out in resident #003's written plan of care, as it relates to the use of their assistive device. [s. 6. (7)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan.

A record review of the progress notes for resident #002 received a procedure in the hospital and was readmitted back to the home with continued treatment.

A record review of resident #002's written plan of care from when they returned to the home indicated the resident had a continued risk for falls. Fall prevention interventions were identified in their written plan of care.

An observation conducted by Inspector #760 of resident #002 with RPN #113 noted that resident #002 did not have their fall prevention interventions present, as per their written plan of care.

An interview with NM #101 indicated that further fall prevention interventions were implemented when resident #002 returned back to the home. These interventions were observed to be not in place during Inspector #760's observation with RPN #113.

RPN #113 was interviewed and confirmed the observations made with Inspector #760 were supposed to be in place, as per resident #002's written plan of care.

An interview with DOC #107 indicated that the fall prevention interventions should have been in place, as per resident #002's plan of care. DOC #107 indicated that the resident did not have the safety tools in place to prevent further injury. DOC #107 confirmed the home failed to ensure that resident #002's written plan of care was provided to them, as it relates to their fall prevention interventions.

The home failed to ensure that the plan of care for resident #002 and resident #003 was being provided to them as it relates to their fall prevention interventions. [s. 6. (7)]

***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 there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident; to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.***

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**WN #4: 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 failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any system, the system was complied with.

In accordance with O.Reg. 79/10, s. 49(2), the licensee was required to ensure that a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Specifically, staff did not comply with the licensee's policy titled "Falls- Resident", with a policy number of 05-02-01, effective December 2018, which was part of the licensee's fall prevention and management program. The policy indicates that a post fall assessment would be completed to review triggers that might have contributed to the fall.

A CIS report was submitted by the home related to a fall that resident #001, which lead to an injury.

A record review of resident #001's post fall documentation did not produce a completed post fall assessment that utilizes a clinically appropriate tool, related to their fall.

An interview with NM #111 indicated that the post fall assessment was completed and documented by RPN #109 after resident #001's fall. However, an interview with RPN #109 indicated that NM #111 was going to do the post fall assessment. RPN #109 could not produce a post fall assessment for resident #001's fall.

PT #106 indicated in their interview that it was mandatory for nursing staff to complete a post fall assessment after each residents' fall and could not produce the post fall assessment that utilizes a clinically appropriate assessment instrument for resident #001's fall.

DOC #107 was interviewed and confirmed that a post fall assessment that uses a clinically appropriate assessment instrument was not completed for resident #001's fall.

The home failed to ensure that the home's policy was complied with, related to completing a post fall assessment that uses a clinically appropriate assessment instrument for resident #001's fall. [s. 8. (1) (a),s. 8. (1) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure 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 (b) is complied with., to be implemented voluntarily.***

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**WN #5: 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. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the results of the abuse investigation were reported to the Director.

A CIS report was submitted by the home and indicated an allegation of staff to resident physical abuse that occurred between resident #004 and PSW #115 that resulted in an injury with resident #004.

A record review of the CIS report did not indicate the results of the home's investigation into the allegation of staff to resident physical abuse.

An interview with DOC #107 confirmed that the CIS report was not updated with the results of the investigation of the allegation of staff to physical abuse between resident #004 and PSW #115.

The home failed to ensure that the results of an investigation related to an incident of staff to resident physical abuse were reported to the Director. [s. 23. (2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure to report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b), to be implemented voluntarily.***

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**WN #6: 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 failed to ensure that an allegation of abuse to a resident by the staff of the home that resulted in harm was immediately reported to the Director.

A CIS report was submitted by the home and indicated an allegation of staff to resident physical abuse that occurred between resident #004 and PSW #115 that resulted in an injury with resident #004.

A record review of the CIS report indicated that it was submitted a day after the incident occurred. The CIS report indicated that the Ministry of Long-Term Care (MLTC) after hours line was not contacted related to this incident.

An interview with DOC #107 confirmed that the MLTC after hours line was not contacted about this incident and that NM #111 should have contacted the MLTC after hours line related to this incident.

The home failed to ensure that the Director was immediately informed related to an allegation of abuse to resident #004 by the staff of the home and resulted in harm. [s. 24. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure 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: 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, to be implemented voluntarily.***

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**WN #7: 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 failed to ensure the resident’s substitute decision maker (SDM) was immediately notified upon becoming aware of an allegation of staff to resident physical abuse with resident #004 that resulted in a physical injury.

A CIS report was submitted by the home and indicated an allegation of staff to resident physical abuse that occurred between resident #004 and PSW #115 that resulted in an injury with resident #004.

A record review of the progress notes indicated that when RPN #113 became aware that

resident #004 sustained an injury from an interaction with PSW #115 on the day it occurred, they notified the nurse manager and stated the SDM will be informed. BSO RPN #112 documented the next day that resident #004's SDM was informed of the incident that occurred the previous day.

An interview with RPN #113 indicated that they did not call resident #004's SDM and delegated the next shift to inform the SDM.

BSO RPN #112 confirmed in their interview that the SDM of resident #004 was informed of the staff to resident physical abuse incident, a day after it occurred.

An interview with DOC #107 verified that the SDM of resident #004 was contacted a day after it occurred in regards to the incident of staff to resident abuse. DOC #107 confirmed the home failed to ensure that the SDM of resident #004 was informed immediately in an allegation of staff to resident physical abuse that resulted in an injury. [s. 97. (1) (a)]

2. The licensee failed to ensure that resident #006's SDM was notified upon becoming aware of a witnessed incident of abuse from resident #005.

A CIS report was submitted by the home to the Director, indicating resident #005 made a threatening remark about resident #006 in front of a staff member. Resident #006 was not harmed by resident #005 during this incident and resident #005 provided further clinical interventions following this incident.

A record review was done for resident #006's electronic chart and did not produce any documentation related to the incident between resident #005.

RPN #118 was interviewed and indicated that they did not contact the SDM of resident #006 about the abuse incident with resident #005. RPN #118 stated it was the nurse manager or BSO nurse who would be involved in contacting the resident's SDM.

BSO RPN #112 and RN #119 were interviewed and indicated that there was no documentation provided to support that resident #006's SDM was contacted. BSO RPN #112 indicated this was would be the responsibility of the unit RPN.

An interview with DOC #107 indicated that during their investigation, they could not find documentation to support that the SDM of resident #006 was contacted about the abuse they sustained from resident #005.

The home failed to ensure resident #006's SDM was contacted related to a witnessed incident of abuse that resident #006 sustained from resident #005. [s. 97. (1) (b)]

***Additional Required Actions:***

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

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**WN #8: 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 failed to ensure that the appropriate police force was immediately notified of any alleged incident of abuse of resident #004 that the licensee suspects may constitute a criminal offence.

A CIS report was submitted by the home and indicated an allegation of staff to resident physical abuse that occurred between resident #004 and PSW #115 that resulted in an injury with resident #004.

A record review of the CIS report indicated that the police were not contacted with regards to this incident.

A record review of the progress notes indicated that RN #114 interviewed resident #004 in relation to the incident and resident #004 indicated that they wanted the police to be involved.

An interview with RN #114 indicated that they do not believe the police were contacted regarding this incident.

DOC #107 confirmed in their interview that the home did not contact the police. DOC #107 indicated that the home should have called the police about this incident of staff to resident abuse.

The home failed to ensure the appropriate police force was immediately notified related to an incident of staff to resident physical abuse, which resulted in resident #004 sustaining an injury. [s. 98.]

***Additional Required Actions:***

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

**Issued on this 18th day of June, 2020**

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| **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

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|---|---|
| **Name of Inspector (ID #) / Nom de l’inspecteur (No) :** | JACK SHI (760) |
| **Inspection No. / No de l’inspection :** | 2020_838760_0008 |
| **Log No. / No de registre :** | 006808-20, 007930-20, 007936-20, 008140-20, 008319-20 |
| **Type of Inspection / Genre d’inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Jun 17, 2020 |
| **Licensee / Titulaire de permis :** | Royal Canadian Legion District 'D' Care Centres<br>59 Lawson Rd, TORONTO, ON, M1C-2J1 |
| **LTC Home / Foyer de SLD :** | Tony Stacey Centre for Veterans' Care<br>59 Lawson Road, TORONTO, ON, M1C-2J1 |
| **Name of Administrator / Nom de l’administratrice ou de l’administrateur :** | Melissa Elliott |

To Royal Canadian Legion District 'D' Care Centres, you are hereby required to comply with the following order(s) by the date(s) set out below:

## 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

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**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. 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).

**Order / Ordre :**

The licensee must be compliant with s.19 of the LTCH Act.

Specifically, the licensee must:
1. Educate all the home's front line staff of the following items, including but not limited to:

a. Educate staff on what constitutes abuse and neglect.
b. Educate staff on the appropriate response to residents requests.
c. Educate staff on the reporting requirements of abuse when abuse is alleged or witnessed.

**Grounds / Motifs :**

1. The licensee failed to ensure that resident #006 was protected from emotional abuse by resident #005.

In accordance with O.Reg. 79/10, s. 2 (1), "emotional abuse" means any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.

A Critical Incident System (CIS) report was submitted by the home to the Director, indicating resident #005 made a threatening remark about resident #006 in front of a staff member. Resident #006 was not harmed by resident #005 during this incident and resident #005 provided further clinical interventions following this incident.

A record review of the progress notes indicated, resident #005 became upset at recreation aide (RA) #105 after RA #105 brought resident #006 close to them. RA #105 removed resident #006 from resident #005 and attempted to redirect resident #005. At that point, resident #005 made a threatening comment about resident #006. Staff came to intervene and provided clinical interventions to resident #005, following this incident.

A record review of the progress notes also noted that resident #005 had a similar prior interaction with the home's social worker. Staff intervened and redirected resident #005 and the social worker left the area. Furthermore, the progress notes indicated that resident #005 had a potential physical altercation with a co-resident following the incident with resident #006. Staff intervened and was able to deescalate this situation.

RA #105 was interviewed and confirmed the incident occurred as specified.

An interview with DOC #107 confirmed resident #006 was emotionally abused by resident #005.

The home failed to ensure resident #006 was protected from emotional abuse by resident #005. (760)

2. The licensee failed to ensure resident #004 was protected from physical and verbal abuse by the staff in the home.

In accordance with O.Reg. 79/10, s. 2 (1), "physical abuse" means the use of physical force by anyone other than a resident that causes physical injury or pain. In accordance with O.Reg. 79/10, s. 2 (1), "verbal abuse" means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A CIS report was submitted by the home and indicated an allegation of staff to resident physical abuse that occurred between resident #004 and PSW #115 that resulted in an injury with resident #004.

A record review of the progress notes indicated RPN #113 went into resident #004's room and noticed visible injuries to the resident. Resident #004 alleged PSW #115 had used an object to hit them causing the injury. The nurse manager was informed, and interventions were rendered by RPN #113 to resident #004's injury afterwards.

A record review of the home's investigation notes indicated that a verbal altercation ensued between resident #004 and PSW #115 prior to the incident, where resident #004 was heard by PSW #116 arguing with PSW #115 and PSW #115 was shouting to resident #004. Later, PSW #115 provided assistance to resident #004 and was noted that there was struggle the resident and PSW #115 over an object in the room.

An interview with RPN #113 confirmed the findings that were documented in the progress notes and in the home's investigation. RPN #113 indicated there were previous concerns with PSW #115's approach to other residents on the unit.

DOC #107 confirmed that the allegation of physical and verbal abuse from PSW #115 was substantiated and the interaction that took place between resident #004 and PSW #115 was not appropriate, including the shouting that occurred prior to this incident.

The home failed to ensure resident #004 was protected from verbal and physical abuse by PSW #115.

The severity of this issue for resident #006 was potential risk of harm. The severity of this issue for resident #004 was actual harm as the resident sustained an injury. The scope of the issue was a level 3 as it related to two of two residents reviewed. The home had a level 4 history of on-going non-compliance with this subsection of the Regulation that included: Compliance Order (CO) issued on November 13, 2019, (2019_823653_0026). (760)

**This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le :** Sep 30, 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

## 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

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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 17th day of June, 2020**

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

**Name of Inspector /**
**Nom de l’inspecteur :** Jack Shi

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