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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l’inspection	Log # / No de registre	Type of Inspection / Genre d’inspection
Aug 19, 2019	2019_659189_0008	013211-19	Critical Incident System

Licensee/Titulaire de permis

Mississauga Long Term Care Facility Inc.
26 Peter Street North MISSISSAUGA ON L5H 2G7

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

Mississauga Long Term Care Facility
26 Peter Street North MISSISSAUGA ON L5H 2G7

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

NICOLE RANGER (189)

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): July 29, 30, 2019.

The following intake was inspected:
Log # 013211-19 related to prevention of abuse and neglect

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, registered nurse, Behavioural Support Ontario (BSO) PSW, personal support workers, residents and family member.

During the course of the inspection the inspector observed staff to resident interactions, conducted observations of the residents, reviewed residents' health records, relevant policies and procedures.

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.
- **1 WN(s)**
- **1 VPC(s)**
- **0 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. 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 ensure that resident #001 was protected from abuse by

anyone.

The home submitted Critical Incident System (CIS) report to the Ministry of Health and Long Term Care (MOHLTC) regarding an incident of resident to resident abuse. According to the CIS, on an identified date, RN#101 found the resident in bed with an injury to an identified area. The resident reported to the RN that a co-resident came into their room and injured them. Through investigation, resident #001 was able to identify that resident #002 was involved in the altercation.

A review of resident #002's care plan indicated that the resident exhibits responsive behaviour towards other residents.

Interviews with PSW #102 and BSO PSW #104 revealed they worked on the day of the incident. PSW #102 reported that after the meal services, they and PSW #103 went to assist another resident with transfers. PSW #102 reported that they heard a call bell ringing, however they were attending to the other resident for the transfer.

BSO PSW #104 reported that after meal services, they were attending to two co-residents who were demonstrating responsive behaviors. BSO PSW #104 reported that while attending to the two co-residents, they were informed by RN #101 that resident #001 was injured. BSO PSW #104 reported that they went into the room to assist the RN, and found resident #001 injured. BSO PSW #104 reported that there were no other residents in sight, however resident #001 reported that they were attacked by another resident. BSO PSW #104 reported that the RN brought three co-residents into resident #001's room for the resident to identify who injured them, and immediately resident #001 identified that resident #002 had injured them. Both PSW #102 and BSO PSW #104 reported that resident #002 demonstrates responsive behaviours with co-residents and requires close monitoring by staff. The inspector inquired who was monitoring resident #002 after the meal service at the time of the incident, and both PSW #102 and BSO PSW #104 reported that they were attending to other residents and that resident #002 was not monitored during that time.

Interview with RN #101 reported that they are familiar with resident #002, and that resident #002 demonstrates responsive behaviour with co-residents.

Interview with resident #001's Substitute Decision Maker (SDM) revealed that on the day of the incident, they received a call from resident #001 stating that a resident came into their room and injured them. The SDM stated that resident #001 was clearly able to

identify that it was resident #002 who injured them.

Interview with Director of Care (DOC) revealed that there were no staff present to witness the incident as they were attending to other residents and it was unclear which resident injured resident #001. However resident #001 was able to identify that resident #002 had injured them. Given the fact that resident #002 has a history of responsive behaviour towards co-residents, that resident #002 requires monitoring and supervision related to their behaviours, and that the staff were not present to monitor the resident prior to the incident, the inspector concluded that the home did not protect resident #001 from abuse. [s. 19. (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 residents are protected from abuse by anyone, to be implemented voluntarily.

Issued on this 4th day of September, 2019

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

Original report signed by the inspector.