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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 12, 2018	2018_486653_0015	017958-18	Critical Incident System

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Rockcliffe Care Community
3015 Lawrence Avenue East SCARBOROUGH ON M1P 2V7

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

ROMELA VILLASPIR (653)

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 26, and 27, 2018.

During this inspection, Critical Incident Log #017958-18 related to a fall and staff to resident abuse and neglect, had been inspected.

During the course of the inspection, the inspector reviewed the staff schedule, clinical health records, the home's video surveillance and investigation notes, training records, employee records, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Behavioural Support Ontario (BSO) Nurse, Assistant Director of Care (ADOC)/ Responsive Behaviour Program Lead, interim Director of Care (iDOC) and the Executive Director (ED).

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.

- **3 WN(s)**
- **1 VPC(s)**
- **3 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 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 had failed to ensure that residents were protected from abuse by anyone and free from neglect by the staff in the home.

On an identified date and time, the home submitted a Critical Incident Report (CIR) to the Director, for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIR indicated on an identified date and time, resident #001 was up in the hallway and approached the nursing station. The resident took an identified item off the nursing station and would not return them to the Personal Support Worker (PSW). The PSW tried to take the identified item from the resident and the resident fell over their assistive device. Resident #001 was sent to the hospital for further assessment. An interview with the interim Director of Care (iDOC) indicated that after reviewing the home's video surveillance, they deemed that staff to resident abuse had occurred prior to the fall incident, and the iDOC subsequently submitted another CIR to the Director, reporting abuse and neglect of resident #001 by staff.

A review of resident #001's Point Click Care (PCC) profile indicated they were admitted to the home on an identified date with identified medical diagnoses. A review of resident #001's identified admission assessment indicated they had moderate cognitive impairment and no demonstrated behaviours towards self or others, and no inappropriate social behaviours noted. The assessment further indicated that resident #001 was transitioning relatively well into the home, but has some moments of confusion due to newness to the facility.

A review of resident #001's progress notes between an identified period and separate interviews with PSWs #100, #101, and Registered Practical Nurses (RPNs) #103, #105, revealed resident #001 had identified responsive behaviours and exhibited behaviours towards co-residents and staff.

Interviews with PSWs #100 and #101 indicated their interventions to manage resident #001's responsive behaviours were not always effective. An interview with RPN #105 stated they had an identified intervention, however, it was challenging to manage resident #001's responsive behaviours when they attempted to do an identified activity.

On an identified date, the iDOC provided the inspector a copy of the two video footages from the home's video surveillance from an identified date. The iDOC confirmed that resident #001, PSWs #108 and #110 were identified in the video, and that the two PSWs had worked on the identified shift.

A review of the home's video surveillance from an identified date and from two separate

times revealed PSW #110 performed inappropriate actions towards resident #001, and PSW #108 did not do anything to protect the resident and prevent further inappropriate actions by PSW #110. Resident #001 ended up having a fall and was taken to hospital for further assessment.

A telephone interview with PSW #108 indicated that on the identified shift, resident #001 exhibited an identified responsive behaviour. The PSW indicated their interventions to manage resident #001's responsive behaviour, and stated that their identified strategy was ineffective at the time. PSW #108 reported to RPN #103 that resident #001 was exhibiting a responsive behaviour, which was interfering with other residents on the floor. When asked by the inspector what instructions the RPN gave them in regards to this, the PSW stated the RPN did not tell them anything. PSW #108 denied being aware of the interaction that had occurred between resident #001 and PSW #110 on the identified date and time of the incident. PSW #108 also insisted that at an identified time, when they were documenting on the computer inside the nursing station, they were not aware of what was going on between resident #001 and PSW #110. The PSW further indicated that when they heard resident #001's assistive device fall down to the floor, they did not immediately attend to the resident.

An interview with RPN #103 revealed that on the identified shift, the RPN noted the resident exhibited responsive behaviours. RPN #103 further indicated that the PSWs had told them resident #001 exhibited responsive behaviours and the PSWs tried to intervene as it was interfering with other residents. The PSWs stated to the RPN that resident #001 was exhibiting responsive behaviours with them. RPN #103 instructed the PSWs to just observe resident #001 if the resident displays an identified responsive behaviour. The RPN checked the resident's medications and confirmed no medication could be provided at this time. When asked by the inspector how the staff manage resident #001's responsive behaviours, the RPN stated staff have identified interventions, however most of the time these strategies were ineffective.

The inspector attempted to do a telephone interview with PSW #110 and the PSW refused to proceed with the interview, indicating they were not prepared to do it without their legal counsel.

A review of the home's separate letters to PSWs #108 and #110 from two identified dates, indicated their employment with the home had been terminated as the home determined the PSWs had engaged in act of resident abuse and neglect.

An interview with the iDOC acknowledged abuse of resident #001 by PSW #110 and neglect of resident #001 by PSW #108 in the above mentioned incident. The iDOC also found that the PSW did not manage the resident's behaviours appropriately as observed from the home's video surveillance. The iDOC stated that the home's expectation was for the staff to follow the home's policies to help deescalate residents exhibiting responsive behaviours. PSW #108's inaction jeopardized resident #001's health and safety. The iDOC acknowledged that in the above mentioned incident, the licensee of the long-term care home had failed to ensure that resident #001 was protected from abuse by anyone and the licensee had failed to ensure that the resident was not neglected by the licensee or staff.

Based on record reviews and staff interviews, resident #001 had exhibited responsive behaviours from the time they were admitted to the home. Apart from resident #001's identified admission assessment, there were no other assessments and reassessments that had been completed related to their responsive behaviours. Furthermore, resident #001's plan of care did not demonstrate that the home had taken actions to respond to their needs, including assessments, reassessments, and interventions as it relates to their responsive behaviours. Therefore, the licensee had failed to provide resident #001 with the treatment, care, services or assistance required for health, safety or well-being as it relates to their responsive behaviours.

A follow-up telephone interview with the iDOC indicated that resident #001 was discharged from the home on an identified date. [s. 19. (1)]

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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee had failed to ensure that a written record was kept relating to each evaluation under clause (b) that included the date of the evaluation, names of the persons who participated in the evaluation, a summary of the changes made, and the date that those changes were implemented.

An interview with Assistant Director of Care (ADOC) #109, the lead for the home's responsive behaviour program indicated the Responsive Behaviour program is evaluated on an annual basis and the home uses the Responsive Behavoiur Inspection protocol as guide. The inspector requested to review the written record relating to the most recent evaluation of the responsive behaviour program in the home, but the ADOC stated that the previous DOC who had just left, was the one responsible for the evaluation, and was not able to locate any written record from previous evaluations. The ADOC

acknowledged that the licensee had failed to ensure that a written record was kept relating to each evaluation under clause (b) that included the date of the evaluation, names of the persons who participated in the evaluation, a summary of the changes made, and the date that those changes were implemented. [s. 53. (3) (c)]

2. The licensee had failed to ensure that for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible.

On an identified date and time, the home submitted a CIR to the Director for alleged abuse and neglect of resident #001 by staff.

A review of resident #001's PCC profile indicated they were admitted to the home on an identified date with identified medical diagnoses. A review of resident #001's identified admission assessment indicated they had moderate cognitive impairment.

A review of resident #001's progress notes between an identified period and separate interviews with PSWs #100, #101, and RPNs #103, #105, revealed resident #001 had identified responsive behaviours and exhibited behaviours towards co-residents and staff.

Interviews with PSWs #100 and #101 indicated their interventions to manage resident #001's responsive behaviours were not always effective. An interview with RPN #105 stated they had an identified intervention, however, it was challenging to manage resident #001's responsive behaviours when they attempted to do an identified activity.

A telephone interview with PSW #108 indicated that on the identified shift, resident #001 exhibited an identified responsive behaviour. The PSW indicated their interventions to manage resident #001's responsive behaviour, and stated that their identified strategy was ineffective at the time. PSW #108 reported to RPN #103 that resident #001 was exhibiting a responsive behaviour, which was interfering with other residents on the floor. When asked by the inspector what instructions the RPN gave them in regards to this, the PSW stated the RPN did not tell them anything.

An interview with RPN #103 revealed that on the identified shift, the RPN noted the resident exhibited responsive behaviours. RPN #103 further indicated that the PSWs had told them resident #001 exhibited responsive behaviours and the PSWs tried to intervene with resident #001 because they were exhibiting responsive behaviours. RPN #103

instructed the PSWs to just observe resident #001 if the resident displays an identified responsive behaviour. The RPN checked the resident's medications and confirmed no medication could be provided at this time. When asked by the inspector how the staff manage resident #001’s responsive behaviours, the RPN stated staff have identified interventions and most of the time these strategies were ineffective.

During an interview with the home's Behavioural Support Ontario (BSO) Nurse, they had reviewed with the inspector resident #001’s progress notes under behaviour from an identified period, and identified them as responsive behaviours exhibited by resident #001. The BSO Nurse then reviewed resident #001’s current written plan of care with the inspector, and acknowledged there was no focus, goal, nor interventions related to resident #001’s responsive behaviours. The BSO Nurse could not demonstrate to the inspector that strategies were developed and implemented to respond to resident #001’s behaviours, where possible.

An interview with ADOC #109 acknowledged the above mentioned information and that strategies were not developed and implemented to respond to resident #001’s behaviours, where possible. [s. 53. (4) (b)]

3. The licensee had failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions were documented.

On an identified date and time, the home submitted a CIR to the Director for alleged abuse and neglect of resident #001 by staff.

A review of resident #001's identified assessment on PCC from an identified date indicated no demonstrated behaviours towards self or others, and no inappropriate social behaviours noted. The assessment further indicated that resident #001 was transitioning relatively well into the home, but has some moments of confusion due to newness to the facility.

A review of resident #001’s progress notes between an identified period and separate interviews with PSWs #100, #101, and RPNs #103, #105, revealed resident #001 had identified responsive behaviours and exhibited behaviours towards co-residents and staff.

Interviews with PSWs #100 and #101 indicated their interventions to manage resident #001's responsive behaviours were not always effective. An interview with RPN #105 stated they had an identified intervention, however, it was challenging to manage resident #001's responsive behaviours when they attempted to do an identified activity.

Further review of resident #001's PCC assessments did not identify any reassessment related to responsive behaviours subsequent to the identified admission assessment.

During an interview with RPN #105, the inspector asked the RPN to look through resident #001's chart for an identified intervention and any behavioural assessment that had been completed, and the RPN indicated that the intervention and behavioural assessment were not completed as they could not find one to show to the inspector.

During an interview with the home's BSO Nurse, they had reviewed with the inspector resident #001's progress notes under behaviour from an identified period, and identified them as responsive behaviours exhibited by resident #001. The BSO Nurse then reviewed resident #001's current written plan of care with the inspector, and acknowledged there was no focus, goal, nor interventions related to resident #001's responsive behaviours. The BSO Nurse further indicated that they never received a referral for resident #001, and could not demonstrate to the inspector that actions were taken to respond to the needs of resident #001, including assessments, reassessments, and interventions and that the resident's responses to interventions were not documented as it related to responsive behaviours.

During an interview with Assistant Director of Care (ADOC) #109, they acknowledged the above mentioned information and indicated that if a resident is exhibiting responsive behaviours, the nurse can initiate an identified intervention for a specific number of days and then refer to the physician. The registered staff can make recommendations related to interventions, and refer to the BSO Nurse electronically on PCC, or verbally tell the BSO Nurse when they do their rounds. The ADOC further indicated that identified responsive behaviours required the completion of the intervention and further assessments. If further intervention is needed, the resident would be referred to the attending physician, and an order is obtained to refer to the external consultant, Psychogeriatric Outreach Program (POP) team. The ADOC stated that the registered staff responsible for a resident's care can initiate the written plan of care, and include interventions based on their assessment, the BSO Nurse's assessment, and the POP team's recommendations if applicable. ADOC #109 acknowledged that resident #001 exhibited responsive behaviours, and actions were not taken to respond to the needs of

the resident, including assessments, reassessments and interventions, and that the resident's responses to interventions were not documented as it relates to responsive behaviours. [s. 53. (4) (c)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee had failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Mood and behaviour patterns, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

On an identified date and time, the home submitted a CIR to the Director for alleged abuse and neglect of resident #001 by staff.

A review of resident #001's identified assessment on PCC from an identified date indicated no demonstrated behaviours towards self or others, and no inappropriate social behaviours noted. The assessment further indicated that resident #001 was transitioning

relatively well into the home, but has some moments of confusion due to newness to the facility.

A review of resident #001's plan of care including the written plan of care did not identify their mood and behaviour patterns, any identified responsive behaviours, any potential behavioural triggers, and variations in resident functioning at different times of the day.

A review of resident #001’s progress notes between an identified period and separate interviews with PSWs #100, #101, and RPNs #103, #105, revealed resident #001 had identified responsive behaviours and exhibited behaviours towards co-residents and staff.

During an interview with the home's BSO Nurse, they had reviewed with the inspector resident #001’s progress notes under behaviour from an identified period, and identified them as responsive behaviours exhibited by resident #001. The BSO Nurse further acknowledged that the identified intervention and any other interdisciplinary assessment related to behaviours had not been completed for resident #001. During separate interviews with RPN #105 and the BSO Nurse, resident #001's plan of care including the written plan of care were reviewed with the inspector, and both staff acknowledged that it did not identify their mood and behaviour patterns, any identified responsive behaviours, any potential behavioural triggers, and variations in resident functioning at different times of the day.

An interview with ADOC #109 indicated that identified responsive behaviours required the completion of the intervention and further assessments. If further intervention is needed, the resident would be referred to the attending physician, and an order is obtained to refer to the external consultant, POP team. The ADOC stated that the registered staff responsible for a resident's care can initiate the written plan of care, and include interventions based on their assessment, the BSO Nurse’s assessment, and the POP team's recommendations if applicable. The ADOC further acknowledged that resident #001's plan of care was not based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: mood and behaviour patterns, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it related to one of three residents reviewed. The home had a level 2 compliance history as they had one or more unrelated

non-compliances in the last three years. [s. 26. (3) 5.]

Additional Required Actions:

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

Issued on this 18th day of October, 2018

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ROMELA VILLASPIR (653)
Inspection No. / No de l'inspection :	2018_486653_0015
Log No. / No de registre :	017958-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 12, 2018
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Rockcliffe Care Community 3015 Lawrence Avenue East, SCARBOROUGH, ON, M1P-2V7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Shelley Fazackerley

To Vigour Limited Partnership on behalf of Vigour General Partner Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Order # / Ordre no : 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 (1) of the Long-Term Care Homes Act (LTCHA).

Specifically, the licensee shall do the following:

1. Provide training and re-education to all direct care staff on the home's policy on prevention of abuse and neglect of a resident. The education shall include the following items:
-Case study scenarios including but not limited to staff to resident abuse and neglect;
-All areas of abuse and neglect including corresponding definitions as identified within the home's prevention of abuse and neglect policy, and within the LTCHA 2007, Ontario Regulations 79/10;
-Steps to be taken immediately by direct care staff in their identified roles when incidents of abuse and/ or neglect take place in the home.

2. The education to all direct care staff should also include how to identify, report, and assist, when a colleague may be exhibiting inappropriate behaviours that may pose a risk to residents in the home.

3. At the end of the training and education, all direct care staff shall be able to recognize and define all forms of abuse and neglect under the legislation.

4. Maintain a record of the training and education provided, including dates, times, trainers, attendees, and material taught.

5. Complete a root cause analysis of the incident. Maintain a record of the analysis including dates, times, content, and the participants.

The above mentioned documentation shall be made available to the inspector upon request. This order shall be complied no later than January 7, 2019.

Grounds / Motifs :

1. The licensee had failed to ensure that residents were protected from abuse by anyone and free from neglect by the staff in the home.

On an identified date and time, the home submitted a Critical Incident Report (CIR) to the Director, for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in

the resident's health status. The CIR indicated on an identified date and time, resident #001 was up in the hallway and approached the nursing station. The resident took an identified item off the nursing station and would not return them to the Personal Support Worker (PSW). The PSW tried to take the identified item from the resident and the resident fell over their assistive device. Resident #001 was sent to the hospital for further assessment. An interview with the interim Director of Care (iDOC) indicated that after reviewing the home's video surveillance, they deemed that staff to resident abuse had occurred prior to the fall incident, and the iDOC subsequently submitted another CIR to the Director, reporting abuse and neglect of resident #001 by staff.

A review of resident #001's Point Click Care (PCC) profile indicated they were admitted to the home on an identified date with identified medical diagnoses. A review of resident #001's identified admission assessment indicated they had moderate cognitive impairment and no demonstrated behaviours towards self or others, and no inappropriate social behaviours noted. The assessment further indicated that resident #001 was transitioning relatively well into the home, but has some moments of confusion due to newness to the facility.

A review of resident #001's progress notes between an identified period and separate interviews with PSWs #100, #101, and Registered Practical Nurses (RPNs) #103, #105, revealed resident #001 had identified responsive behaviours and exhibited behaviours towards co-residents and staff.

Interviews with PSWs #100 and #101 indicated their interventions to manage resident #001's responsive behaviours were not always effective. An interview with RPN #105 stated they had an identified intervention, however, it was challenging to manage resident #001's responsive behaviours when they attempted to do an identified activity.

On an identified date, the iDOC provided the inspector a copy of the two video footages from the home's video surveillance from an identified date. The iDOC confirmed that resident #001, PSWs #108 and #110 were identified in the video, and that the two PSWs had worked on the identified shift.

A review of the home's video surveillance from an identified date and from two separate times revealed PSW #110 performed inappropriate actions towards resident #001, and PSW #108 did not do anything to protect the resident and prevent further inappropriate actions by PSW #110. Resident #001 ended up

having a fall and was taken to hospital for further assessment.

A telephone interview with PSW #108 indicated that on the identified shift, resident #001 exhibited an identified responsive behaviour. The PSW indicated their interventions to manage resident #001's responsive behaviour, and stated that their identified strategy was ineffective at the time. PSW #108 reported to RPN #103 that resident #001 was exhibiting a responsive behaviour, which was interfering with other residents on the floor. When asked by the inspector what instructions the RPN gave them in regards to this, the PSW stated the RPN did not tell them anything. PSW #108 denied being aware of the interaction that had occurred between resident #001 and PSW #110 on the identified date and time of the incident. PSW #108 also insisted that at an identified time, when they were documenting on the computer inside the nursing station, they were not aware of what was going on between resident #001 and PSW #110. The PSW further indicated that when they heard resident #001's assistive device fall down to the floor, they did not immediately attend to the resident.

An interview with RPN #103 revealed that on the identified shift, the RPN noted the resident exhibited responsive behaviours. RPN #103 further indicated that the PSWs had told them resident #001 exhibited responsive behaviours and the PSWs tried to intervene as it was interfering with other residents. The PSWs stated to the RPN that resident #001 was exhibiting responsive behaviours with them. RPN #103 instructed the PSWs to just observe resident #001 if the resident displays an identified responsive behaviour. The RPN checked the resident's medications and confirmed no medication could be provided at this time. When asked by the inspector how the staff manage resident #001's responsive behaviours, the RPN stated staff have identified interventions, however most of the time these strategies were ineffective.

The inspector attempted to do a telephone interview with PSW #110 and the PSW refused to proceed with the interview, indicating they were not prepared to do it without their legal counsel.

A review of the home's separate letters to PSWs #108 and #110 from two identified dates, indicated their employment with the home had been terminated as the home determined the PSWs had engaged in act of resident abuse and neglect.

An interview with the iDOC acknowledged abuse of resident #001 by PSW #110

and neglect of resident #001 by PSW #108 in the above mentioned incident. The iDOC also found that the PSW did not manage the resident's behaviours appropriately as observed from the home's video surveillance. The iDOC stated that the home's expectation was for the staff to follow the home's policies to help deescalate residents exhibiting responsive behaviours. PSW #108's inaction jeopardized resident #001's health and safety. The iDOC acknowledged that in the above mentioned incident, the licensee of the long-term care home had failed to ensure that resident #001 was protected from abuse by anyone and the licensee had failed to ensure that the resident was not neglected by the licensee or staff.

Based on record reviews and staff interviews, resident #001 had exhibited responsive behaviours from the time they were admitted to the home. Apart from resident #001's identified admission assessment, there were no other assessments and reassessments that had been completed related to their responsive behaviours. Furthermore, resident #001's plan of care did not demonstrate that the home had taken actions to respond to their needs, including assessments, reassessments, and interventions as it relates to their responsive behaviours. Therefore, the licensee had failed to provide resident #001 with the treatment, care, services or assistance required for health, safety or well-being as it relates to their responsive behaviours.

A follow-up telephone interview with the iDOC indicated that resident #001 was discharged from the home on an identified date.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it related to one of three residents reviewed. The home had a level 2 compliance history as they had one or more unrelated non-compliances in the last three years. (653)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 07, 2019

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee must be compliant with r. 53 (4) of O. Reg. 79/10.

Specifically, the licensee shall do the following:

1. Provide training and re-education to all direct care staff on the home's policy on responsive behaviours – management. The education shall enable all direct care staff to recognize potential behavioural triggers and factors of responsive behaviours demonstrated by residents, as well as the steps to be taken by direct care staff in their identified roles.

2. Maintain a record of the training and education provided, including dates, times, trainers, attendees, and material taught.

3. Develop and implement a process in place to ensure residents demonstrating responsive behaviours are assessed, monitored, and referred to the BSO nurse, the physician, and external behaviour consultant as required.

4. For residents identified with responsive behaviours, ensure that strategies and interventions are developed and implemented to respond to these behaviours, based on the interdisciplinary assessment of the resident. The strategies and interventions must be clearly identified in the resident's written plan of care and kardex.

5. Explore case study scenarios focusing on the identified behaviour of residents who are non-compliant with an identified intervention, and present strategies on how staff should manage in these cases.

6. Maintain a record of all activities carried out under items 3, 4, and 5 above.

The above mentioned documentation shall be made available to the inspector upon request. This order shall be complied no later than January 7, 2019.

Grounds / Motifs :

1. The licensee had failed to ensure that for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible.

On an identified date and time, the home submitted a CIR to the Director for alleged abuse and neglect of resident #001 by staff.

A review of resident #001's PCC profile indicated they were admitted to the home on an identified date with identified medical diagnoses. A review of resident #001's identified admission assessment indicated they had moderate cognitive impairment.

A review of resident #001's progress notes between an identified period and separate interviews with PSWs #100, #101, and RPNs #103, #105, revealed resident #001 had identified responsive behaviours and exhibited behaviours towards co-residents and staff.

Interviews with PSWs #100 and #101 indicated their interventions to manage resident #001's responsive behaviours were not always effective. An interview with RPN #105 stated they had an identified intervention, however, it was challenging to manage resident #001's responsive behaviours when they attempted to do an identified activity.

A telephone interview with PSW #108 indicated that on the identified shift, resident #001 exhibited an identified responsive behaviour. The PSW indicated their interventions to manage resident #001's responsive behaviour, and stated that their identified strategy was ineffective at the time. PSW #108 reported to RPN #103 that resident #001 was exhibiting a responsive behaviour, which was interfering with other residents on the floor. When asked by the inspector what instructions the RPN gave them in regards to this, the PSW stated the RPN did not tell them anything.

An interview with RPN #103 revealed that on the identified shift, the RPN noted the resident exhibited responsive behaviours. RPN #103 further indicated that the PSWs had told them resident #001 exhibited responsive behaviours and the PSWs tried to intervene with resident #001 because they were exhibiting responsive behaviours. The RPN checked the resident's medications and confirmed no medication could be provided at this time. When asked by the inspector how the staff manage resident #001's responsive behaviours, the RPN stated staff have identified interventions and most of the time these strategies were ineffective.

During an interview with the home's Behavioural Support Ontario (BSO) Nurse, they had reviewed with the inspector resident #001's progress notes under behaviour from an identified period, and identified them as responsive

behaviours exhibited by resident #001. The BSO Nurse then reviewed resident #001's current written plan of care with the inspector, and acknowledged there was no focus, goal, nor interventions related to resident #001's responsive behaviours. The BSO Nurse could not demonstrate to the inspector that strategies were developed and implemented to respond to resident #001's behaviours, where possible.

An interview with ADOC #109 acknowledged the above mentioned information and that strategies were not developed and implemented to respond to resident #001's behaviours, where possible. (653)

2. The licensee had failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

On an identified date and time, the home submitted a CIR to the Director for alleged abuse and neglect of resident #001 by staff.

A review of resident #001's identified assessment on PCC from an identified date indicated no demonstrated behaviours towards self or others, and no inappropriate social behaviours noted. The assessment further indicated that resident #001 was transitioning relatively well into the home, but has some moments of confusion due to newness to the facility.

A review of resident #001's progress notes between an identified period and separate interviews with PSWs #100, #101, and RPNs #103, #105, revealed resident #001 had identified responsive behaviours and exhibited behaviours towards co-residents and staff.

Interviews with PSWs #100 and #101 indicated their interventions to manage resident #001's responsive behaviours were not always effective. An interview with RPN #105 stated they had an identified intervention, however, it was challenging to manage resident #001's responsive behaviours when they attempted to do an identified activity.

Further review of resident #001's PCC assessments did not identify any reassessment related to responsive behaviours subsequent to the identified admission assessment.

During an interview with RPN #105, the inspector asked the RPN to look through resident #001's chart for an identified intervention and any behavioural assessment that had been completed, and the RPN indicated that the intervention and behavioural assessment were not completed as they could not find one to show to the inspector.

During an interview with the home's BSO Nurse, they had reviewed with the inspector resident #001's progress notes under behaviour from an identified period, and identified them as responsive behaviours exhibited by resident #001. The BSO Nurse then reviewed resident #001's current written plan of care with the inspector, and acknowledged there was no focus, goal, nor interventions related to resident #001's responsive behaviours. The BSO Nurse further indicated that they never received a referral for resident #001, and could not demonstrate to the inspector that actions were taken to respond to the needs of resident #001, including assessments, reassessments, and interventions and that the resident's responses to interventions were not documented as it related to responsive behaviours.

During an interview with Assistant Director of Care (ADOC) #109, they acknowledged the above mentioned information and indicated that if a resident is exhibiting responsive behaviours, the nurse can initiate an identified intervention for a specific number of days and then refer to the physician. The registered staff can make recommendations related to interventions, and refer to the BSO Nurse electronically on PCC, or verbally tell the BSO Nurse when they do their rounds. The ADOC further indicated that identified responsive behaviours required the completion of the intervention and further assessments. If further intervention is needed, the resident would be referred to the attending physician, and an order is obtained to refer to the external consultant, Psychogeriatric Outreach Program (POP) team. The ADOC stated that the registered staff responsible for a resident's care can initiate the written plan of care, and include interventions based on their assessment, the BSO Nurse's assessment, and the POP team's recommendations if applicable. ADOC #109 acknowledged that resident #001 exhibited responsive behaviours, and actions were not taken to respond to the needs of the resident, including assessments, reassessments and interventions, and that the resident's responses to interventions were not documented as it relates to responsive behaviours.

The severity of this issue was determined to be a level 3 as there was actual

harm to the resident. The scope of the issue was a level 1 as it related to one of three residents reviewed. The home had a level 4 compliance history as they had on-going non-compliance with r. 53 (4) (c) of the O. Reg. 79/10 that included a Voluntary Plan of Correction issued June 21, 2016, (2016_302600_0006). (653)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 07, 2019

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order / Ordre :

The licensee must be compliant with r. 26 (3) (5) of O. Reg. 79/10.

Upon receipt of this order the licensee shall: prepare, submit, and implement a plan to ensure the following:

1. The plan of care of residents exhibiting responsive behaviours must be based on an interdisciplinary assessment of the resident's mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

2. A designate must be in charge of reviewing, assessing, and following up on reported responsive behaviours on admission or when the resident's responsive behaviour changes.

3. The plan shall include the three requirements above, the person responsible for completing the tasks, and the timelines for completion.

4. Maintain a record of all activities carried out under items 1 to 3 above.

The plan is to be submitted by e-mail to CentralEastSAO.MOH@ontario.ca referencing report #2018_486653_0015 to Romela Villaspir, LTC Homes Inspector, MOHLTC, by October 26, 2018, and implemented by January 7, 2019.

Grounds / Motifs :

1. The licensee had failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Mood and behaviour patterns, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

On an identified date and time, the home submitted a CIR to the Director for alleged abuse and neglect of resident #001 by staff.

A review of resident #001's identified assessment on PCC from an identified date indicated no demonstrated behaviours towards self or others, and no

inappropriate social behaviours noted. The assessment further indicated that resident #001 was transitioning relatively well into the home, but has some moments of confusion due to newness to the facility.

A review of resident #001's plan of care including the written plan of care did not identify their mood and behaviour patterns, any identified responsive behaviours, any potential behavioural triggers, and variations in resident functioning at different times of the day.

A review of resident #001's progress notes between an identified period and separate interviews with PSWs #100, #101, and RPNs #103, #105, revealed resident #001 had identified responsive behaviours and exhibited behaviours towards co-residents and staff.

During an interview with the home's BSO Nurse, they had reviewed with the inspector resident #001's progress notes under behaviour from an identified period, and identified them as responsive behaviours exhibited by resident #001. The BSO Nurse further acknowledged that the identified intervention and any other interdisciplinary assessment related to behaviours had not been completed for resident #001. During separate interviews with RPN #105 and the BSO Nurse, resident #001's plan of care including the written plan of care were reviewed with the inspector, and both staff acknowledged that it did not identify their mood and behaviour patterns, any identified responsive behaviours, any potential behavioural triggers, and variations in resident functioning at different times of the day.

An interview with ADOC #109 indicated that identified responsive behaviours required the completion of the intervention and further assessments. If further intervention is needed, the resident would be referred to the attending physician, and an order is obtained to refer to the external consultant, POP team. The ADOC stated that the registered staff responsible for a resident's care can initiate the written plan of care, and include interventions based on their assessment, the BSO Nurse's assessment, and the POP team's recommendations if applicable. The ADOC further acknowledged that resident #001's plan of care was not based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: mood and behaviour patterns, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it related to one of three residents reviewed. The home had a level 2 compliance history as they had one or more unrelated non-compliances in the last three years. (653)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 07, 2019

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
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 12th day of October, 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 : Romela Villaspir

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