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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 15, 2019	2018_626501_0022	002118-17, 003755-18, 003763-18, 003766-18, 014857-18, 020016-18, 032836-18	Critical Incident System

Licensee/Titulaire de permis

North York General Hospital
4001 Leslie Street NORTH YORK ON M2K 1E1

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

Seniors' Health Centre
2 Buchan Court NORTH YORK ON M2J 5A3

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

SUSAN SEMEREDY (501), JULIEANN HING (649)

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): December 6, 7, 10, 11, 12, 14, 17, 18, 19, 20, 21, 27, 28, 2018, and January 2, 2019.

The following intakes were inspected during this inspection:
Follow up intakes #003755-18, #003763-18, and #003766-18 related to nutrition and hydration
Follow up intake #014857-18 related to the prevention of abuse and neglect
The following intakes regarding critical incident system reports related to abuse were inspected:
#020016-18 (CIS #2744-000028-18)
#032836-18 (CIS #2744-000052-18)
#002118-17 (CIS #274-000001-17)

Written Notification and Compliance Order related to LTCHA, 2007, S.O. 2007, C.8, s. 19. (1), identified in concurrent inspection #2018_626501_0023 related to intake log #029535-18 will be issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Directors of Care (ADOC), registered staff (RN, RPN), registered dietitian (RD), personal support workers (PSW), Manager of Labour and Employee Relations, physiotherapist, residents, family members, and substitute decision-makers (SDM).

During the course of this inspection the inspectors observed meal services, staff to resident interactions, resident to resident interactions, and the provision of care, reviewed health records, staff training records, and any relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.

- **4 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (4)	CO #001	2018_420643_0001	501
O.Reg 79/10 s. 69.	CO #002	2018_420643_0001	501
O.Reg 79/10 s. 74. (2)	CO #003	2018_420643_0001	501

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 protect resident #015 and #017 from abuse.

A) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) regarding staff to resident abuse. According to the report, resident #017 was found by RN #123 in an identified emotional state. The resident told the RN they wanted another PSW. Resident #017 was assigned another PSW.

Review of the home's investigation notes, indicated that PSW #131 was treating resident #017 differently from other residents. According to PSW #131, resident #017 was refusing to use their identified assistive aide. A previous ADOC and PT said it was okay for the resident not to use this aide. A day later, resident #017 thought PSW #131 was not treating them the same as the PSW was treating another identified resident.

During an interview with resident #017, they told the inspector that PSW #131 treats them well now but the PSW has their favourites and makes it known. Resident #017 stated that in the dining room, PSW #131 always serves them last. The resident also made statements related to feeling ignored and inadequate when PSW #131 was on duty. The resident stated that if PSW #131 is doing this to them, then they could be doing this to others.

Review of resident #017's medical record indicated the resident was cognitively intact. A progress note on an identified date, written by RN #123, indicated resident #017 was in a vulnerable position and emotional. According to the note, the resident asked for another PSW which the RN arranged.

During an interview with RN #123, they indicated they witnessed PSW #131 treating resident #017 in an identified manner and immediately told PSW #131 to stop. The RN stated they took over the situation, switched assignments of the PSWs and informed the DOC. The RN stated they felt this was an incident of abuse as resident #017 was in a vulnerable situation and PSW #131 was not acting appropriately.

During an interview with PSW #131, they admitted resident #017 was in a vulnerable situation when the resident asked to see the charge nurse. The PSW stated they treat all residents with respect and cannot help it if some residents like them more than others. The PSW denied any and all wrongdoing with how they treat some residents and was unable to explain what power imbalance meant in regards to their relationship with residents.

During an interview with DOC #116, they acknowledged that even though the home had switched the PSW assignments regarding the above incident, more could have been done to protect resident #017 from continued abuse. In hindsight, PSW #131 should have been moved to another home area. The DOC confirmed the home did not protect resident #017 from abuse.

B) The following finding was found in concurrent complaint inspection report 2018_626501_0023:

Review of a complaint letter addressed to the home and the MOHLTC, indicated resident #015's substitute decision-maker (SDM) had concerns regarding the care resident #015 was receiving. One of the concerns was that PSW #131 abused resident #015.

According to the letter, resident #015 was admitted to the home following an identified medical procedure and was to be non-weight bearing for both identified extremities until assessed by the physician. The letter stated that PSW #131 insisted resident #015 use one of their identified extremities during an identified activity of daily living (ADL). Resident #015 told their SDM they felt they had no choice but to do as they were told as they were intimidated and afraid of PSW #131.

Review of resident #015's medical record indicated the resident was admitted on an identified date, and on the same date an admission physiotherapist progress note indicated the resident was non-weight bearing on both identified extremities. The resident was cognitively intact.

Further review of progress notes indicated that on an identified date, resident #015's SDM approached registered staff and stated that the resident had pain on their identified extremities and claimed that during an identified ADL the resident was asked to use their identified extremity.

During an interview with resident #015's SDM, they indicated PSW #131 acted inappropriately. According to the SDM, the resident was terrified and did not want to report their concern due to fear of repercussions.

Review of the home's investigation notes, indicated PSW #131 was being interviewed regarding other incidents including the above mentioned interactions with resident #015. As a result of the home's investigation, PSW #131 received disciplinary action.

During an interview with DOC #116, they acknowledged the home failed to protect resident #015 from abuse. [s. 19. (1)]

2. On June 4, 2018, a compliance order (CO) was issued under inspection report #2018_644507_0011 made under LTCHA, 2007 S.O. c.8, s. 19. (1) as follows:

The licensee must be compliant with s. 19. (1) of the Act.

Specifically the licensee must:
a) Ensure interventions are developed and implemented for all responsive behaviours exhibited by any resident.
b) Ensure all interventions developed for all responsive behaviours exhibited by any resident are included in the resident's written plan of care, and the written plan of care is revised and updated when the resident's status changes.
c) Implement an on-going auditing process to ensure that interventions are developed and implemented for residents who exhibit responsive behaviours, and the interventions are included in the resident's written plan of care, and the written plan of care is revised and updated when the resident's status changes.
d) Maintain a written record of audits conducted. The written record must include the date, the resident's name, staff member's name, the name of the person completing the audit and the outcome of the audit.

The compliance date was July 31, 2018.

During this inspection it was found that the home completed steps a, b, and c, but failed to complete step d.

A review of resident #003's progress notes indicated the following responsive behaviours on identified dates:
-Resident #003 was standing in an identified home area when another resident went too close to them and they became physical with the other resident. The other resident also became physical and resident #003 became more physical. This incident was witnessed by an identified staff member.
-Resident #003 was noted restraining another resident. When staff tried to separate the residents, resident #003 became physical with the other resident.
-A PSW witnessed resident #003 become physical with another resident.
-Resident #003 was passing in front of another resident when they suddenly became physical with the other resident.

On an identified date, resident #003 sustained a fall. Observations post fall indicated that the resident was no longer ambulatory and used an identified assistive aid for mobility.

A review of progress notes after the fall indicated the following responsive behaviours by resident #003 on identified dates:
-Resident #003 was noted to be physical with another resident.
-PSW reported that resident #003 threw identified items at another resident across the table. PSW reported resident #003 became physical with them.
-Resident #003 was noted to be pushing identified items towards other residents and threw identified food items on them.
-Resident #003 was observed becoming physical with a tablemate and threw identified items on the floor.

In an interview with RPN #124, they told the inspector that resident #003's behaviour of an identified physical motion with others was new and expressed concern that the resident could hurt someone. According to the RPN, the resident was being assisted with an identified ADL more frequently and closely monitored.

In an interview with RN #105, when asked if resident #003 was a risk to other residents they responded that the resident could hurt other residents. According to the RN, resident #003 had been started on one-to-one monitoring for approximately one week because of their behaviour.

In an interview with DOC #116, they told the inspector that audits were done by going through residents' behaviour notes monthly looking at the severity of their behaviours. According to the DOC, the last audit for resident #003 was completed in an identified month, and confirmed that resident #003's more recent responsive behaviours had not been captured on the home's audit. The DOC confirmed that the home was not in compliance with step (d) of the above mentioned order as evidenced by no written record of audits conducted for resident #003 after an identified month. [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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee had failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A review of the home's policy #VII-G-10.00 titled Prevention of Abuse and Neglect of a Resident with a current revision date of January 2015, stated that the home has a zero tolerance policy for resident abuse and neglect. The policy indicates under abuse definitions that rough handling and pushing constitute examples of physical abuse.

A CIS was submitted to the MOHLTC related to an allegation of abuse involving resident #009 by PSW #120 that was witnessed and reported by a visitor to the home.

According to the CIS, the visitor reported that PSW #120 had been rough with the resident on an identified date in a specific area of the home.

In an interview with the visitor, they told the inspector that PSW #120 suddenly got up and became physical with the resident and said to the resident to stop doing that. According to the visitor, when the PSW was physical with the resident, they were also rough in aiding the resident. According to the visitor, RPN #113 observed the entire incident between PSW #120 and the resident.

In an interview with RPN #113, they denied witnessing the incident that took place between PSW #120 and resident #009 in the dining room, and stated that their back was to the resident while speaking with the visitor. The RPN acknowledged that PSW #120 actions would have constituted physical abuse and told the inspector that they had previously witnessed this PSW speaking to residents in an identified tone of voice.

In an interview with PSW #120, they recalled being sent home before their shift had ended related to an allegation of abuse on the above mentioned date. They told the inspector they were unable to recall what they had done wrong and could not recall any details about the incident.

In an interview, Administrator #132 told the inspector that according to a letter of discipline provided to PSW #120 it was concluded by the home that the above incident was considered abuse. The home's policy had not been complied with. [s. 20. (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 that home's written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had 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.

The home submitted a CIS report to the MOHLTC, regarding staff to resident abuse. According to the CIS report, the incident occurred on an identified date. The resident told the RN they wanted another PSW because PSW #131 was acting in an abusive manner.

Resident #017 was assigned another PSW.

After reviewing the home's investigation notes for incidents that occurred pertaining to PSW #131, the inspector spoke with resident #017 on the above mentioned identified date where it was indicated that abuse by PSW #131 was continuing. The inspector reported this to ADOC #135 who had ADOC #136 submit the above mentioned CIS report.

Review of resident #017's medical record indicated a progress note described the initial incident had occurred more than a month previous to the above reported incident.

During an interview with the DOC, they confirmed that the home had failed to immediately report to the Director the incident that occurred on the initial date when abuse was first suspected. [s. 24. (1)]

2. Review of the home's investigation notes of an identified date, related to PSW #131 and resident #015 indicated the PSW was also being questioned about another incident with resident #016. The interview indicated PSW #131 admitted to refuse to assist resident #016 with an identified ADL on an identified date. Review of the home's discipline provided to PSW #131 indicated the PSW jeopardized the safety of resident #016 by refusing to assist the resident.

Review of resident #016's progress notes indicated that on an identified date resident #016 was concerned about an incident that occurred the previous night and the RN was reporting this to the ADOC.

During an interview with DOC #116, they recalled they had been informed about another incident between resident #016 and PSW #131 and decided not to report this as there was insufficient evidence to suspect abuse. The DOC acknowledged that once they became aware during their investigation that there was another incident of abuse and neglect, they failed to report this to the Director. [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 that 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.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. The licensee has failed to comply with the following requirement of the LTCHA: it is a condition of every licence that the licensee shall comply with every order made under this Act.

On February 9, 2018, compliance order (CO) #001, from inspection #2018_420643_0001 was made under LTCHA 2007, c.8, s. 6. (4):

The licensee must be compliant with s. 6. (4) of the LTCHA.

Specifically, to ensure that the staff and others involved in the different aspects of care of residents #005, #009 and #014 and any other resident with weight variance, collaborate with each other in the assessment of the residents so that their assessments are integrated and consistent with, and complement each other.

Upon receipt of this compliance order the licensee shall prepare, submit and implement a plan to achieve compliance with LTCHA 2007, c. 8, s. 6. (4). The plan will include but not be limited to:
1. Development of a system to audit resident weights on a monthly basis to ensure residents with documented weight changes are re-weighed to verify the validity of the weight changes, and
2. Providing education to registered staff on the weight monitoring policy in the home to ensure that resident weight changes are monitored and evaluated from an interdisciplinary approach and that referrals to the Registered Dietitian are made when warranted.

The compliance date was June 21, 2018.

During this inspection it was found that the home completed step 2 but failed to complete step 1.

Review of resident records indicated resident #009 passed away and was replaced with resident #006.

Review of resident #006's medical record revealed the resident had significant weight loss during an identified time period representing a change of 9 per cent of body weight over one month. The weight loss was more than 2 kilograms.

Review of resident #006's most recent plan of care indicated the resident was at high nutritional risk related to variable intake.

Review of a weight change progress note to address the above noted weight change, indicated resident #006 had identified interventions in place and a dietary referral was not to be made at this time.

During an interview with PSW #101 they stated they were not aware of resident #006's recent weight loss and they usually do a re-weigh of a resident when there is a change in weight of 2 kg or more.

During an interview with RPN #102, they indicated that registered staff will direct PSWs to do a re-weigh if there is a difference of 2 kg. RPN #102 acknowledged that they had entered an identified weight for resident #006 into the electronic documentation system and completed the assessment in the weight change note without having had a re-weigh

completed.

Review of some of the home's audit reports completed by ADOC #104 revealed that the audit did not check if documented weight changes had had re-weighs completed to verify the validity of the weight change. During an interview with ADOC #104 and RD #106, they acknowledged that this auditing system did not include whether re-weighs had been completed as was specified in item number 1 of the above compliance order. [s. 101. (3)]

Issued on this 25th day of January, 2019

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

Ministère 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) :	SUSAN SEMEREDY (501), JULIEANN HING (649)
Inspection No. / No de l'inspection :	2018_626501_0022
Log No. / No de registre :	002118-17, 003755-18, 003763-18, 003766-18, 014857-18, 020016-18, 032836-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 15, 2019
Licensee / Titulaire de permis :	North York General Hospital 4001 Leslie Street, NORTH YORK, ON, M2K-1E1
LTC Home / Foyer de SLD :	Seniors' Health Centre 2 Buchan Court, NORTH YORK, ON, M2J-5A3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Susan Bock

To North York General Hospital, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2018_644507_0011, CO #001;

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 Act.

Specifically the licensee must:

1. Ensure PSW #131 is retrained on:
a. the home's policy that promotes zero tolerance of abuse and neglect of residents;
b. power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care; and,
c. situations that may lead to abuse and neglect and how to avoid such situations.

The home will document the above training which will include the contents, date the training occurred and the person providing the training. The home will also demonstrate that PSW #131 is knowledgeable and has a thorough understanding of the contents.

2. Develop and implement a process to monitor staff to resident interactions to ensure the prevention of abuse and neglect.

Grounds / Motifs :

1. 1. The licensee has failed to protect resident #015 and #017 from abuse.

A) The home submitted a Critical Incident System (CIS) report to the Ministry of

Health and Long-Term Care (MOHLTC) regarding staff to resident abuse. According to the report, resident #017 was found by RN #123 in an identified emotional state. The resident told the RN they wanted another PSW. Resident #017 was assigned another PSW.

Review of the home's investigation notes, indicated that PSW #131 was treating resident #017 differently from other residents. According to PSW #131, resident #017 was refusing to use their identified assistive aide. A previous ADOC and PT said it was okay for the resident not to use this aide. A day later, resident #017 thought PSW #131 was not treating them the same as the PSW was treating another identified resident.

During an interview with resident #017, they told the inspector that PSW #131 treats them well now but the PSW has their favourites and makes it known. Resident #017 stated that in the dining room, PSW #131 always serves them last. The resident also made statements related to feeling ignored and inadequate when PSW #131 was on duty. The resident stated that if PSW #131 is doing this to them, then they could be doing this to others.

Review of resident #017's medical record indicated the resident was cognitively intact. A progress note on an identified date, written by RN #123, indicated resident #017 was in a vulnerable position and emotional. According to the note, the resident asked for another PSW which the RN arranged.

During an interview with RN #123, they indicated they witnessed PSW #131 treating resident #017 in an identified manner and immediately told PSW #131 to stop. The RN stated they took over the situation, switched assignments of the PSWs and informed the DOC. The RN stated they felt this was an incident of abuse as resident #017 was in a vulnerable situation and PSW #131 was not acting appropriately.

During an interview with PSW #131, they admitted resident #017 was in a vulnerable situation when the resident asked to see the charge nurse. The PSW stated they treat all residents with respect and cannot help it if some residents like them more than others. The PSW denied any and all wrongdoing with how they treat some residents and was unable to explain what power imbalance meant in regards to their relationship with residents.

During an interview with DOC #116, they acknowledged that even though the home had switched the PSW assignments regarding the above incident, more could have been done to protect resident #017 from continued abuse. In hindsight, PSW #131 should have been moved to another home area. The DOC confirmed the home did not protect resident #017 from abuse.

B) The following finding was found in concurrent complaint inspection report 2018_626501_0023:

Review of a complaint letter addressed to the home and the MOHLTC, indicated resident #015's substitute decision-maker (SDM) had concerns regarding the care resident #015 was receiving. One of the concerns was that PSW #131 abused resident #015.

According to the letter, resident #015 was admitted to the home following an identified medical procedure and was to be non-weight bearing for both identified extremities until assessed by the physician. The letter stated that PSW #131 insisted resident #015 use one of their identified extremities during an identified activity of daily living (ADL). Resident #015 told their SDM they felt they had no choice but to do as they were told as they were intimidated and afraid of PSW #131.

Review of resident #015's medical record indicated the resident was admitted on an identified date, and on the same date an admission physiotherapist progress note indicated the resident was non-weight bearing on both identified extremities. The resident was cognitively intact.

Further review of progress notes indicated that on an identified date, resident #015's SDM approached registered staff and stated that the resident had pain on their identified extremities and claimed that during an identified ADL the resident was asked to use their identified extremity.

During an interview with resident #015's SDM, they indicated PSW #131 acted inappropriately. According to the SDM, the resident was terrified and did not want to report their concern due to fear of repercussions.

Review of the home's investigation notes, indicated PSW #131 was being interviewed regarding other incidents including the above mentioned interactions with resident #015. As a result of the home's investigation, PSW #131 received disciplinary action.

During an interview with DOC #116, they acknowledged the home failed to protect resident #015 from abuse. (501)

2. On June 4, 2018, a compliance order (CO) was issued under inspection report #2018_644507_0011 made under LTCHA, 2007 S.O. c.8, s. 19. (1) as follows:

The licensee must be compliant with s. 19. (1) of the Act.

Specifically the licensee must:
a) Ensure interventions are developed and implemented for all responsive behaviours exhibited by any resident.
b) Ensure all interventions developed for all responsive behaviours exhibited by any resident are included in the resident's written plan of care, and the written plan of care is revised and updated when the resident's status changes.
c) Implement an on-going auditing process to ensure that interventions are developed and implemented for residents who exhibit responsive behaviours, and the interventions are included in the resident's written plan of care, and the written plan of care is revised and updated when the resident's status changes.
d) Maintain a written record of audits conducted. The written record must include the date, the resident's name, staff member's name, the name of the person completing the audit and the outcome of the audit.

The compliance date was July 31, 2018.

During this inspection it was found that the home completed steps a, b, and c, but failed to complete step d.

A review of resident #003's progress notes indicated the following responsive behaviours on identified dates:
-Resident #003 was standing in an identified home area when another resident went too close to them and they became physical with the other resident. The

other resident also became physical and resident #003 became more physical. This incident was witnessed by an identified staff member.
-Resident #003 was noted restraining another resident. When staff tried to separate the residents, resident #003 became physical with the other resident.
-A PSW witnessed resident #003 become physical with another resident.
-Resident #003 was passing in front of another resident when they suddenly became physical with the other resident.

On an identified date, resident #003 sustained a fall. Observations post fall indicated that the resident was no longer ambulatory and used an identified assistive aid for mobility.

A review of progress notes after the fall indicated the following responsive behaviours by resident #003 on identified dates:
-Resident #003 was noted to be physical with another resident.
-PSW reported that resident #003 threw identified items at another resident across the table. PSW reported resident #003 became physical with them.
-Resident #003 was noted to be pushing identified items towards other residents and threw identified food items on them.
-Resident #003 was observed becoming physical with a tablemate and threw identified items on the floor.

In an interview with RPN #124, they told the inspector that resident #003's behaviour of an identified physical motion with others was new and expressed concern that the resident could hurt someone. According to the RPN, the resident was being assisted with an identified ADL more frequently and closely monitored.

In an interview with RN #105, when asked if resident #003 was a risk to other residents they responded that the resident could hurt other residents. According to the RN, resident #003 had been started on one-to-one monitoring for approximately one week because of their behaviour.

In an interview with DOC #116, they told the inspector that audits were done by going through residents' behaviour notes monthly looking at the severity of their behaviours. According to the DOC, the last audit for resident #003 was completed in an identified month, and confirmed that resident #003's more

recent responsive behaviours had not been captured on the home's audit. The DOC confirmed that the home was not in compliance with step (d) of the above mentioned order as evidenced by no written record of audits conducted for resident #003 after an identified month. [s. 19. (1)]

The severity was determined to be a level two indicating minimum harm or potential for actual harm. The scope was determined to be a level two indicating a pattern and the compliance history was determined to be a level four indicating on-going non-compliance with this section of the LTCHA that included:
-Inspection #2018_644507_0011 issued June 4, 2018, served a written notice with a compliance order that was due July 31, 2018;
-Inspection #2018_420643_0001 issued January 8, 2018, served a written notice with a voluntary plan of correction; and,
-Inspection #2016_413500_0009 issued October 3, 2016, served a written notice with a compliance order.
(649)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 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
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 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)
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 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 15th day of January, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Susan Semeredy

Service Area Office /
Bureau régional de services : Toronto Service Area Office