Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 19, 2019	2019_807644_0019	002789-19, 015344-19, 017358-19, 018981-19, 019299-19, 020767-19, 021988-19	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 365 Bloor Street East, 15th Floor TORONTO ON M4W 3L4

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

Seven Oaks
9 Neilson Road SCARBOROUGH ON M1E 5E1

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

ANGIEM KING (644), AMANDEEP BHELA (746), SUSAN SEMEREDY (501)

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): November 27, 28, 29, December 2, 3, 4, 5, 6, 9 and 10, 2019.

This inspection was conducted concurrently with complaint inspection 2019_594746_0024.
The following follow-up was inspected during this inspection:
Follow-up Log- related to admission process.

During this inspection the following critical incident system (CIS) reports were inspected:
Three logs related to prevention of falls,
One log related to maintenance and safe and secure home,
One log related to prevention of abuse and neglect and responsive behaviours.

The following intakes were completed in this Critical Incident System Inspection:
One log related to prevention of falls.

During the course of the inspection, the inspector(s) spoke with the Administrator, Interim Director of Nursing (DON), Nurse Managers (NM), Medical Director, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Care Aide (PCA), Physiotherapist (PT), Occupational Therapist (OT), Resident Intake Clerk, Registered Practical Nurse-BSO, Nurse Consultant, Receptionist, Manager of Resident Services, Counsellor, Central East LHIN Placement Co-ordinator, residents and Substitute Decision Makers (SDM's).

During the course of the inspection, the inspector(s) conducted observations of staff and resident interactions and resident to resident interactions; reviewed health records, staffing schedules, home's complaint and critical incident system investigation records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 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. 44. (7)	CO #001	2019_595110_0006	644

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

Findings/Faits saillants :

1. The licensee has failed to ensure steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations.

The home submitted a Critical Incident System (CIR) report to the Ministry of Long-Term Care (MLTC) related to an incident of resident to resident physical abuse that occurred. According to the report, resident #002 was observed pushing resident #003 who fell to the floor and sustained injuries.

A review of resident #002 and #003's progress notes indicated there were three separate incidents of physical aggression towards resident #003 from resident #002. On the first occurrence, resident #002 slapped resident #003, the second when resident #002 pushed resident #003 to the floor and the third incident when resident #003 was wandering the hallway and was found sitting on the floor in front of resident #002's room with a resident standing over them stating for them to go away. No injuries were noted. It was discovered a few days later after the second incident that resident #003 sustained an injury.

A review of both resident #002 and #003's most recent plans of care indicated both residents had responsive behaviours but there was no indication that resident #003 was a trigger for resident #002 and there were no interventions identified to address this trigger.

Interviews with Personal Care Aide (PCA) #139, #140, #135 and Registered Practical Nurse (RPN) #134 indicated they were aware that resident #003 triggered resident #002 by identified specific actions. As well, resident #003 was known to wander on a specific shift and needed constant monitoring in order to be kept safe.

Interviews with Behavioural Support Ontario (BSO) RPN #129 and Registered Nurse (RN) #123 indicated resident #003 was not a target for resident #002 but did acknowledge resident #003's behaviours could be a trigger for resident #002 as resident #002 responds in the moment.

An interview with Acting Nurse Manager (ANM) #143 indicated that after viewing video surveillance the resident who was standing over resident #003 on a specified date was resident #002. The ANM acknowledged that the team needed to review and revise their strategies for resident #002 and #003 to prevent further altercations.

Resident #002 and #003 had three separate altercations and the home failed to identify that resident #003's responsive behaviours were a trigger for resident #002's responsive behaviours and failed to take steps to prevent these altercations. [s. 54. (a)]

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 steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #003 was protected from abuse by resident #002.

The home submitted a Critical Incident System (CIR) report to the Ministry of Long-Term Care (MLTC) related to an incident of resident to resident physical abuse that occurred. According to the report, resident #002 was observed pushing resident #003 who fell to the floor and sustained injuries.

A review of resident #002's medical record indicated the resident was admitted to the home after having been hospitalized for over a year. A progress note stated the resident was known to have physical responsive behaviours. The note also indicated the resident's specific triggers.

A review of resident #003's medical record indicated the resident had impaired cognitive status and behavioural symptoms that occurred daily and was not easily altered.

A review of resident #002 and #003's progress notes indicated there were three separate incidents of physical aggression towards resident #003 from resident #002. On the first incident, resident #002 slapped resident #003, the second when resident #002 pushed resident #003 to the floor and the third incident when resident #003 was wandering the hallway and was found sitting on the floor in front of resident #002's room with a resident standing over them stating for them to go away. No injuries were noted. It was discovered a few days later after the second incident that resident #003 sustained an injury. Other incidents continued to occur for resident #002 with other residents and staff and as needed behavioural medications were administered but were ineffective. On a specified date resident #002 was sent to the hospital for a specific assessment.

An interview with Personal Care Aide (PCA) #139 indicated resident #003 may trigger resident #002 as resident #003 does not talk and may trigger resident #002 responsive behaviour. PCA #130 also stated resident #002 has a specific behaviour and can be unpredictable.

An interview with PCA #140 indicated they did not think resident #003 was safe on the unit because they are unaware that they trigger resident #002. PCA #140 added that resident #003 can become resistive at times and could fall.

An interview with PCA #135 indicated resident #002 has specific behaviours and thinks resident #003 triggers resident #002. PCA #135 described resident #003 has specific behaviours on a specific shift.

An interview with Registered Practical Nurse (RPN) #134 who witnessed the responsive behaviours, stated resident #003 has responsive behaviours that trigger other residents that included specific behaviours. RPN #134 stated that resident #003 needed to be closely monitored because they might approach and trigger some of the residents, including resident #002

An interview with Acting Nurse Manager (ANM) #143 acknowledged that the home was unsuccessful in protecting resident #003 from resident #002's physical abuse that caused injury.

The following is further evidence to support the order issued on Nov 12, 2019, during complaint inspection 2019_714673_0007 to be complied Feb 28, 2020. [s. 19. (1)]

Issued on this 7th day of January, 2020

[redacted]

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

Original report signed by the inspector.