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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jan 24, 2019	2018_578672_0004 (A1)	001765-18	Resident Quality Inspection

Licensee/Titulaire de permis

Glen Hill Terrace Christian Homes Inc.
200 Glen Hill Drive South WHITBY ON L1N 9W2

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

Glen Hill Strathaven
264 King Street East Bowmanville ON L1C 1P9

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

Amended by PATRICIA MATA (571) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

This report has been amended at the licensee's request, following a meeting with MOHLTC managers. Please see the following for changes:
WN #1-The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect
WN #2-The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
WN #8-The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs
WN #10-The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Issued on this 24th day of January, 2019 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

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

Amended by PATRICIA MATA (571) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): February 13, 14, 15, 16, 19, 20, 22, 23, 26, 27, 28, 2018 and March 1, 2, 5, 6, 7, 2018

The following inspections were completed concurrently during this inspection:

Critical Incidents related to allegations of resident abuse and/or neglect: Log #024406-17, Log #024414-17, Log #025884-17, Log #029243-17, and Log #002353-18

Critical Incidents related to falls resulting in an injury and transfer to hospital: Log #020559-17, Log #027377-17, Log #003079-18

Critical Incident related to resident elopement: Log #019993-17

Log #025521-17 was followed up on, related to an outstanding Order from inspection #2017_591623_0017 / 016959-17, which was complied.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Social Service Manager (SSM), Environmental Services Manager (ESM), Registered Nurses (RN), Nurse Practitioner (NP), Registered Practical Nurses (RPN), Personal Support Workers (PSW), receptionist, Residents Council president, family members, visitors, and residents.

During the course of the inspection, the inspector(s) toured the home; observed nourishment pass(es); observed a medication administration pass; reviewed the following documents: resident health records, Residents Council meeting minutes, monthly newsletters, PAC meeting minutes, monthly BSO meeting minutes, monthly family meeting minutes, medication incident reports, and the home's internal investigations.

The following policies were also reviewed: Abuse and Neglect of a Resident - Actual or Suspected, Fall Prevention and Management, Responsive Behaviours, Medications - Security and Accountability, Medication Incident Reporting, Diabetes-Hypoglycemia, Skin and Wound Care Management Protocol, Restraints and PASDs, Sexual Expression and Intimacy, Narcotic Counts, and Staff Education Records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

12 WN(s)
8 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	2017_591623_0017	623

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 :

(A1)
1. The licensee has failed to ensure that resident #038 was protected from abuse.

A Critical Incident Report was submitted to the Director, related to an alleged incident of resident to resident abuse, which occurred on a specified date, between resident #037 and resident #038. Resident #037 was observed by PSW #135 to be exhibiting a specified responsive behaviour of an abusive nature towards resident #038. Following the incident, resident #037 had a specified intervention implemented, and the BSO team assessed and spoke with resident #037.

According to the CIR, staff were to monitor the whereabouts of resident #038, but no specific directions were given in relation to how often staff were to observe resident #038.

A second Critical Incident Report was submitted to the Director, related to an alleged incident of resident to resident abuse, which occurred on a specified date, between resident #037 and resident #038. Resident #037 was observed by PSW #140 to be exhibiting a specified responsive behaviour towards resident #038. PSW #140 intervened, and separated the residents. Resident #038 was closely monitored by staff.

Inspector #672 reviewed resident #037's health care records, and written plan of care, and noted that in a specified month and year, resident #037 had a specified intervention implemented, related to specified exhibited responsive behaviours. Despite this incident, resident #037 did not have any focuses related to the specified responsive behaviours in the written plan of care until an identified amount of time after the incident with resident #038. Following this incident, interventions were put in place for resident #037.

While reviewing the health care record for resident #037, Inspector #672 observed a notation from a specified date and time, which indicated that resident #037 was observed by a PSW to be exhibiting specified responsive behaviours towards resident #006. The PSW intervened and separated the residents, before resident #037 was able to follow through with the behaviour.

During separate interviews, PSW #126, RPN #131, and RN #132 indicated they were not aware that resident #037 exhibited responsive behaviours, and as a

result interventions were not put in place.

Inspector #672 reviewed a specified policy related to the management of the responsive behaviours exhibited by resident #37. During an interview, the DOC indicated the actions that would be taken by staff and the licensee when an incident of a specified responsive behaviour occurred.

Inspector #672 reviewed the health care record and written plan of care for resident #038, and noted that prior to the incident with resident #037, resident #038 also had a history of a specified exhibited responsive behaviours. Resident #038 was assessed by the Nurse Practitioner, and a specified intervention was implemented. The plan of care also indicated that staff were to monitor resident #038, but failed to indicate how staff were to monitor resident #038, and did not include the incidents which had occurred between resident #037 and resident #038 until several months after the initial incident.

During an interview, RPN #125 indicated that on specified date, resident #038 and resident #020 where observed to be displaying a specified responsive behaviour. RPN #125 further indicated that the residents had been separated, the incident was reported to the RN Supervisor, and front line staff were to frequently observe resident #038. No specific interventions were discussed or agreed upon, related to how often the staff were to observe resident #038.

Inspector #672 reviewed resident #020's written plan of care in place at the time of the incident. The written plan of care indicated that resident #020 had a history of exhibiting specified responsive behaviours, and had interventions in place as a result.

During separate interviews, RPNs #107, #134, and PSWs #130, #140, #141 indicated not being aware that resident #038 exhibited any specified responsive behaviours, or that resident #038 was to be monitored when interacting with other residents with identified responsive behaviours.

During an interview, the DOC indicated that all Registered Staff had been trained on the policy, and the policy had been implemented and in effect in the home, with the expectation being that the Registered Staff would complete an assessment following every incident of an exhibited specified observed responsive behaviour between residents, as directed in the policy.

The licensee failed to ensure that staff were aware of specific sections of the licensee's abuse policy. Additionally, direct care staff were not fully aware of the identified exhibited responsive behaviours identified for resident #038, #037 and #020, which the records indicated were a risk to themselves and other residents in the home. The licensee failed to put appropriate interventions in place to ensure that resident #038 was protected from incidents of resident to resident abuse, specifically related to resident #037 and #020. [s. 19. (1)] (672)

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

(A1)

1. The licensee has failed to ensure that where bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

Inspector #571 observed the bedrails and bed systems in the home for resident #021.

On August 21, 2012, a notice was issued to Long-Term Care Home Administrators from the Director identifying a document produced by Health Canada titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" (referred to as Health Canada Guidance Document). In the notice, it was written that this Health Canada Guidance Document was expected to be used "as a best practice document".

The Health Canada Guidance Document included the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States. The companion documents referred to in the Health Canada Guidance Document were identified as useful resources, and outlined prevailing practices related to the use of bed rails. Prevailing practices were predominant, generally accepted and widespread practices that were used as a basis for clinical decision-making.

In addition, a specified type of mattress and similar products for a specified use were easily compressed by the weight of a patient and may pose an additional risk of entrapment when used with conventional hospital bed systems. When these types of mattresses compress, the space between the mattress and the bed rail may increase and pose an additional risk of entrapment. While entrapments have occurred with the use of specified beds and specified mattress replacements, these products were excluded from the dimensional limit recommendations, except for those spaces within the perimeter of the rail (see Zone 1 description in section 2.7.1). This partial exemption was due to a specified reason.

Appendix F “Dimensional Test Methods for Bed Systems” in the document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" outlined a summary of the test zones (seven zones), the required testing equipment (each test required the use of simple tools, including a cone, a cylinder, and a spring scale) and how to use the equipment to test the

zones.

A review of the progress notes by Inspector #571 indicated the following:
- on a specified date, resident #027 had a specified diagnosis and was at risk for a specified complication; a new mattress was applied to the resident's bed.
- on a specified date, an intervention was initiated, at family request.
- on a specified date, resident #027 was found with a specified number of injuries on a specified number of separate identified areas of their body, related to the bedrails.

In an interview, with Inspector #571, the Environmental Services Manager (ESM) indicated that upon hire, all of the beds in the home had already been assessed for zones of entrapment. The ESM further indicated that bed systems were only assessed for entrapment when a new mattress was installed in a resident bed, and the bed systems were assessed by looking at the bed and determining if there were gaps between the mattress and frame, and/or side rails. If there were gaps noted, gap fillers were used. The ESM was not aware that resident #027 received a new mattress on a specified date, and did not assess the bed for zones of entrapment. The ESM also indicated that resident #027's bed was not assessed for zones of entrapment after an intervention was initiated on a specified date.

The ESM provided a record of the original bed entrapment tests for the entire facility, which were completed by an outside company, on a specified date. The ESM also provided documentation related to records for bed testing for zones of entrapment for the facility. No documentation was provided to indicate that resident #027's bed was assessed for zones of entrapment when a new mattress was applied on the specified date, or when the intervention was implemented on a later specified date. In addition, the ESM indicated that during the time that the ESM had been employed at the home, they had not seen or used the equipment which was used to test for zones of entrapment, such as the cone. The ESM indicated that during their employment, all beds which had been assessed by the ESM or the maintenance staff were only assessed by visually looking for gaps between the mattress and head/foot board and side rails, which were remedied by applying gap fillers. [s. 15. (1) (a)] (571)

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 be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged incident of resident to resident abuse was immediately investigated.

During an interview, RPN #125 indicated that on a specified date, resident #038 and resident #020 where observed to be displaying a specified responsive behaviour. RPN #125 further indicated that the residents had been separated, and the incident was reported to the RN Supervisor.

During an interview, the RN Supervisor indicated the incident between resident #038 and #020 had been reported by RPN #125 during report at the end of the shift. The RN Supervisor further indicated they had not reported to the manager on call, nor to the MOHLTC after hours pager.

During an interview, the DOC indicated not being aware of the incident between resident #020 and resident #038. The DOC stated the RN Supervisor had not notified the manager on call of the incident, and the ADOC became aware of the incident while reviewing the daily reports the following day. The DOC indicated the incident was considered to be an allegation of abuse, and would investigate.

During an interview, the DOC indicated that an internal investigation into the incident of alleged abuse that had occurred two days prior between resident #038 and #020, had not been completed. The DOC further indicated being aware of the legislation, which required any suspicion or allegation of resident abuse to be immediately investigated.

The licensee failed to ensure that an incident of alleged resident to resident abuse which occurred between resident #020 and resident #038 was investigated, once the licensee became aware of the allegation. [s. 23. (1) (a)] (672)

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 all allegations of resident abuse/neglect are immediately investigated, and appropriate actions are taken to prevent further incidents from occurring., to be implemented voluntarily.

WN #4: 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 when there were reasonable grounds to suspect that an abuse of a resident had occurred, that the suspicion and the information upon which it was based was immediately reported to the Director.

A Critical Incident Report was submitted to the Director, related to an alleged incident of resident to resident abuse, which occurred on a specified date, between resident #037 and resident #038. Resident #037 was observed by PSW #135 to be exhibiting specified responsive behaviours of an abusive nature towards resident #038. Following the incident, resident #037 had a specified intervention implemented, and the BSO team assessed and spoke with resident

#037. According to the CIR, staff were to monitor the whereabouts of resident #038, but no specific directions were given in relation to how often staff were to observe resident #038.

Upon review of the internal investigation into the incident, it was noted that the interaction between resident #037 and resident #038 occurred on a specified date and time. RN #137 did not report the incident to the manager on call, nor notify the Director, following notification by RPN #136. The ADOC became aware of the incident the next day. The ADOC reported the incident to the Director on that date.

During an interview, the ADOC indicated the expectation in the home was that the RN Supervisor should have immediately notified the manager on call, along with the Director, after becoming aware of the incident.

Inspector #672 then reviewed the internal policy entitled "Abuse and Neglect of a Resident – Actual or Suspected"; policy number: VII-G-10.00; current revision: December 2017. The policy stated the following:

"All staff members are required to report any abuse or suspected abuse immediately to the Administrator, Director of Care or designate and the Ministry of Health and Long Term Care".

The licensee failed to ensure that when there were reasonable grounds to suspect that an abuse of resident #038 had occurred by resident #037, the suspicion and the information upon which it was based was immediately reported to the Director. [s. 24. (1)] (672)

2. The licensee has failed to ensure that when there were reasonable grounds to suspect that an abuse of a resident had occurred, that the suspicion and the information upon which it was based was immediately reported to the Director.

Resident #038 had been involved in two previous Critical Incidents, on two separate specified dates, related to resident to resident abuse.

During an interview, RPN #125 indicated that during a specified date and time, resident #038 and resident #020 were observed to be displaying a specified responsive behavior of an abusive nature. RPN #125 indicated that the residents

had been separated, and the incident had been reported to the RN Supervisor.

During an interview, the RN Supervisor indicated that the incident between resident #038 and #020 had been reported by RPN #125 during report at the end of their shift. The RN Supervisor further indicated that the incident had not been reported to the manager on call, nor to the MOHLTC after hours pager.

During an interview, the DOC indicated not being aware of the incident between resident #020 and resident #038. The DOC further indicated that the RN Supervisor had not notified the manager on call of the incident, however, the ADOC became aware of the incident after reviewing the daily incident reports the next day. The DOC indicated that the incident was of an allegation of abuse, and would be investigated. The DOC further indicated that the expectation in the home was that the RN, who was the person in charge at the time of the incident, should have notified both the manager on call, and the MOHLTC after hours pager.

During an interview, the DOC indicated that the Director had not been notified of the incident. The DOC further indicated being aware of the legislation, which required any suspicion or allegation of resident abuse to be immediately reported to the Director.

The licensee failed to ensure that the Director was immediately notified of the incident of resident to resident abuse which had occurred between resident #020 and resident #038. [s. 24. (1)] (672)

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 all allegations of resident abuse/neglect are immediately reported to the Director, to be implemented voluntarily.

WN #5: 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:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

(A1)
1. The licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of resident #014's safety risks.

Inspector #571 reviewed the progress notes for resident #014 for a specified time period. The following was indicated:
-on identified dates and times- nursing staff documented that resident #014 was found to be in situations that put their safety at risk related to an identified factor on eight separate occasions, on six different dates, over a five week period
-during the same time period, resident #014's cognitive functioning and physical abilities declined and the resident was deemed incapable

In an interview with Inspector #571, RPN #105 indicated resident #014 had declined cognitively and physically.

A review of the plan of care for the same period of time indicated there had been no interdisciplinary assessments of resident #014's identified safety risks included in their plan of care.

The licensee failed to ensure that the plan of care for resident #014 was based on, at a minimum, an interdisciplinary assessment of resident #014's safety risks related to an identified factor, specifically when resident #014's capacity for decision making was impaired and documented evidence indicated they were physical deteriorating.

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 all plans of care are based on, at a minimum, safety risks, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a restraint by a physical device was included in a resident's plan of care.

A review of the clinical record indicated that resident #016 exhibited a communication impairment. On a specified date, Inspector #571 observed resident #016 to be lying in bed with an intervention implemented. The bed was not in the lowest position. Resident #016 was noted by Inspector #571 to be displaying specified exhibited behaviours in the bed.

A review of the progress notes for a specified time period, related to falls, indicated the resident had a specified number of unwitnessed falls during that time period.

A review of the clinical health records for resident # 016 indicated that an order obtained from Nurse Practitioner #108 on a specified date, directed that an intervention was to be implemented while resident #016 was in bed for specified

reasons. The following day, RPN #105 documented that the SDM for resident #016 consented to the intervention. RPN #105 informed the SDM that the intervention was considered to be a personal assistive service device (PASD).

In separate interviews on a specified date, PSWs #113, #114 and #115 all indicated that resident #016 was unable to use the intervention as a PASD. In an interview on a specified date, RPN #105 indicated that resident #016 could not use the intervention as a PASD and the resident was capable of getting out of the bed prior to Nurse Practitioner #108 changing the intervention order. RPN #105 further indicated that the purpose of the intervention ordered by Nurse Practitioner was for the intervention to be utilized as a restraint. RPN #105 indicated that at the time of NP #108's order, they were not aware if the intervention would have a restraining effect on the resident.

In an interview on a specified date, the Administrator indicated not being aware that resident #016 could not use the specified intervention as a PASD. The Administrator made a specified change, so that the specified intervention did not act as a restraint, after reviewing the plan of care for resident #016. [s. 31. (1)] (571)

2. The licensee has failed to ensure that the restraint plan of care for resident #034 included an order by the physician or the registered nurse in the extended class.

A CIR was submitted to the Director on a specified date, related to an incident which occurred on a specified date, resulting in an injury to resident #034 which caused a significant change in health status. Resident #034 was admitted to the home on a specified date with several specified diagnoses. Resident #034 required assistance with ADL's, and had a history of falls.

Inspector #672 observed resident #034 at three separate times in three separate areas: Inspector #672 noted on one occasion that resident #034 had three specified assistive devices that prevented the resident from rising; on another occasion resident #034 was observed with a specified intervention engaged which prevented the resident from rising, and two specified assistive devices in place; on another occasion, Inspector #672 requested resident #034 to disengage one of the specified assistive devices that was preventing the resident from rising. Resident #034 was unable to disengage the device.

During an interview, resident #034's SDM indicated that three of the specified assistive devices could not be removed by the resident and therefore prevented the resident from rising. Resident #034's SDM further indicated these assistive devices were implemented to attempt to restrain the resident in an attempt to decrease the incidents of falls with serious injury. Resident #034's SDM indicated belief that consent forms had been signed for the use of the different restraints, and believed they were necessary to keep resident #034 safe from further falls.

During separate interviews, PSW #143 and RPN #100 indicated that resident #034 would be at risk for falls if three specified interventions were not in place. PSW #143 further indicated that resident #034 was not able to utilize the three specified interventions as PASDs.

Inspector #672 reviewed the health care record for orders for the three specified restraints for resident #034, and noted that resident #034 did not have a physician or registered nurse in the extended class order for restraints as the restraints had been identified as PASD's instead. Instead, an order for two of the three PASD's were observed in resident #034's health record.

The licensee failed to ensure that resident #034 had an order from a physician or registered nurse in the extended class for restraints. [s. 31. (2) 4.] (672)

3. The licensee has failed to ensure that the restraint plan of care for resident #034 included consent by the SDM.

A CIR was submitted to the Director on a specified date, related to an incident which occurred on a specified date, resulting in an injury to resident #34 which caused a significant change in health status. Resident #034 was admitted to the home on a specified date with several specified diagnoses. Resident #034 required assistance with ADL's, and had a history of falls.

Inspector #672 observed resident #034 at three separate times in three separate areas: Inspector #672 noted on one occasion that resident #034 had three specified assistive devices that prevented the resident from rising; on another occasion resident #034 was observed with a specified intervention engaged which prevented the resident from rising, and two specified assistive devices in place; on another occasion, Inspector #672 requested resident #034 to disengage one of

the specified assistive devices that was preventing the resident from rising. Resident #034 was unable to disengage the device.

During an interview, resident #034's SDM indicated that three of the specified assistive devices could not be removed by the resident and therefore prevented the resident from rising. Resident #034's SDM further indicated these assistive devices were implemented to attempt to restrain the resident, in an attempt to decrease the incidents of falls. Resident #034's SDM indicated belief that consent forms had been signed for the use of the different restraints, and believed they were necessary to keep resident #034 safe from further falls.

During an interview, RPN #100 indicated that resident #034 did not have signed consent forms for the use of restraints, as the home did not classify the tools being used by resident #034 as restraints, but as PASDs. RPN #100 further indicated that consent forms for the use of PASDs had been signed by resident #034's family member.

Inspector #672 reviewed the health care record for resident #034, and noted that resident #034 did not have a signed consent form for restraints. Instead, resident #034 had a signed consent for two identified PASD's on two specified dates. There were no consents related to the third specified PASD observed in resident #034's health care record.

The licensee failed to ensure that resident #034's plan of care included consent from the SDM, related to the use of restraints as falls prevention interventions. [s. 31. (2) 5.] (672)

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 all residents in the home utilizing PASDs meet the required definition for use. If the resident does not meet the requirements, and therefore is noted to have a restraint in place, the home is to enure an order is in place for each restraint, consent is received to use each restraint, and all required monitoring is completed while restraints are in place., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.

A Critical Incident Report (CIR) was submitted to the Director related to an

allegation of staff to resident neglect. On a specified date, PSW #124 reported to the Director of Care (DOC) that on the previous day, two residents did not receive a scheduled bath. A third resident was not put to bed at a specified time for a rest.

A review of the licensee's internal investigation indicated that the following residents were identified by PSW #124 as not receiving proper care from PSW #123: resident #018, #035, #036 and #041. The CIR indicated that resident #036's SDM was notified of the alleged neglect. There was no indication in the CIR or progress notes that resident #018, #035 and #041's SDM's were notified.

During an interview with Inspector #623, the Director of Care (DOC) indicated that the SDM for resident #035 was notified, but the DOC did not document this on the CIR. The DOC indicated that resident #018 and #041's SDM's were not notified of the incident.

The licensee failed to ensure that resident's #018 and #041's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident. [s. 97. (1) (b)] (623)

2. The licensee has failed to ensure that resident #020 and #038's SDMs were notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.

During an interview, RPN #125 indicated that during the evening of a specified date, resident #020 was observed abusing resident #038. RPN #125 indicated that the residents had been immediately separated, and staff continued to monitor both residents, for further incidents of responsive behaviours.

During an interview, the DOC indicated not being aware of the incident between resident #020 and resident #038, but would investigate the matter, as the incident was considered to be abuse.

Upon review of resident #020's progress notes for the date specified, there were no entries observed related to notification of the SDM, related to the incident, or the internal investigation which was to be completed. Review of resident #038's progress notes indicated that the SDM had been notified of the incident by RPN

#125 two days after the incident occurred.

During an interview, the DOC indicated that resident #020's SDM had not been notified of the incident, therefore had instructed RPN #125 to notify the SDM following the interview. The DOC further indicated being aware of the legislation directing the licensee to inform SDMs of any alleged, suspected or witnessed incident of abuse or neglect of the resident within 12 hours of becoming aware, and that this had not been completed.

The licensee failed to ensure that the SDM of resident #020 and resident #038 were notified within 12 hours of becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident. [s. 97. (1) (b)] (672)

3. The licensee has failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

A Critical Incident Report (CIR) was submitted to the Director, related to an allegation of staff to resident neglect. On a specified date, PSW #124 reported to the Director of Care (DOC) that on the previous day, two residents did not receive a scheduled bath. A third resident was not put to bed at a specified time for a rest.

A review of the CIR and the licensee's internal investigation was completed by Inspector #623. There was no indication that the SDM for resident's #018, #035, #036 and #041 were notified of the outcome of the investigation. A review of the progress notes for resident's #018, #035, #036 and #041 failed to identify documentation to indicate that the SDMs were notified of the outcome of the investigation.

During an interview, the DOC indicated that the SDM's for residents #035 and #036 were notified of the allegation of neglect but were not notified of the outcome of the internal investigation. Resident's #018 and #041 were also not notified of the results of the investigation.

The licensee failed to ensure that the resident and resident's SDMs were notified of the results of the alleged abuse or neglect investigation immediately upon the completion. [s. 97. (2)] (623)

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 all SDMs are notified within the specified time limits of any allegation of resident abuse/neglect, along with the outcome of all investigations into allegations of resident abuse/neglect., to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Inspector #623 reviewed a medication incident report for a specified date, for resident #030. The incident report indicated that a specified drug was signed as administered on the medication administration record (MAR) sheets, but was not given by RPN #104 on a specified date and time.

A review of the Physician's orders for resident #030 directed staff to provide resident #030 a specified drug on a specified time and date.

Inspector #623 reviewed a medication incident report completed on a specified date, which indicated that resident #031 was ordered to receive a specified drug at specified times and date. RPN #103 signed the medication administration records (MAR's) indicating that the medication had been administered. A specified documentation record completed at a specified time and date, identified that the specified drug was still in an area of the medication cart for a specified date and time, and had not been administered.

Inspector #623 reviewed a medication incident report completed on a specified date, by RPN #109, which indicated that resident #032 was ordered to receive a specified drug on specified dates and times. RPN #109 discovered on a specified date and time, the specified drug remained in a specified area of the medication cart, and had not been administered to resident #032. The MAR and a specified documentation record for resident #032 indicated that RPN #102 signed as administering the drug at a specified date and time.

Inspector #623 reviewed a medication incident report completed on a specified date, which indicated on a specified date and time, resident #029 had two containers of a specified drug. One of the containers had a pharmacy label which indicated a specified drug was supposed to be in the container, but was noted to contain the wrong specified drug.

The medication incident report indicated that resident #029 was to receive a specified dose of the specified drug on a specified date and time. It was noted by RPN #106 that the wrong drug was in one of the containers for resident #029. RPN #101 signed the MAR on a specified date and time, which indicated that RPN #101 had administered the incorrect medication.

On a specified date and time, a review of documentation indicated that RPN #107 held a medication for resident #029 for a specified reason. There was no documented evidence that the physician or Nurse Practitioner were advised that the medication was held by RPN #107.

The licensee failed to ensure that residents #029, #030, #031 and #032 received medications as prescribed. [s. 131. (2)] (623)

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 all medications are administered to residents in accordance with the directions for use specified by the prescriber., to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident, and the pharmacy service provider.

Inspector #623 reviewed a medication incident report for a specified date, which indicated that resident #032 had a physician's order to receive a specified drug on specified dates and times. RPN #109 discovered on a specified date that a specified drug remained in a specified area of the medication cart, and had not been administered to resident #032. The MAR for resident #032 indicated that RPN #102 signed as administering the drug on a specified date and time. A specified documentation record for resident #032 also indicated that RPN #102 administered the specified drug on the specified date and time.

Review of the medication incident report indicated that the physician was not notified of the incident. There was also no evidence to support that resident #023 or the resident's SDM were notified of the medication omission.

Review of the progress notes for resident #032 over a specified time period failed to identify the omission of the specified drug, and there was no documented record of the immediate actions taken to assess and maintain the resident's health including assessing the resident.

The licensee failed to document a record of the immediate actions taken to assess and maintain the resident's health, and failed to report the medication incident to the resident or the resident's SDM. [s. 135. (1)] (623)

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 there is a record of the immediate actions taken to assess and maintain a resident's health status, following any medication incident; and to ensure the resident and/or SDM are notified of all medication incidents., to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care for resident #037 collaborated with each other, so that the assessments were integrated, consistent with, and complemented each other.

A Critical Incident Report was submitted to the Director, related to an alleged incident of resident to resident abuse, which occurred on a specified date, between resident #037 and resident #038. Resident #038 was observed to be abusing resident #037. PSW #135 intervened, and removed resident #038 from the room. Following the incident, resident #037 was placed on a specified increased observation schedule. According to the CIR, staff were to monitor the whereabouts of resident #038, but no specific directions were given in relation to how often staff were to observe resident #038.

A second Critical Incident Report was submitted to the Director, related to an

alleged incident of resident to resident abuse, which occurred on a specified date, between resident #037 and resident #038. The incident was observed by PSW #140.

During a review of the health care record for resident #037, Inspector #672 observed a notation from a specified date and time, which indicated that resident #037 was observed by a PSW, abusing resident #006. The PSW intervened and separated the residents, then reported the incident to the Registered Staff.

During an interview, the Social Services Manager (SSM) indicated that an ethics meeting had taken place in the home on a specified date, to discuss the incident between resident #037 and #038, which occurred on a specified date. Review of the progress notes in PCC with the SSM did not reveal any documentation from the meeting, or any notation that a meeting had taken place. The SSM then indicated there were notes taken during the meeting, which were stored in a binder in a specified office. The SSM further indicated that notes were usually stored in the specified office, and staff could review the notes on days when the office was open, and the staff requested to do so. The SSM was unable to indicate how the front line staff would have knowledge that an ethics meeting had taken place, or that notes were available for review.

A review of the documentation indicated that a specified number of recommendations for managing resident #037's responsive behaviour were made by a specified party. Inspector #672 reviewed resident #037's plan of care a specified period of time after the recommendations were made. Evidence that a specified number of the identified recommended interventions implemented were not found.

During an interview, RN #132 indicated that no one had requested a specified intervention be ordered by the NP, and was unaware if anyone had shared the recommended interventions from the specified party with the NP. RN #132 further indicated being unaware if a specified number of other recommended interventions had been implemented. RN #132 indicated that the recommendations had not been reviewed or discussed by the Registered Staff on the unit, and was unsure if they had been reviewed or discussed by anyone else in the home.

During separate interviews, RN #132 and RPN #127 indicated that a specified number of other specified recommended interventions for resident #037 were not

implemented. RN #132 and RPN #127 were unaware of the recommendation to try to provide resident #037 with an additional specified intervention.

During a second interview, the SSM indicated being a member of the internal BSO team. The SSM further indicated not being kept up to date with which residents in the home were exhibiting responsive behaviours, or which residents were being monitored related to responsive behaviours, as this information would only be available through reading the progress notes for each resident on a daily basis, which the SSM indicated was not done. The SSM indicated that the BSO lead was kept up to date with the residents exhibiting responsive behaviours within the home, and front line staff would be expected to go to the BSO lead with questions or concerns. The SSM further indicated being unaware of how the front line staff were kept up to date in regards to residents exhibiting responsive behaviours, or the interventions implemented for those residents, but the expectation for the BSO team was that the BSO lead would discuss every resident on the BSO caseload at the monthly BSO meeting.

Inspector #672 reviewed copies of the monthly BSO meeting minutes for a specified time period. During a meeting in a specified month within in the specified time period, resident #037 was discussed, but resident #038 was not. During meetings in two additional specified months, neither resident #037 nor resident #038 were discussed, despite the incidents of resident to resident abuse which occurred between them during the specified time period. During the interview, the SSM indicated that resident to resident abuse was something which would be expected to be discussed during the monthly BSO meetings, and could not recall why resident #037 and #038 were not discussed during the monthly BSO meetings.

The licensee failed to ensure that staff and others involved in the different aspects of resident #037’s care collaborated with each other, so that their assessments were integrated, consistent with, and complemented each other.

Please note, an Order under section s.6 (4) a, of the LTCHA was issued previously under inspection #2017_591623_0017/016959-17, with a compliance date of February 5, 2018. These incidents of non-compliance occurred before the compliance date, therefore a WN is being issued. [s. 6. (4) (a)] (672)

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident was bathed, at a minimum, twice weekly by the method of their choice, including tub baths, showers and full body sponge baths, and more frequently, as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A Critical Incident Report (CIR) was submitted to the Director, related to an allegation of staff to resident neglect. PSW #124 reported to the Director of Care (DOC) that on a specified date, a specified number of residents did not receive a scheduled bath.

Review of the internal investigation conducted by the DOC was completed by Inspector #623. The investigation indicated that it was determined residents #035 and #036 did not receive their scheduled bath on a specified date. The investigation indicated this was confirmed by no documentation on the PSW flow sheet records for that day, as well as by interviewing resident #035.

Inspector #623 reviewed the plan of care and the PSW flow sheets for resident #035 for a specified time period, which indicated the following:
The written plan of care indicated that resident #035 was to receive a specified type of bath on a specified number of specified days per week, at specified times.

On a specified number of days during a specified time period, there was no documentation to indicate that a specified type of bath was received by resident

#035 on the scheduled bath days, or on any other day in between.

Inspector #623 reviewed the plan of care and the PSW flow sheets for resident #036 for a specified time period, which indicated that resident #036 was to receive a specified type of bath on specified days per week. There was no documentation to indicate that any type of bath was provided for the resident on a specified number of dates. On a specified number of separate dates, documentation indicated that a specified type of bath was provided to the resident, despite the preference being a different type of bath.

During separate interviews with Inspector #623, PSW #133 and PSW #138 both indicated that when a resident was provided a specified type of bath, the resident did not receive a specified personal care service.

During an interview with Inspector #623, the DOC indicated that when the allegations of neglect were investigated, during an interview with resident #035, the resident indicated that they had not received a specified type of bath the day before, but felt that they had been washed. Resident #035 could not recall the last time a specified type of bath had been provided, and a specified type of bath was the resident's preference as indicated in the written plan of care. The DOC indicated the licensee's expectation was that all residents were offered a minimum of two baths per week. A bath schedule was provided with specified days and times. If a resident requested to be changed to a different day or shift, then accommodations were made for the resident. The DOC indicated that the type of bath that was provided was based on the resident's preferences, related to receiving a tub bath, a shower or a bed bath. The written plan of care was expected to reflect the preferences of the resident. The DOC indicated that the PSW was expected to document on the PSW flow sheets to indicate that a bath was completed. If a resident refused a bath, then the expectation was that the PSW would communicate that to the RPN, and the RPN would document in Point Click Care, and the information would be passed on during shift report, so that a bath could be offered the following day. The DOC indicated that if a specified type of bath was provided for a resident, that would include a specified personal care service, with tools which were available to the PSW staff.

The licensee failed to ensure that residents #035 and #036 were bathed, at a minimum, twice weekly by the method of their choice, including tub baths, showers and full body sponge baths. [s. 33. (1)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director regarding an incident of alleged resident to resident abuse between resident #037 and resident #038 included the names of any staff members who were present at or discovered the incident, and the names of staff members who responded to the incident.

A Critical Incident Report was submitted to the Director on a specified date, related to an alleged incident of resident to resident abuse between resident #037 and resident #038. Resident #037 was observed by PSW #135 abusing resident #038 in a specified manner. Following the incident, interventions were initiated in resident #037's plan of care related to preventing further incidents of abuse. In addition, staff were to monitor the whereabouts of resident #038, but no specific directions were given in relation to how often staff were to observe resident #038.

The CIR did not indicate the name of the PSW who observed the incident, and removed resident #038 from the situation; nor did it include the name of RPN #136, who assessed the residents following the incident. The CIR further indicated that a specified individual was to assess resident #037, review the incident and implement specified interventions on resident #037's plan of care, but the name of the specified individual was not contained within the report to the Director. The CIR indicated that the Social Service Manager was also involved in investigating the incident and implementing specified interventions. The name of the Social Services Manager was not included in the report to the Director.

The licensee failed to ensure that the report to the Director included the name of the PSW who witnessed the incident, the name of the RPN who followed up with the residents following the incident, the name of the specified individual who implemented interventions, and further investigation of residents #037 and #038, or the name of the Social Services Manager, who implemented interventions for resident #037 following the incident. [s. 104. (1) 2.] (672)

Issued on this 24th day of January, 2019 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by PATRICIA MATA (571) - (A1)
Inspection No. / No de l'inspection :	2018_578672_0004 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	001765-18 (A1)
Type of Inspection / Genre d'inspection :	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 24, 2019(A1)
Licensee / Titulaire de permis :	Glen Hill Terrace Christian Homes Inc. 200 Glen Hill Drive South, WHITBY, ON, L1N-9W2
LTC Home / Foyer de SLD :	Glen Hill Strathaven 264 King Street East, Bowmanville, ON, L1C-1P9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michelle Stroud

To Glen Hill Terrace Christian Homes Inc., 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)

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 is ordered to:

Ensure that procedures and interventions are implemented to assist residents who are at risk of harm or who are harmed as a result of another resident's responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents including but not limited to the following:

1) Ensure the Behaviour Support Ontario (BSO) team is immediately notified of all residents, including residents #020 and #037, demonstrating altercations and potentially harmful interactions between and among other residents, specifically related to residents #006, and #038.

2) Ensure the BSO team and the interdisciplinary team identify factors which could potentially trigger a resident altercation or incident for residents identified as having responsive behaviours, specifically responsive behaviours of a sexual nature, and residents #020 and #037 individually. Identify and implement interventions to manage these responsive behaviours through appropriate assessments (i.e. BAT/PIECES/DOS).

3) Develop and implement a process to ensure the plan of care for residents exhibiting responsive behaviours of a sexual nature, or are demonstrating altercations and potentially harmful interactions between and among other residents, are reviewed and revised, and to incorporate assessments completed by BSO.

4) Develop and implement a process to ensure all staff providing care to those residents know which of the residents are at risk for altercations and potentially harmful interactions, and understand how and when to implement the planned interventions to manage responsive behaviours.

5) Retrain all Registered nursing staff on the licensee's Responsive Behaviour Prevention and Management policy; the licensee's Abuse and Neglect - Prevention, Reporting & Investigation policy; the licensee's Sexual expression and intimacy policy; and the overall BSO program, with the goal of ensuring the staff are aware of their roles and responsibilities, related to managing residents demonstrating identified responsive behaviours, and ensuring all residents exhibiting those behaviours are assessed at the time of each incident for capacity to consent. In addition, retraining the Registered Nursing staff on when to refer to additional services (i.e. psychogeriatric services, BSO, and when to implement one to one monitoring)

6) Develop and implement a monitoring tool to ensure the planned, revised interventions and strategies are effective in managing the responsive behaviours of residents #037 and #020, with special attention to minimizing risks associated with potentially harmful interactions between residents #037 and #020 with cognitively impaired residents, along with residents #038, and #006.

7) Develop and put in place a process whereby the Director of Care and/or delegates are reviewing all documentation and communication from the front line staff at least daily to determine if any high risk responsive behaviours have occurred in the home; and this shall continue until compliance is achieved.

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure that resident #038 was protected from abuse.

Related to Log #025844-17:

A Critical Incident Report (CIR #2605-000035-17) was submitted to the Director on

November 6, 2017, related to an alleged incident of resident to resident sexual abuse, which occurred on November 5, 2017, between resident #037 and resident #038. Residents #037 and #038 were observed by PSW #135 to be in resident #037’s bedroom, where resident #037's pants were down around the ankle area, and resident #037 had an arm around resident #038, forcefully pulling resident #038 closer, to attempt to kiss resident #038. Resident #038 was observed to be actively attempting to refuse the advances of resident #037, by pushing back. PSW #135 intervened, and removed resident #038 from the room. Following the incident, resident #037 was placed on increased observation of every 30 minutes, and the BSO team assessed and spoke with resident #037. Resident #037 had a Cognitive Performance Scale (CPS) score of 1, and did not have a medical diagnosis related to possible cognitive impairment. Resident #038 was noted to have cognitive impairment related to a medical diagnosis of vascular dementia, with a CPS score of 5. According to the CIR, staff were to monitor the whereabouts of resident #038, but no specific directions were given in relation to how often staff were to observe resident #038.

A second Critical Incident Report (CIR #2605-000038-17) was submitted to the Director on December 19, 2017, related to an alleged incident of resident to resident sexual abuse, which occurred on December 19, 2017, between resident #037 and resident #038. Resident #037 was observed by PSW #140 to be holding resident #038’s hands down, and kissing resident #038 on the lips and cheeks. PSW #140 intervened, and separated the residents, with resident #037 being brought back to the bedroom area, and resident #038 was brought to the nursing station for observation.

For the purposes of the definition of "abuse" in subsection 2(1) of the Long Term Care Homes Act, 2007, "sexual abuse" means,

(a) Subject to subsection (3), any consensual or non-consensual touching, behaviour or remarks of
a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff
member, or

(b) Any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation

directed towards a resident by a person other than a licensee or staff member.

Inspector #672 reviewed resident #037's health care records, and written plan of care, and noted that in October 2017, resident #037 had been placed on increased observation of every 15 minutes, related to exhibited responsive behaviours of a sexual nature, when resident #037 was found in the bedroom of a co-resident, who had a CPS score of 5, and was kissing the co-resident. Despite this incident, resident #037 did not have any focuses related to responsive behaviours of a sexual nature in the written plan of care until after the incident with resident #038 in November 2017. Following the incident in November, interventions were put in place for resident #037, such as increased observation of every 30 minutes, and for staff to "protect other residents if unable to protect themselves".

While reviewing the health care record for resident #037, Inspector #672 observed a notation from the evening shift of February 23, 2018, which indicated that resident #037 was observed by a PSW to be holding resident #006's walker in place and holding resident #006's hands, while attempting to kiss resident #006 on the lips. The PSW intervened and separated the residents, before resident #037 was physically able to kiss resident #006.

During separate interviews on February 27, and 28, 2018, PSW #126, RPN #131, and RN #132 indicated they were not aware that resident #037 exhibited responsive behaviours of a sexual nature, that any interventions were in place as a result, or that there were any residents who specifically required protection from resident #037.

Inspector #672 reviewed the internal policy entitled "Sexual expression and intimacy", original issue September 2017. The policy indicated the following:

"This policy recognizes and supports the adult's right to engage in sexual activity, so long as there is consent among those involved. Consent may be demonstrated by the words and/or affirmative actions of the adult:
 With intact decision making ability; or
 With intact decision making ability who is non-verbal; or
 With Alzheimer's disease or dementia.
The former requires an assessment conducted by clinical staff, using the home's "assessment of capacity to consent to sexual activity".

The policy goes on to state the following:

"Residents with physical and/or cognitive impairment noted to have sexual expression:

1. Registered Staff will inform the Social Services Manager who will complete a Mini-Mental State Exam (MMSE).
2. The Social Service Manager or Registered Staff will them complete the "Lichtenberg Preliminary Decision Tree for assessing competency to participate in an intimate relationship" assessment located in PCC.
3. The Social Service Manager or Registered Staff will the complete the "Assessment of Capacity to consent to Sexual Activity" assessment located in PCC."

During an interview on February 27, 2018, at 1045 hours, the DOC indicated that if residents were found to be involved in a sexual/intimate act, staff were to immediately separate the residents, and report the incident to the manager. The DOC further indicated that when notification was received that an incident had occurred, the DOC would determine whether the residents were able to have consented to the act by reviewing the CPS score of each resident, and whether the family were aware and had consented to the act. After taking those areas into account, a decision would be made by the manager regarding the resident's capacity to consent. The DOC acknowledged the above mentioned policy contained direction for determining a resident's capacity for consent.

Inspector #672 reviewed the health care record and written plan of care for resident #038, and noted that prior to the incident with resident #037 in November, resident #038 had a history of responsive behaviours of a sexual nature, where resident #038 would participate in intimate/sexual activities with co-residents, as a result of cognitive impairment. Resident #038 was assessed by the Nurse Practitioner on September 6, 2017, and placed on an antidepressant medication, in an attempt to "curb hypersexual behaviours". Upon review of the written plan of care following the incident in November 2017, the interventions listed were to "involve family, social worker and BSO with intervention" and that a Mini Mental Status Exam (MMSE) had been completed. Following the incident in December, the intervention added to the written plan of care was to "monitor for safety from sexual advances from co-residents". The care plan did not list how or when staff were to monitor resident #038 for safety, which residents may exhibit sexual advances toward resident #038,

and did not mention either of the incidents of resident to resident sexual abuse which had occurred with resident #037, until February 22, 2018, when a focus was added to the written plan of care which indicated that resident #038 had been a victim of sexual assault, and required protection from resident #037. The written plan of care for resident #038 also listed interventions as follows: 1) Display an accepting, non-judgemental manner to encourage resident to discuss concerns about sexuality
2) Explain and explore with resident the effect their behaviour has on other residents and staff
3) Determine what triggered/lead up to the behavior. Staff to redirect resident from going in to male residents rooms.

During an interview on March 5, 2018, RPN #125 indicated that resident #038 would not be cognitively capable of discussing what triggered or lead up to an exhibited responsive behaviour, could not discuss or verbalize any feelings or concerns related to sexuality, and would not be able to understand how the exhibited responsive behaviours were possibly affecting co-residents or staff, related to cognitive impairment. RPN #125 further indicted that resident #038 would have no memory of an intimate/sexual encounter, therefore could not report to staff any issues or concerns related to sexuality or if an incident had occurred.

During an interview on February 27, 2018, RPN #125 indicated that on February 26, 2018, resident #038 was observed to be sitting on the lap of resident #020, while intimately embracing each other. RPN #125 further indicated that the residents had been separated, the incident was reported to the RN Supervisor, and front line staff were to “frequently observe” resident #038, to ensure resident #038's safety. No specific interventions were discussed or agreed upon, related to how often the staff were to observe resident #038.

Inspector #672 reviewed resident #020's written plan of care, dated January 15, 2018. The written plan of care indicated that resident #020 had a history of responsive behaviours of a sexual nature, and had interventions in place as a result.

During separate interviews on February 28, March 1, 5, 2018, RPNs #107, #134, and PSWs #130, #140, #141 indicated not being aware that resident #038 exhibited any responsive behaviours of a sexual nature, or that resident #038 required protection from any other resident in the home as a result of the identified behaviours.

During an interview on February 27, 2018, at 1115 hours, the DOC indicated that all Registered Staff had been trained on the policy, and the policy had been implemented and in effect in the home since September 2017, with the expectation being that the Registered Staff would complete an assessment following every incident observed of resident to resident sexuality/intimacy, as directed in the policy.

During separate interviews on February 26, 28, and March 1, 2018, RPNs #100, #107, #121, #127, #131, #134, and RN#132 indicated that they were not aware of any directions of how to determine capacity to consent for residents engaging in sexual activities. The staff members further indicated that resident #038 and #006 were cognitively impaired, and would not have been able to consent to the acts indicated above.

The licensee failed to ensure that staff were aware of the licensee's sexuality abuse policy which included directions for determining capacity and consent of residents engaging in acts of a sexual nature. Additionally, direct care staff were not fully aware of the identified sexually responsive behaviours identified for resident #038, #037, and #020, which the records indicated were a risk to themselves and other residents in the home. The licensee failed to put appropriate interventions in place to ensure that resident #038 was protected from incidents of resident to resident sexual abuse, specifically related to resident #037 and #020. (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 20, 2018

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:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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 24th day of January, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by PATRICIA MATA (571) - (A1)

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