Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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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
May 21, 2019	2019_643111_0006	012110-18, 015570-18, 019586-18, 031256-18, 004376-19, 004665-19	Follow up

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): February 26, 28, March 1, 4 to 8, 12 to 14, 18 and 20, 2019. The inspection was conducted off-site on Febraruy 27and March 26, 2019 (off-site).

A follow-up inspection was completed related to Compliance Order (CO) #001 for duty to protect.

In addition, the following Critical Incident inspections were completed concurrently during this inspection:
-Log #012110-18, Log #015570-18, Log #019586-18, and Log #004376-19, related to alleged resident to resident abuse.
-Log #004665-19, related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), the Behaviour Supports Ontario (BSO) RPN, Personal Support Workers (PSW), residents, Social Worker(SW), Activity Aide and Housekeeping Aide.

During the course of the inspection, the inspector: reviewed health care records of residents, reviewed the licensee's investigations, reviewed employee records, staff training records and reviewed the licensee policy, Abuse and Neglect of a Resident- Actual or Suspected.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **3 VPC(s)**
- **2 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. 19. (1)	CO #001	2018_578672_0004	111

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 :

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

Related to resident #003:

A critical incident report (CIR) was submitted to the Director for an alleged, resident to resident abuse incident that occurred on a specified date and time. The CIR indicated PSW #114 reported to RPN #113 that there had been an altercation between resident #003 and resident #004. Resident #004 complained of pain to a specified area and sustained an injury to a specified area. The CIR indicated the actions to prevent a recurrence included resident #003 placed on increased monitoring and a specified strategy, for a specified area.

A second critical incident report (CIR) was submitted to the Director for an alleged, resident to resident abuse incident that occurred on a specified date and time. The CIR indicated two residents reported witnessing an altercation between resident #003 and #013, that resulted in resident #013, sustaining a fall. Resident #013 complained of pain to a specified area and was transferred to hospital for an assessment. The resident later returned from hospital with a specified injury to a specified area. The CIR indicated specified actions that were to be taken to prevent a recurrence, including increased monitoring of resident #003.

Review of the progress notes for resident #003, during a specified period of time, indicated there were ongoing altercations and/or abuse incidents in a specified area, involving resident #003 towards resident #004, #013 and other unidentified residents. After the first critical incident, resident #003 was placed on increased monitoring for a few days and another specified strategy. The specified responsive behaviour continued, the same specified strategy was put in place, despite being ineffective. The BSO staff also indicated the specified behaviour had no longer occurred since the last critical incident, despite the documentation indicating the responsive behaviour continued. Resident #003 continued to demonstrate the specified responsive behaviour, in the specified area. The family of resident #003 had requested the resident's medications be reassessed. After a specified period, a specified assessment was implemented by the BSO staff, as the

resident continued to demonstrate the specified responsive behaviour, in the specified area. A few days later, the second critical incident occurred. The following day, the resident was witnessed engaging in the same specified responsive behaviour, in the same specified area and the same specified intervention was implemented. The resident was assessed by the physician the following day. Approximately a week after the last critical incident occurred, additional specified triggers and strategies were identified and implemented to manage resident #003's specified responsive behaviours in the specified area. There was also a referral to a specialized service completed.

Review of the written care plan for resident #003 related to responsive behaviours indicated the resident demonstrated specified responsive behaviours, in a specified area, identified the specified area as a trigger and identified specified strategies. New specified strategies were identified, a number of days after the second altercation and were to be implemented when the responsive behaviour occurred.

On a specified date and time, resident #003 was observed by the Inspector, in the specified area. The resident was pleasant and there was a specified strategy in place. There were other residents near by. The resident denied any concerns with other residents.

During an interview with PSW #118 by Inspector #111, they indicated resident #003 demonstrated specified responsive behaviours, in a specified area and had many altercations with other residents in the specified area.

During an interview with RPN #113 by Inspector #111, they indicated that resident #003 had ongoing altercations with other residents and they usually occurred in the specified area. The RPN indicated whenever there was an altercation involving resident #003 and another resident in the specified area, they would place the resident on increased monitoring, at specified intervals.

During an interview with RPN #115 by Inspector #111, they indicated resident #003 was independently with mobility with the use of a mobility aid, and would generally be in a specified area, considered the area belonging to them and required an ongoing specified intervention. The RPN indicated the resident only engaged in altercations with other residents, in the specified area. The RPN indicated specified strategies that were used to manage the responsive behaviour/altercations. The RPN indicated after the last critical incident that occurred, resident #003 was placed on increased monitoring at specified intervals and remains on hourly monitoring. The RPN indicated no awareness of any

further altercations, involving resident #003, since then.

During an interview with BSO RPN (#112) by Inspector #111, the RPN indicated resident #003 demonstrated specified responsive behaviours towards staff and other residents. RPN #112 indicated the resident usually spent most of the their time in a specified area and demonstrated specified responsive behaviours and/or altercations with other residents, in the specified area. RPN #112 indicated a specified medication was initiated on a specified date, but then the resident's responsive behaviours increased, so the medication was discontinued. RPN #112 indicated when the resident demonstrated specified responsive behaviours in the specified area, staff were to implemented a specified intervention to prevent an altercation with other residents. RPN #112 confirmed awareness that both critical incidents of abuse towards other residents and the ongoing altercations with other residents occurred in the specified area. RPN #112 indicated a specified strategy was implemented after the first critical incident and confirmed it was ineffective, as the altercations continued. The RPN indicated the resident was referred to specialized services, additional assessments were completed and additional strategies were implemented after the second critical incident of abuse occurred.

The licensee had failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #003 and other residents by identifying and implementing interventions. Other interventions were not implemented until a period of time after the second critical incident occurred, despite resident #003 having two resident to resident abuse incidents and ongoing altercations with other residents, all around the same identified trigger, in a specified area.

2. Related to resident #005:

A follow- up inspection was completed related to Compliance Order (CO) #001 under LTCHA, 2007, s.19(1) which included resident #005.

Review of the progress notes for resident #005 indicated the resident was involved in ongoing altercations with other residents (resident #015, #017, #018, #019 and #022) and the incidents usually occurred on other units. There were also alleged, suspected and/or witnessed incidents of resident to resident abuse that occurred. After the first critical incident of resident to resident abuse, involving resident #005 and #008, where resident #008 sustained an injury, resident #005 was placed on increased monitoring and given a specified medication. After the second critical incident of resident to resident abuse, involving resident #005 and #006, where resident #006 sustained an injury,

resident #005 was placed on increased monitoring, given a specified medication and the Nurse Practitioner (NP) was notified. Resident #005 was then witnessed on a number of occasions by staff demonstrating a different specified responsive behaviour, towards resident #011, #015 and other residents on another unit. Resident #005 was then placed on increased monitoring and directed to keep the residents apart. The resident was assessed by the Social Worker (SW) and BSO after the third incident of the specified responsive behaviour and indicated to reassess each interaction to determine consent. Resident #005 was also witnessed demonstrating the same specified responsive behaviour towards other residents. On a specified date, a care conference was held with the SDM to discuss the residents specified responsive behaviour towards resident #011. Resident #005 continued to demonstrate the specified responsive behaviour with other residents. The resident was given a specified intervention for distraction and a specified medication. The resident was then assessed by the NP, who reviewed the recommendations from the specialized services and ordered a different specified medication.

Review of the written plan of care for resident #005 indicated the resident demonstrated specified responsive behaviours and identified specified strategies. Resident #016 was identified as a trigger.

During an interview with RPN #126 by Inspector #111, they indicated resident #005 demonstrated specified responsive behaviours. The RPN identified specified triggers and strategies used to manage the responsive behaviours.

During an interview with RPN #125 by Inspector #111, the RPN indicated resident #005 demonstrated specified responsive behaviours and had an altercation with resident #016. The RPN identified specified triggers (resident #011 and #016) and strategies used to manage the responsive behaviours.

During an interview with RPN #104 by Inspector #111, they indicated resident #005 demonstrated specified responsive behaviours and demonstrated other specified responsive behaviours towards other residents (resident #011, #016 and #20). RPN #104 indicated resident #019 would become upset and engage in an altercations with resident #005, when they demonstrated their specified responsive behaviours towards resident #016. RPN #104 indicated resident #021 would also engage in an altercations with resident #005, when they demonstrated specified responsive behaviours towards resident #020. The RPN also identified specified strategies used to manage resident #005 specified responsive behaviours. The RPN indicated they were also aware of a

suspected abuse incident between resident #005 and #015.

During an interview with the SW by Inspector #111, the SW indicated resident #005 demonstrated a specified responsive behaviour which they did not consider as abuse. The SW indicated the specified responsive behaviour occurred between resident #005 and resident #011. The SW confirmed they had a discussed the specified responsive behaviour with the SDM of resident #005 and confirmed they did not contact the SDM of resident #011. The SW provided specified strategies related to resident #005 and #001, despite incidents with resident #005 and other residents and confirmed those strategies were not included in the written plan of care for resident #005.

During an interview with RPN #112 (BSO) by Inspector #111, the BSP RPN indicated the BSO team included RN #121, SW, two Activity Aide's(AA), HSK and four PSWs. The BSO RPN indicated the BSO team is immediately notified of any residents demonstrating altercations and potentially harmful interactions, between and among residents by submitting via an email from the charge nurse or a referral to BSO. RPN #112 indicated the BSO team reviews the 24 hour report on PCC daily when they arrive and identifies factors which could potentially trigger a resident altercation or incident for residents identified as having responsive behaviours, identify and implement interventions to manage these responsive behaviours through appropriate assessments. RPN #112 indicated the BSO team met monthly, discussed residents with high risk responsive behaviours, discussed their triggers and interventions to manage the behaviours and any previous interventions that may or may not have been effective. RPN #112 indicated the BSO team ensures the plan of care for residents were also updated monthly. RPN #112 indicated they also complete a progress note when the review is completed. RPN #112 indicated a picture of residents with high risk responsive behaviours and a quick list of interventions is posted in specified areas so that all staff are aware. RPN #112 indicated the 24 hour binder also indicates which residents have a referral to specialized services. RPN #112 indicated they used a specified monitoring tool which is to identify the behaviour, care precautions and the frequency of monitoring. RPN #112 indicated they generally used only one of the specified monitoring frequencies, which was implemented right after an incident occurred and was kept in place for a specified number of days. RPN #112 indicated the monitoring tool was used to determine the responsive behaviour patterns and possible triggers. RPN #112 indicated the use of one to one staffing was up to the management team to implement.

During an interview with the DOC by Inspector #111, they indicated the process that was developed and implemented, as per the Compliance Order, where the DOC and/or

delegate would be aware of any high risk responsive behaviours that were occurring in the home included: a daily report held with the leadership members (Administrator, DOC, ADOC and Staff Development Coordinator-RN #121) during the week, who review the last 24 hours in PCC on each home area, to ensure that any high risk responsive behaviours have been addressed as required, or have been followed up on. The DOC indicated this information is also put into the daily report sheet and is emailed to leadership team and the RN Supervisors on the weekends. The DOC indicated they would expect all registered nursing staff or BSO RPN to update the residents care plans, but it usually is the BSO RPN.

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #005 and other residents, as the resident was involved in two abuse incidents and two suspected abuse incidents. The home failed to identify and implement strategies to minimize the risk.

Additional Required Actions:

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

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

The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

A follow up inspection was completed for a Compliance Order (CO) #001 that was related to LTCHA, 2007, s.19(1) duty to protect residents from abuse and the order included resident #005.

Review of the health care record for resident #005, indicated they were the recipient of witnessed, abuse incidents by other residents and also a suspected incident of resident to resident abuse as follows:
-On a specified date and time, RPN #125 indicated the charge nurse from another unit reported that resident #016 had been involved in an altercation with resident #005, resulting in resident #005 being upset, had no injury but was given an analgesic for comfort. The RN supervisor was notified but there was no indication the incident was reported to the Director, despite the resident being upset.
-On a specified date and time, RN #131 indicated a PSW reported witnessing resident #022 being abusive towards resident #005, resulting in the resident being upset and sustaining an injury to a specified area. Resident #022 confirmed being abusive towards resident #005 due to resident #005 responsive behaviours. There was no indication the incident was reported to the Director.

During an interview with RPN #125 by Inspector #111, they indicated resident #005 demonstrated specified responsive behaviours towards other residents and staff. RPN #125 indicated resident #005 demonstrated specified responsive behaviours towards resident #011, but staff had to also assess each interaction to ensure the behaviours were consensual. The RPN indicated they determined consent by their refusal with a verbal response or any visual display of refusing consent. The RPN indicated the incident that occurred on a specified date, the charge nurse and PSW from another unit had reported witnessing that resident #016 had engaged in an altercation towards resident #005. The RPN indicated that RN #129 was immediately notified.The RPN indicated resident #005 had no pain or injury as a result of the incident, but confirmed the resident was upset. The RPN indicated they expected the RN to report the incident to the Ministry of Health and Long Term Care (MOHLTC).

During an interview with RN #129 by Inspector #111, they confirmed they were aware of the altercation incident involving resident #016 towards resident #005, but could not recall if they were working when the incident occurred. RN #129 indicated whenever they are notified of an altercation between residents, they would usually assess both residents involved for any injury, document the assessment and then immediately report the incident to the manager. The RN confirmed they did not report the incident to the MOHLTC.

During an interview with the DOC and Administrator by Inspector #111, they both confirmed the above incidents were not reported to the Director.

2. A critical incident report (CIR) was submitted to the Director for a resident to resident abuse incident that occurred on a specified date and time. The CIR indicated RN #120 heard an altercation and witnessed resident #005 being abusive towards resident #008, resulting in a fall. Resident #008 complained of pain to a specified area, sustained injuries to specified areas and was transferred to hospital for assessment. The resident sustained an injury to a specified area. The incident was not reported to the Director until the day after the incident occurred.

During an interview with the Administrator by Inspector #111, they confirmed the Director was not informed of the incident until the CIR was submitted, the day after the incident occurred.

The licensee had failed to ensure that when the person who had reasonable grounds to suspect abuse of resident #005, that may have occurred on two separate dates, immediately reported the suspicion and the information upon which it was based, to the Director. The licensee had also failed to ensure that the Director was immediately notified of suspected abuse of resident #008, as this incident was not reported until the following day.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A critical indicate report (CIR) was submitted to the Director for an witnessed staff to resident abuse incident that occurred on a specified date and time. The CIR indicated AA #102 witnessed PSW #101 being abusive towards resident #014.

Review of the written plan of care for resident #014 indicated under toileting, the resident required one staff assistance with the entire process due to impaired mobility and a specified diagnosis.

Review of the progress notes for resident #014 indicated the entry was completed by the ADOC, a number of days after the incident occurred and indicated resident #014 was not provided assistance with toileting when requested by PSW #101.

During an initial interview with the DOC by Inspector #111, the DOC indicated the investigation into the alleged staff to resident abuse incident, involving PSW #101 towards resident #014, was still ongoing at that time. The DOC indicated on a later date, that the investigation was concluded and it was founded that PSW #101 failed to provide resident #014 with toileting as per the resident's care needs.

The licensee has failed to ensure that the care set out in the plan of care for resident #014, was provided to the resident as specified in the plan related to toileting needs.

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 care set out in the plan of care is provided to residents as specified in the plan, specifically around toileting needs, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that the a written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Review of the licensee`s Abuse and Neglect of a Resident -Actual or Suspected policy (VII-G-10.00) revised September 2018 indicated under Immediate Action, a staff member receiving a report of or observing anyone abusing a residents in any manner will immediately report the abuse to the DOC or designate.

A. Related to resident #014:

A critical indicate report (CIR) was submitted to the Director for an witnessed, staff to resident abuse incident that occurred on a specified date and time. The CIR indicated AA #102 witnessed PSW #101 being abusive towards resident #014.

Review of the progress notes for resident #014 indicated there was no progress note completed on the day the incident occurred. An entry was completed a number of days later, by the ADOC regarding the incident.

During an interview with the ADOC by Inspector #111, they confirmed the staff to resident abuse incident involving PSW #101 occurred on a specified date and time, they interviewed Activity Aide #102, resident #014, another witness (visitor), RPN #104 and PSW #103, who all confirmed the incident and verified that PSW #101 had also neglected to provide the resident with care. The ADOC indicated they also spoke to PSW #101 who continued to be inappropriate regarding the incident. The ADOC confirmed they also notified the DOC. The ADOC indicated PSW #106 and #107 were also working when the incident occurred, but they only spoke to PSW #106. The ADOC confirmed the incident was not documented until a number of days later.

During an interview with RPN #104 by Inspector #111, the RPN indicated resident #014 required assistance with toileting/incontinence. RPN #104 confirmed they were present when the staff to resident abuse and neglect incident occurred, involving PSW #101 towards resident #104. The RPN indicated PSW #103, #106 and #107 were also aware of the incident. The RPN indicated they did not report the incident to anyone until the ADOC contacted them to discuss what had occurred. The RPN confirmed they did not speak to resident #014 to assess the resident, did not inform the physician and did not document in the residents chart, regarding the incident.

During an interview with the DOC by Inspector #111, they indicated the investigation into the alleged staff to resident abuse and neglect incident with resident #014 was completed and was determined to be founded. The DOC confirmed the nursing staff did not document the incident on the resident's health record, until a number of days later.

The licensee failed to ensure the licensee`s Abuse and Neglect of a Resident- Actual or Suspected policy, was complied with. The Registered nursing staff were responsible to immediately report the abuse to the DOC or designate and RPN #104 did not immediately report the incident to the ADOC or DOC, despite being aware of the incident. Both RPN #104 and the ADOC did not document the events related to the witnessed staff to resident abuse and neglect incident, in the resident's chart, ensuring all assessments were documented on the date the incident occurred. RPN #104 did not document the incident and the ADOC did not document the incident until a number of days later.

B. Related to resident #003 and #004:

A critical incident report (CIR) was submitted to the Director for a suspected resident to

resident abuse incident that occurred on a specified date and time. The CIR indicated PSW #114 reported to RPN #113 that there had been an altercation incident between resident #003 and #004. RPN #113 indicated resident #004 was found upset, complained of pain and sustained an injury to a specified area as a result. The CIR indicated the physician was not contacted.

Review of the progress notes for resident #003 had no documented record that the physician and/or NP was notified of the resident to resident abuse incident. Review of the progress notes for resident #004 indicated the initial assessment (post incident), the resident complained of pain, sustained an injury to a specified area and was given an analgesic. There was no documented evidence the physician and/or NP was notified, despite the resident sustaining pain and injury.

Review of the incident investigation indicated PSW #114, RPN #113 and RN #120 were all aware and/or responded to the incident. The incident investigation was signed as completed, by the Administrator.

During an interview with RPN #113 by Inspector #111, they confirmed they were working when the resident to resident abuse incident occurred, involving resident #003 and #004. The RPN indicated they immediately notified RN #120, confirmed that they did not inform the physician, but assumed the RN would have.

Interview with the Administrator by Inspector #111, they confirmed they were aware of the resident to resident abuse incident that occurred on a specified date/time and assumed RN #120 would have notified the physician and/or NP of the incident.

The licensee failed to ensure the licensee`s Abuse and Neglect of a Resident- Actual or Suspected policy, was complied with as the physician and/or NP was not informed of the resident to resident abuse incident that resulted in pain and injury to resident #004.

C. Related to resident #003 and #013:

A critical incident report (CIR) was submitted to the Director for a resident to resident abuse incident that occurred on a specified date and time. The CIR indicated resident #003 had engaged in abuse towards resident #013 in a specified area, resulting the resident sustaining a fall. Resident #013 complained of pain to a specified area and was transferred to hospital for an assessment.

Review of the licensee's investigation indicated on a specified date and time, the resident to resident abuse incident that occurred involving resident #003 towards resident #013, was witnessed by two other residents (resident #022 and #023). PSW #118, RPN #115 and RN #119 were aware of the incident. The Administrator provided the Inspector an incident investigation template, that was dated as completed a number of days after the incident occurred. There were no signed statements or interviews from staff and/or residents included. A week later, the DOC provided the Inspector with a second incident investigation template that was dated the same day the incident occurred and included typed summaries of telephone conversations the DOC had with staff (PSW #118, RPN #115 and RN #119). There were no signed statements from any of the staff/residents provided at that time. The following day, the DOC provided three typed statements, from staff (PSW #118, RPN #115 and RN #119) that were signed by the staff, but not dated to indicate when the statements were actually received. There were no signed statements by either of the two residents that witnessed the incident.

During an interview with PSW #118 by Inspector #111 (the day after the signed statements were received), they confirmed responding to the resident to resident abuse incident that occurred on a specified date and time. The PSW indicated the incident involved resident #003 towards resident #013 and they immediately reported the incident to RPN #115. The PSW indicated that resident #007 was present and confirmed witnessing the incident. The PSW confirmed the DOC had requested their signed statement of the incident, the day before the Inspector interviewed them and a number of days after the incident occurred.

During an interview with RPN #115 by Inspector #111 (the day after the signed statements were received), they confirmed responding to the resident to resident abuse incident that occurred on a specified date and time. The RPN indicated PSW #118 reported the incident involved resident #003 towards resident #013 and they immediately reported the incident to RN #119. RPN #115 confirmed the DOC had requested their signed statement of the incident, the day before the Inspector interviewed them and a number of days after the incident occurred.

During an interview with RN #119 by Inspector #111 (the day after the signed statements were received), they confirmed responding to the resident to resident abuse incident that occurred on a specified date and time, involving resident #003 towards resident #013, when they were notified by RPN #115. The RN indicated they reported the incident to the ADOC and DOC.The RN indicated they were asked about the incident a number of days after the incident occurred and provided their own written statement regarding the

incident. The RN could not recall when their written statement was actually provided to the DOC and confirmed the statement was not dated.

During an interview with the DOC by Inspector #111, the DOC indicated they initially contacted all the staff who were present, regarding the resident to resident abuse incident and then later received their written statements. The DOC confirmed the written statements were not dated to indicate when they were received and they did obtain any written statements or documented interviews with any other witnesses (residents) as per the policy.

The licensee failed to ensure their Abuse and Neglect of a Resident -Actual or Suspected policy was complied with, as it related to the investigation, as all the staff and/or any witnesses (residents) who were aware of or directly involved in the resident to resident abuse incident, involving resident #003 and #013, were not requested to provide a written statement until a number of days after. There were also no documented interviews in the investigation of the residents who actually witnessed the incident. The DOC and Administrator, who completed the investigation, did not ensure that all written documentation was signed and dated, with the time of recording as per the policy.

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 the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #5: 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).

Findings/Faits saillants :

The licensee has failed to ensure that the resident's SDM and any other person specified by the resident, were immediately notified upon becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that caused distress to the resident, that could potentially be detrimental to the resident' s health or well-being.

A critical indicate report (CIR) was submitted to the Director for a staff to resident abuse incident. The CIR indicated on a specified date and time, resident #014 had reported that they had called for staff assistance for toileting when Activity Aide #102 overheard PSW #101, being abusive to the resident. The CIR indicated the SDM was not contacted.

Review of the health care record for resident #014 indicated the resident had two SDM's identified.

During an interview with resident #014 on a specified date by Inspector #111, the resident indicated they had an SDM, confirmed the SDM was not informed of the staff to resident abuse incident because when they spoke to them, the SDM was not aware of the incident. The resident indicated their SDM should have been notified.

During an interview with the ADOC by Inspector #111, they confirmed they were notified of the staff to resident abuse incident involving resident #014 when the incident occurred. The ADOC verified the information with staff and the resident who were present and confirmed they did not contact the SDM.

During an interview with the DOC by Inspector #111, they indicated that the resident was their own POA so no one else was notified regarding the staff to resident abuse incident. During a later interview, the DOC confirmed that they should have consulted with the resident to determine if their SDM was to be notified.

The licensee has failed to ensure that resident #014's SDM were immediately notified upon becoming aware of a witnessed incident of staff to resident abuse incident.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident's SDM and any other person specified by the resident, are immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that caused distress to the resident that could potentially be detrimental to the resident' s health or well-being, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the resident's right to be told who is responsible for and who is providing his or her direct care, was fully respected and promoted.

A critical indicate report (CIR) was submitted to the Director for a staff to resident abuse incident. The CIR indicated on a specified date and time, resident #014 had reported that they had called for staff assistance for toileting, had attempted to self toilet and AA #102 overheard PSW #101 being abusive to the resident. Resident #014 had asked the PSW for their name and the information was not provided.

Review of the progress notes for resident #014 indicated on a specified date and time, the ADOC spoke to resident #014, the resident confirmed that a PSW was abusive towards them during toileting, the resident was upset with the PSW as a result of the incident and the PSW refused to provide their name.

During an interview with resident #014 on a specified date by Inspector #111, the resident recalled the incident when they were not provided with assistance with toileting, a PSW had been abusive towards them and did not know their name. The resident was upset regarding the incident.

Review of the licensee's investigation and interviews with staff, indicated RPN #104, Activity Aide #102 and PSW #103 all verified that PSW #101 was directly involved in the incident.

The licensee has failed to ensure that resident #014's right to be told who is responsible for and who is providing their direct care, was fully respected and promoted.

Issued on this 19th day of June, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2019_643111_0006
Log No. / No de registre :	012110-18, 015570-18, 019586-18, 031256-18, 004376-19, 004665-19
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 21, 2019
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:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. 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.

Order / Ordre :

The licensee must be compliance with O.Reg.79/10, s.54(a)(b),

Specifically,

1. Ensure the plan of care for residents exhibiting responsive behaviours, or are demonstrating altercations and potentially harmful interactions between residents (including resident #003 and #005), are reviewed and revised, incorporating assessments completed by BSO.

2. Develop and implement a process to ensure all staff providing care to resident #003 and #005 (and any other residents exhibiting responsive behaviours), know which residents are at risk for altercations and potentially harmful interactions, including those residents exhibiting a responsive behaviour and understand how and when to implement planned interventions to manage the responsive behaviours.

3. In addition, ensure any residents exhibiting responsive behaviours, are assessed at the time of each incident, for the capacity to consent, and based on a clear understanding of the legislative definition of abuse in O.Reg.79/10.

Grounds / Motifs :

1. The licensee has failed to ensure that steps were taken to minimize the risk of

altercations and potentially harmful interactions between residents by identifying and implementing interventions.

Related to resident #003:

A critical incident report (CIR) was submitted to the Director for an alleged, resident to resident abuse incident that occurred on a specified date and time. The CIR indicated PSW #114 reported to RPN #113 that there had been an altercation between resident #003 and resident #004. Resident #004 complained of pain to a specified area and sustained an injury to a specified area. The CIR indicated the actions to prevent a recurrence included resident #003 placed on increased monitoring and a specified strategy, for a specified area.

A second critical incident report (CIR) was submitted to the Director for an alleged, resident to resident abuse incident that occurred on a specified date and time. The CIR indicated two residents reported witnessing an altercation between resident #003 and #013, that resulted in resident #013, sustaining a fall. Resident #013 complained of pain to a specified area and was transferred to hospital for an assessment. The resident later returned from hospital with a specified injury to a specified area. The CIR indicated specified actions that were to be taken to prevent a recurrence, including increased monitoring of resident #003.

Review of the progress notes for resident #003, during a specified period of time, indicated there were ongoing altercations and/or abuse incidents in a specified area, involving resident #003 towards resident #004, #013 and other unidentified residents. After the first critical incident, resident #003 was placed on increased monitoring for a few days and another specified strategy. The specified responsive behaviour continued, the same specified strategy was put in place, despite being ineffective. The BSO staff also indicated the specified behaviour had no longer occurred since the last critical incident, despite the documentation indicating the responsive behaviour continued. Resident #003 continued to demonstrate the specified responsive behaviour, in the specified area. The family of resident #003 had requested the resident's medications be reassessed. After a specified period, a specified assessment was implemented by the BSO staff, as the resident continued to demonstrate the specified

responsive behaviour, in the specified area. A few days later, the second critical incident occurred. The following day, the resident was witnessed engaging in the same specified responsive behaviour, in the same specified area and the same specified intervention was implemented. The resident was assessed by the physician the following day. Approximately a week after the last critical incident occurred, additional specified triggers and strategies were identified and implemented to manage resident #003's specified responsive behaviours in the specified area. There was also a referral to a specialized service completed.

Review of the written care plan for resident #003 related to responsive behaviours indicated the resident demonstrated specified responsive behaviours, in a specified area, identified the specified area as a trigger and identified specified strategies. New specified strategies were identified, a number of days after the second altercation and were to be implemented when the responsive behaviour occurred.

On a specified date and time, resident #003 was observed by the Inspector, in the specified area. The resident was pleasant and there was a specified strategy in place. There were other residents near by. The resident denied any concerns with other residents.

During an interview with PSW #118 by Inspector #111, they indicated resident #003 demonstrated specified responsive behaviours, in a specified area and had many altercations with other residents in the specified area.

During an interview with RPN #113 by Inspector #111, they indicated that resident #003 had ongoing altercations with other residents and they usually occurred in the specified area. The RPN indicated whenever there was an altercation involving resident #003 and another resident in the specified area, they would place the resident on increased monitoring, at specified intervals.

During an interview with RPN #115 by Inspector #111, they indicated resident #003 was independently with mobility with the use of a mobility aid, and would generally be in a specified area, considered the area belonging to them and required an ongoing specified intervention. The RPN indicated the resident only engaged in altercations with other residents, in the specified area. The RPN indicated specified strategies that were used to manage the responsive

behaviour/altercations. The RPN indicated after the last critical incident that occurred, resident #003 was placed on increased monitoring at specified intervals and remains on hourly monitoring. The RPN indicated no awareness of any further altercations, involving resident #003, since then.

During an interview with BSO RPN (#112) by Inspector #111, the RPN indicated resident #003 demonstrated specified responsive behaviours towards staff and other residents. RPN #112 indicated the resident usually spent most of the their time in a specified area and demonstrated specified responsive behaviours and/or altercations with other residents, in the specified area. RPN #112 indicated a specified medication was initiated on a specified date, but then the resident's responsive behaviours increased, so the medication was discontinued. RPN #112 indicated when the resident demonstrated specified responsive behaviours in the specified area, staff were to implemented a specified intervention to prevent an altercation with other residents. RPN #112 confirmed awareness that both critical incidents of abuse towards other residents and the ongoing altercations with other residents occurred in the specified area. RPN #112 indicated a specified strategy was implemented after the first critical incident and confirmed it was ineffective, as the altercations continued. The RPN indicated the resident was referred to specialized services, additional assessments were completed and additional strategies were implemented after the second critical incident of abuse occurred.

The licensee had failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #003 and other residents by identifying and implementing interventions. Other interventions were not implemented until a period of time after the second critical incident occurred, despite resident #003 having two resident to resident abuse incidents and ongoing altercations with other residents, all around the same identified trigger, in a specified area. (111)

2. Related to resident #005:

A follow- up inspection was completed related to Compliance Order (CO) #001 under LTCHA, 2007, s.19(1) which included resident #005.

Review of the progress notes for resident #005 indicated the resident was

involved in ongoing altercations with other residents (resident #015, #017, #018, #019 and #022) and the incidents usually occurred on other units. There were also alleged, suspected and/or witnessed incidents of resident to resident abuse that occurred. After the first critical incident of resident to resident abuse, involving resident #005 and #008, where resident #008 sustained an injury, resident #005 was placed on increased monitoring and given a specified medication. After the second critical incident of resident to resident abuse, involving resident #005 and #006, where resident #006 sustained an injury, resident #005 was placed on increased monitoring, given a specified medication and the Nurse Practitioner (NP) was notified. Resident #005 was then witnessed on a number of occasions by staff demonstrating a different specified responsive behaviour, towards resident #011, #015 and other residents on another unit. Resident #005 was then placed on increased monitoring and directed to keep the residents apart. The resident was assessed by the Social Worker (SW) and BSO after the third incident of the specified responsive behaviour and indicated to reassess each interaction to determine consent. Resident #005 was also witnessed demonstrating the same specified responsive behaviour towards other residents. On a specified date, a care conference was held with the SDM to discuss the residents specified responsive behaviour towards resident #011. Resident #005 continued to demonstrate the specified responsive behaviour with other residents. The resident was given a specified intervention for distraction and a specified medication. The resident was then assessed by the NP, who reviewed the recommendations from the specialized services and ordered a different specified medication.

Review of the written plan of care for resident #005 indicated the resident demonstrated specified responsive behaviours and identified specified strategies. Resident #016 was identified as a trigger.

During an interview with RPN #126 by Inspector #111, they indicated resident #005 demonstrated specified responsive behaviours. The RPN identified specified triggers and strategies used to manage the responsive behaviours.

During an interview with RPN #125 by Inspector #111, the RPN indicated resident #005 demonstrated specified responsive behaviours and had an altercation with resident #016. The RPN identified specified triggers (resident #011 and #016) and strategies used to manage the responsive behaviours.

During an interview with RPN #104 by Inspector #111, they indicated resident #005 demonstrated specified responsive behaviours and demonstrated other specified responsive behaviours towards other residents (resident #011, #016 and #20). RPN #104 indicated resident #019 would become upset and engage in an altercations with resident #005, when they demonstrated their specified responsive behaviours towards resident #016. RPN #104 indicated resident #021 would also engage in an altercations with resident #005, when they demonstrated specified responsive behaviours towards resident #020. The RPN also identified specified strategies used to manage resident #005 specified responsive behaviours. The RPN indicated they were also aware of a suspected abuse incident between resident #005 and #015.

During an interview with the SW by Inspector #111, the SW indicated resident #005 demonstrated a specified responsive behaviour which they did not consider as abuse. The SW indicated the specified responsive behaviour occurred between resident #005 and resident #011. The SW confirmed they had a discussed the specified responsive behaviour with the SDM of resident #005 and confirmed they did not contact the SDM of resident #011. The SW provided specified strategies related to resident #005 and #001, despite incidents with resident #005 and other residents and confirmed those strategies were not included in the written plan of care for resident #005.

During an interview with RPN #112 (BSO) by Inspector #111, the BSP RPN indicated the BSO team included RN #121, SW, two Activity Aide's (AA), HSK and four PSWs. The BSO RPN indicated the BSO team is immediately notified of any residents demonstrating altercations and potentially harmful interactions, between and among residents by submitting via an email from the charge nurse or a referral to BSO. RPN #112 indicated the BSO team reviews the 24 hour report on PCC daily when they arrive and identifies factors which could potentially trigger a resident altercation or incident for residents identified as having responsive behaviours, identify and implement interventions to manage these responsive behaviours through appropriate assessments. RPN #112 indicated the BSO team met monthly, discussed residents with high risk responsive behaviours, discussed their triggers and interventions to manage the behaviours and any previous interventions that may or may not have been effective. RPN #112 indicated the BSO team ensures the plan of care for

residents were also updated monthly. RPN #112 indicated they also complete a progress note when the review is completed. RPN #112 indicated a picture of residents with high risk responsive behaviours and a quick list of interventions is posted in specified areas so that all staff are aware. RPN #112 indicated the 24 hour binder also indicates which residents have a referral to specialized services. RPN #112 indicated they used a specified monitoring tool which is to identify the behaviour, care precautions and the frequency of monitoring. RPN #112 indicated they generally used only one of the specified monitoring frequencies, which was implemented right after an incident occurred and was kept in place for a specified number of days. RPN #112 indicated the monitoring tool was used to determine the responsive behaviour patterns and possible triggers. RPN #112 indicated the use of one to one staffing was up to the management team to implement.

During an interview with the DOC by Inspector #111, they indicated the process that was developed and implemented, as per the Compliance Order, where the DOC and/or delegate would be aware of any high risk responsive behaviours that were occurring in the home included: a daily report held with the leadership members (Administrator, DOC, ADOC and Staff Development Coordinator-RN #121) during the week, who review the last 24 hours in PCC on each home area, to ensure that any high risk responsive behaviours have been addressed as required, or have been followed up on. The DOC indicated this information is also put into the daily report sheet and is emailed to leadership team and the RN Supervisors on the weekends. The DOC indicated they would expect all registered nursing staff or BSO RPN to update the residents care plans, but it usually is the BSO RPN.

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #005 and other residents, as the resident was involved in two abuse incidents and two suspected abuse incidents. The home failed to identify and implement strategies to minimize the risk.

The scope was a level 2, a pattern, as two of the three residents reviewed had ongoing altercations and/or incidents of physical or sexual abuse. The severity was a level 3, actual harm as some of the recipient residents sustained injuries as a result of the responsive behaviours from resident #003 and #005. The

compliance history was a level 2, as the home has had one or more unrelated non-compliances in last 36 month. (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The licensee shall comply with LTCHA, 2007, s.24(1).

Specifically,

1. Ensure that any alleged, suspected or witnessed incidents of abuse and/or neglect of any resident are immediately reported, including resident #005.

Grounds / Motifs :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

A follow up inspection was completed for a Compliance Order (CO) #001 that was related to LTCHA, 2007, s.19(1) duty to protect residents from abuse and the order included resident #005.

Review of the health care record for resident #005, indicated they were the recipient of witnessed, abuse incidents by other residents and also a suspected

incident of resident to resident abuse as follows:
-On a specified date and time, RPN #125 indicated the charge nurse from another unit reported that resident #016 had been involved in an altercation with resident #005, resulting in resident #005 being upset, had no injury but was given an analgesic for comfort. The RN supervisor was notified but there was no indication the incident was reported to the Director, despite the resident being upset.
-On a specified date and time, RN #131 indicated a PSW reported witnessing resident #022 being abusive towards resident #005, resulting in the resident being upset and sustaining an injury to a specified area. Resident #022 confirmed being abusive towards resident #005 due to resident #005 responsive behaviours. There was no indication the incident was reported to the Director.

During an interview with RPN #125 by Inspector #111, they indicated resident #005 demonstrated specified responsive behaviours towards other residents and staff. RPN #125 indicated resident #005 demonstrated specified responsive behaviours towards resident #011, but staff had to also assess each interaction to ensure the behaviours were consensual. The RPN indicated they determined consent by their refusal with a verbal response or any visual display of refusing consent. The RPN indicated the incident that occurred on a specified date, the charge nurse and PSW from another unit had reported witnessing that resident #016 had engaged in an altercation towards resident #005. The RPN indicated that RN #129 was immediately notified.The RPN indicated resident #005 had no pain or injury as a result of the incident, but confirmed the resident was upset. The RPN indicated they expected the RN to report the incident to the Ministry of Health and Long Term Care (MOHLTC).

During an interview with RN #129 by Inspector #111, they confirmed they were aware of the altercation incident involving resident #016 towards resident #005, but could not recall if they were working when the incident occurred. RN #129 indicated whenever they are notified of an altercation between residents, they would usually assess both residents involved for any injury, document the assessment and then immediately report the incident to the manager. The RN confirmed they did not report the incident to the MOHLTC.

During an interview with the DOC and Administrator by Inspector #111, they both confirmed the above incidents were not reported to the Director.

2. A critical incident report (CIR) was submitted to the Director for a resident to resident abuse incident that occurred on a specified date and time. The CIR indicated RN #120 heard an altercation and witnessed resident #005 being abusive towards resident #008, resulting in a fall. Resident #008 complained of pain to a specified area, sustained injuries to specified areas and was transferred to hospital for assessment. The resident sustained an injury to a specified area. The incident was not reported to the Director until the day after the incident occurred.

During an interview with the Administrator by Inspector #111, they confirmed the Director was not informed of the incident until the CIR was submitted, the day after the incident occurred.

The licensee had failed to ensure that when the person who had reasonable grounds to suspect abuse of resident #005, that may have occurred on two separate dates, immediately reported the suspicion and the information upon which it was based, to the Director. The licensee had also failed to ensure that the Director was immediately notified of suspected abuse of resident #008, as this incident was not reported until the following day.

The scope was a level 2, a pattern, as two out of two residents that were reviewed, were involved in resident to resident physical abuse and were either not reported, or immediately reported. The severity was a level 3, actual harm/actual risk as there was injury to residents. The compliance history was a level 4, as the home has had ongoing non-compliance under LTCHA, 2007, s.24(1) as follows:
-issued a Voluntary Plan of Correction (VPC) on August 9, 2016 during inspection # 2016_389601_0018
-issued a VPC on June 20, 2018 during inspection #2018_578672_0004.
-issued a Written Notification (WN) on July 26, 2018 during inspection #2018_643111_0011. (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2019

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 21st day of May, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

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