Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 13, 2019	2019_578672_0001	026155-18, 026160-18	Follow up

Licensee/Titulaire de permis

Unionville Home Society
4300 Highway #7 MARKHAM ON L3R 1L8

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

Union Villa
4300 Highway #7 Unionville ON L3R 1L8

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

JENNIFER BATTEN (672)

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): December 17-21, 24, 27, 28, 2018; January 2, 3, February 5, 8, 14, 15, 19, 20, 2019

The following logs were inspected during this inspection:

Log #026155-18, related to follow-up Order #001, served on a specified date within report # 2018_685648_0011, under LTCHA, 2007, c.8.s.19 (1), related to the duty to protect.

Log #026160-18, related to follow up Order #002, served on a specified date within report # 2018_685648_0011, under O. Reg 79/10. s 53 (4) b, related to responsive behaviours.

The following Critical Incident (CI) intakes were inspected concurrently:
Log #001488-19, Log #002957-19 and Log #002150-19 regarding alleged incidents of resident to resident abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents, family members and volunteers.

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

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 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
O.Reg 79/10 s. 53. (4)	CO #002	2018_685648_0011	672

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

Related to Log #026155-18:

The licensee was served a Compliance Order (CO#001) pursuant to section s. 19 of the LTCHA, in relation to a Critical Incident System Inspection, with an identified compliance due date. The compliance order indicated the following:

"The licensee must be compliant with s.19 (1) of the Act.
The licensee shall prepare, submit and implement a plan to ensure that all residents are protected from abuse by both resident #002 and any other residents with responsive behaviours that put others at risk of harm. The plan must include and not be limited, to the following:
A description of the training and education that will occur related to the supervision and monitoring of residents with identified responsive behaviours, for all staff having contact with such residents including resident #002, the persons responsible for providing the education, and the dates this training will occur."

The licensee completed and submitted a plan to the CESAO by the required date. The licensee failed to complete the education related to the supervision and monitoring of residents with identified responsive behaviours, for all staff having contact with such residents.

CO#001 was related to resident #002, who was no longer in the home at the time of the follow up inspection, therefore Inspector #672 reviewed incidents of resident to resident abuse which had occurred in the home following the compliance date.

Related to Logs #001488-19 and #002150-19:

A Critical Incident Report was submitted to the Director related to an incident of resident to resident abuse which occurred between residents #006 and #008. According to the CIR, RPN #123 had reported to the BSO nurse on a specified date that during the previous evening, resident #007's SDM had shared video footage they recorded. The video showed resident #006 exhibiting identified responsive behaviours towards resident #008.

A second CIR was submitted to the Director on a specified date. According to the CIR, the SDM of resident #007 informed the DOC of an incident of resident to resident abuse involving residents #006 and #007, which had occurred approximately one month prior. The CIR indicated that on the specified date, the SDM had observed resident #006 exhibiting identified responsive behaviours towards resident #007. The SDM indicated they intervened to stop the identified responsive behaviour and did not report the incident to RPN #123, who was the nurse on duty at the time.

Inspector #672 reviewed an identified internal policy which provided definitions and examples of resident abuse.

Inspector #672 reviewed another identified internal policy which indicated how and when staff were to assess residents possibly involved in incidents of resident to resident abuse, and what assessment tool to utilize to complete the assessment.

During an interview, the Administrator indicated the purpose of the identified assessment tool was to ensure that any resident observed exhibiting or being involved in identified responsive behaviours was cognitively aware of their actions and had the ability to provide informed consent. The Administrator further indicated the assessment was to be completed by staff each time a resident was observed to be exhibiting or participating in the identified responsive behaviours, and staff had been educated on how and when to complete the assessment tool.

Inspector #672 reviewed resident #006's health care records, written plan of care, and progress notes from a specified time period. According to a progress note written on a specified date, resident #006 had been exhibiting identified responsive behaviours towards identified individuals for a specified period of time. The progress notes indicated that between a specified time period, resident #006 was observed exhibiting identified responsive behaviours towards identified individuals on a specified number of occasions.

The progress notes further indicated that following the compliance date, resident #006 had been involved in a specified number of incidents of exhibiting identified responsive behaviours towards identified individuals.

Inspector #672 reviewed resident #006's health care record, and did not observe any completed identified assessment tools during a specified time period.

Inspector reviewed resident #007's health care records and did not observe any completed identified assessment tools during a specified time period.

Inspector #672 then reviewed resident #008's health care records and did not observe any completed identified assessment tools during a specified time period.

During separate interviews, PSW #117, RPN #123, RPN #106, the Social Worker and the BSO nurse all indicated that residents #007 and #008 were unable to participate in the identified responsive behaviours for a specified reason. RPN #123 and the BSO nurse further indicated that they were not aware of how and when staff were to assess residents possibly involved in incidents of resident to resident abuse, and what assessment tool to utilize to complete the assessment.

During separate interviews with resident #006's regular staff members, PSW #117 and RPN #123 both indicated that resident #006 had a history of exhibiting the identified responsive behaviours, and staff had been directed to implemented a specified intervention for resident #006 to assist in managing the identified responsive behaviours. Both RPN #123 and PSW #117 further indicated that the intervention was not effective in preventing the resident from exhibiting the identified responsive behaviours for specified reasons. According to RPN #123, resident #006's identified responsive behaviours were "normalized" by staff, due to a lack of staff education and awareness. RPN #123 indicated that staff members normalizing resident #006's identified responsive behaviours led to staff not reporting incidents of exhibited identified responsive behaviours and not completing identified assessment tools related to the behaviours.

Inspector #672 reviewed resident #006's progress notes for a specified time period. During this time, the notes indicated resident #006 was observed exhibiting identified responsive behaviours towards identified individuals on a specified number of occasions. The progress notes did not indicate that any of the incidents had been reported.

During an interview, the DOC indicated that the first internal investigation conducted

related to resident #006's identified responsive behaviours was on a specified date, after the incident between residents #006 and #008 had been reported. The DOC further indicated this was due to staff not reporting incidents of exhibited identified responsive behaviours from resident #006. The DOC indicated belief staff were not reporting the incidents as a result of the staff normalizing the resident's identified responsive behaviours, therefore registered staff had received education related to definitions and examples of resident abuse, how and when staff were to assess residents possibly involved in incidents of resident to resident abuse, and what assessment tool to utilize to complete the assessment.

During an interview, the Administrator indicated the expectation was that all residents were to be protected from abuse by anyone at all times. The Administrator further indicated that co-residents in the home had not been protected from resident #006's identified responsive behaviours due to staff normalizing the behaviours which led to staff not completing assessments or reporting the incidents. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident was provided the opportunity to participate fully in the development and implementation of the plan of care.

Related to Logs #001488-19 and #002150-19:

During review of the compliance orders served in relation to a Critical Incident System Inspection related to resident #002, who was no longer in the home at the time of the follow up inspection, Inspector #672 reviewed incidents of resident to resident abuse which had occurred in the home following the specified compliance due date. During the review of the incidents of resident to resident abuse, it was observed that resident #006 had been involved in a specified number of incidents of resident to resident abuse which were reported to the Director after the identified compliance due date.

On a specified date and time, Inspector #672 observed resident #006 sitting outside of the Administrator's office, waiting to speak with the Administrator. At the time of the observation, resident #006 appeared to be visibly upset.

During an interview later the same day, resident #006 indicated to Inspector #672 that they were upset due to an incident which had occurred during an activity of daily living that day, and no explanations had been provided to the resident. Resident #006 indicated the experience upset them and during the conversation with Inspector #672 resident #006 appeared to be visibly upset.

Inspector #672 reviewed resident #006's health care record, and observed that the licensee had sent a specified referral to an identified agency. Review of resident #006's progress notes indicated that on a specified date, a staff member from the identified agency came to conduct an assessment of the resident. Inspector #672 did not observe a progress note which indicated that resident #006 had been informed of the referral to the identified agency, the purpose of the referral or the observation conducted by or introduction to the staff member from the identified agency.

During an interview, PSW #117 indicated that on the specified date, the staff member from the identified agency observed resident #006 during the activity of daily living. PSW #117 further indicated the staff member from the identified agency did not introduce themselves to resident #006 prior to or during the activity of daily living, and was unaware if resident #006 had been informed that an observation related to the referral

was being conducted that day.

During an interview, the Administrator indicated that the expectation in the home was that every resident had a right to know if an assessment was being completed, who was conducting the assessment, the purpose of the assessment, and when the assessment was beginning and ending, in order to fully participate in the plan of care. The Administrator further indicated they were following up with the identified agency in an attempt to ensure a similar situation did not happen again in the future.

The licensee failed to ensure that resident #006 was provided the opportunity to participate fully in the development and implementation of the plan of care when the resident was not informed they were being assessed by an outside agency. [s. 6. (5)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective.

Related to Logs #001488-19 and #002150-19:

A Critical Incident Report was submitted to the Director related to an incident of resident to resident abuse which occurred between residents #006 and #008. According to the CIR, RPN #123 had reported to the BSO nurse on a specified date that during the previous evening, resident #007's SDM had shared video footage they recorded. The video showed resident #006 exhibiting identified responsive behaviours towards resident #008.

Inspector #672 reviewed resident #006's health care records, written plan of care, and progress notes from a specified time period. According to a progress note written on a specified date, resident #006 had been exhibiting identified responsive behaviours towards identified individuals for a specified period of time. The progress notes indicated that between a specified time period, resident #006 was observed exhibiting identified responsive behaviours towards identified individuals on a specified number of occasions. The progress notes further indicated that following the compliance date, resident #006 had been involved in a specified number of incidents of exhibiting identified responsive behaviours towards identified individuals.

During the record review of resident #006's plan of care, staff were directed to respond to resident #006's identified responsive behaviours by implementing identified interventions.

During separate interviews with resident #006's regular staff members, PSW #117 and RPN #123 both indicated that resident #006 had a history of exhibiting the identified responsive behaviours, and staff had been directed to implemented a specified intervention for resident #006 to assist in managing the identified responsive behaviours. Both RPN #123 and PSW #117 further indicated that the intervention was not effective in preventing the resident from exhibiting the identified responsive behaviours for specified reasons. PSW #117 indicated that staff were not implementing other identified interventions listed in resident #006's plan of care due to specified reasons, and RPN#123 and PSW #117 both indicated that the interventions in resident #006's plan of care were not effective in managing resident #006's identified responsive behaviours.

During separate interviews, the Social Worker and BSO nurse both indicated that resident #006 had a history of exhibiting identified responsive behaviours. The Social Worker indicated they would sometimes receive emails from the nursing staff regarding resident #006's identified responsive behaviours and had reported the incidents during the morning management meetings. The Social Worker further indicated the strategies listed within the resident's plan of care were not effective and required revision.

During an interview, the Administrator indicated the expectation in the home was that each resident was to be immediately reassessed and the plan of care reviewed and revised when care set out in the plan had not been effective.

The licensee failed to ensure that resident #006 was reassessed and the plan of care reviewed and revised when care set out in the plan had not been effective, related to exhibited responsive behaviours of a sexual nature. [s. 6. (10) (c)]

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 reviewed and revised when care set out in the plan had not been effective and for all residents to be provided the opportunity to participate fully in the development and implementation of the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Related to Log #001488-19:

A Critical Incident Report was submitted to the Director related to an incident of resident to resident abuse which occurred between residents #006 and #008. According to the CIR, RPN #123 had reported to the BSO nurse on a specified date that during the previous evening, resident #007's SDM had shared video footage they recorded. The video showed resident #006 exhibiting identified responsive behaviours towards resident #008.

Inspector #672 reviewed an identified internal policy, which listed who was required to report any witnessed or alleged incidents of resident abuse or neglect, who the incidents were to be reported to and provided instructions related to how and when to complete the report. The identified internal policy further indicated how residents were to be supported following any alleged incident of resident abuse or neglect, and what identified assessments were to be completed, along with the required documentation.

Inspector #672 reviewed resident #006's progress notes which indicated resident #006 had been observed by a family member to be exhibiting an identified responsive behaviour and RPN #123 had discussed the behaviour with resident #006. There was no documentation related to reporting the incident to the charge nurse, anyone from the management team in the home, the police or the Director.

Inspector #672 reviewed resident #008's progress notes and did not observe any

documentation to support that resident #008 had been assessed by RPN #123 following the documented incident with resident #006, or if the incident had been reported to the charge nurse, anyone from the management team in the home, the police or the Director.

During an interview, RPN #123 indicated that they did not report the incident until the following day, due to being busy during the shift with "competing priorities which were more important". RPN #123 further indicated they had not conducted a specified assessment or any other kind of assessment on resident #008 following the allegation being brought forward; had not implemented any interventions for residents #006 or #008; had not documented or communicated the status of the resident's health condition; and had not communicated any findings to the charge nurse, DOC or Administrator, again due to being too busy during their shift. RPN #123 indicated they had received education in the home on resident abuse and neglect within the previous year, which included the expectations for the staff to follow and the reporting guidelines.

During separate interviews, the DOC and Administrator each indicated that the expectation in the home was that all staff members who were aware of an allegation of resident abuse or neglect were to immediately report the allegation and the information the allegation was based upon to a member of the management team, or to the RN in charge, if the allegation occurred during any time that the management team was not in the home. The RN in charge was then expected to immediately notify the manager on call. The DOC further indicated that RPN #123 had been followed up with after the incident with resident #006, and reminded of the reporting guidelines and expectations. [s. 20. (1)]

2. Related to Log #002957-19:

A Critical Incident Report was submitted to the Director regarding an incident of resident to resident abuse between residents #011 and #012, which occurred on a specified date and time. According to the CIR, resident #011 was attempting to speak with resident #012, but resident #012 could not understand due to a specified reason. As a result, resident #011 exhibited an identified responsive behaviour, which led to the resident loosing their balance, and falling to the floor. The residents were separated and assessed by the nurse. Resident #011 sustained an identified injury as a result of the incident and resident #012 did not.

Inspector #672 reviewed the Ministry of Health and Long Term Care (MOHLTC) after

hours pager, and verified the home had contacted the MOHLTC on a specified date and time, which was more than 24 hours after the incident.

Inspector #672 reviewed an identified internal policy, which listed who was required to report any witnessed or alleged incidents of resident abuse or neglect, who the incidents were to be reported to and provided instructions related to how and when to complete the report. The identified internal policy further indicated how residents were to be supported following any alleged incident of resident abuse or neglect, and what identified assessments were to be completed, along with the required documentation.

During an interview, the DOC indicated they had not immediately informed the Director of the incident of resident to resident abuse between residents #011 and #012, due to not being informed of the incident until the following day. The DOC indicated that an agency nurse had worked the shift when the incident between residents #011 and #012 had occurred, and had informed the DOC of the incident by leaving a note under the DOC's office door, which was not found until the following day. The DOC further indicated that agency staff were expected to follow all internal policies and procedures, and had received orientation prior to working in the home, which included the abuse reporting guidelines and expectations.

During separate interviews, the DOC and Administrator each indicated that the expectation in the home was that all staff members who were aware of an allegation of resident abuse or neglect were to immediately report the allegation and the information the allegation was based upon to a member of the management team, or to the RN in charge, if the allegation occurred during a holiday, weekend or after hours. The RN in charge was then expected to immediately notify the manager on call.

The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with the following requirement of the LTCHA, 2017: it is a condition of every licensee that the licensee shall comply with every order made under this Act.

Related to Log #026155-18:

The licensee was served a Compliance Order (CO#001) pursuant to section s. 19 of the LTCHA, in relation to a Critical Incident System Inspection, with an identified compliance due date. The compliance order indicated the following:

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

The licensee shall prepare, submit and implement a plan to ensure that all residents are protected from abuse by both resident #002 and any other residents with responsive behaviours that put others at risk of harm.

The plan must include and not be limited to the following:

A description of the training and education that will occur related to the supervision and monitoring of residents with identified responsive behaviours, for all staff having contact with such residents including resident #002, the persons responsible for providing the education, and the dates this training will occur."

The licensee completed and submitted a plan to the CESAO by the required date. The licensee failed to complete the education related to the supervision and monitoring of residents with identified responsive behaviours, for all staff having contact with such residents.

A review of the home's compliance plan indicated staff were to be provided education on or by the specified compliance date, related to responsive behaviours and prevention of abuse and neglect, which was to be provided by an outside agency.

During separate interviews, the DOC and Administrator both indicated staff were not provided this education as it was cancelled and had to be re-booked. The Administrator indicated some of the education to be provided by the outside agency was planned to take place over several sessions scheduled over a specified three month time period. The DOC indicated the licensee was attempting to contact staff members who could not attend those sessions, and schedule alternate education sessions, with a goal of reaching 100% compliance by a specified date three months after the required compliance due date.

The licensee has failed to comply with the following requirement of the LTCHA, 2017: it is a condition of every licensee that the licensee shall comply with every order made under this Act, when the licensee failed to comply with Compliance Order (CO #001) issued in relation to a Critical Incident System Inspection, with an identified compliance due date. [s. 101. (3)]

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 the following requirement of the LTCHA, 2017: it is a condition of every licensee that the licensee shall comply with every order made under this Act, to be implemented voluntarily.

WN #5: 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 the person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred, immediately report the suspicion and the information upon which it was based to the Director.

Related to Log #002150-19:

A Critical Incident Report was submitted to the Director regarding an incident of resident to resident abuse which occurred between residents #006 and #007, on a specified date. According to the CIR, the SDM of resident #007 informed the DOC of an incident of resident to resident abuse involving residents #006 and #007, which had occurred approximately one month prior. The CIR indicated that on the specified date, the SDM had observed resident #006 exhibiting identified responsive behaviours towards resident #007. The SDM indicated they intervened to stop the identified responsive behaviour and did not report the incident to RPN #123, who was the nurse on duty at the time.

Inspector #672 observed that the Ministry of Health and Long Term Care after hours pager had been contacted by the DOC on a specified date and time, more than 24 hours after they were notified of the incident by resident #007's SDM.

During an interview, the DOC indicated they had not immediately informed the Director of the allegation due to being confused about whether the information should be added to a previous Critical Incident Report which had been submitted to the Director on an earlier specified date, related to an allegation of resident to resident abuse between residents #006 and #008, or if it should be reported as a separate incident. The DOC further indicated that they had not resolved that the allegations should be reported separately until more than 24 hours after the allegation was brought forward, which resulted in the late reporting. The DOC indicated they were aware that every allegation of resident abuse and/or neglect was to be immediately reported to the Director.

The licensee failed to ensure that the DOC, who had reasonable grounds to suspect that an incident of abuse of a resident had occurred, immediately report the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

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*

Issued on this 14th day of May, 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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JENNIFER BATTEN (672)
Inspection No. / No de l'inspection :	2019_578672_0001
Log No. / No de registre :	026155-18, 026160-18
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 13, 2019
Licensee / Titulaire de permis :	Unionville Home Society 4300 Highway #7, MARKHAM, ON, L3R-1L8
LTC Home / Foyer de SLD :	Union Villa 4300 Highway #7, Unionville, ON, L3R-1L8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Roxanne Adams

To Unionville Home Society, 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)

Linked to Existing Order / Lien vers ordre existant: 2018_685648_0011, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

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

The licensee is ordered to:

1) Educate all staff on the definitions of resident abuse under s. 2. (1) of O.Reg 79/10. The education must include a review of the licensee's specified internal policies.

2) Test the staff member's knowledge to ensure understanding of the different types of abuse, what to do if abuse is suspected/witnessed, when to assess a resident's capacity to consent and what to do if a resident is unable to provide informed consent related to identified behaviours.

3) Keep a documented record of the education and testing provided, along with the testing results and have them available upon Inspector request.

4) Create an auditing process and conduct audits one time monthly for a six month period, to ensure staff are not normalizing exhibited identified responsive behaviours and are assessing resident's capacity to consent, where required.

5) Keep a documented record of the audits conducted and have them available upon Inspector request.

6) Complete the education related to the supervision and monitoring of residents with identified responsive behaviours, for all staff having contact with such residents, as ordered in CO#001, in relation to a Critical Incident System Inspection.

7) Develop an outline of the corrective actions to be taken and by whom, if staff fail to implement the interventions as identified in the plan of care.

8) Keep a documented record of the outline of corrective actions, and have available upon Inspector request.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

Related to Log #026155-18:

The licensee was served a Compliance Order (CO#001) pursuant to section s. 19 of the LTCHA, in relation to a Critical Incident System Inspection, with an identified compliance due date. The compliance order indicated the following:

"The licensee must be compliant with s.19 (1) of the Act.
The licensee shall prepare, submit and implement a plan to ensure that all residents are protected from abuse by both resident #002 and any other residents with responsive behaviours that put others at risk of harm. The plan must include and not be limited, to the following:
A description of the training and education that will occur related to the supervision and monitoring of residents with identified responsive behaviours, for all staff having contact with such residents including resident #002, the persons responsible for providing the education, and the dates this training will occur."

The licensee completed and submitted a plan to the CESAO by the required date. The licensee failed to complete the education related to the supervision and monitoring of residents with identified responsive behaviours, for all staff having contact with such residents.

CO#001 was related to resident #002, who was no longer in the home at the time of the follow up inspection, therefore Inspector #672 reviewed incidents of resident to resident abuse which had occurred in the home following the compliance date.

Related to Logs #001488-19 and #002150-19:

A Critical Incident Report was submitted to the Director related to an incident of resident to resident abuse which occurred between residents #006 and #008. According to the CIR, RPN #123 had reported to the BSO nurse on a specified date that during the previous evening, resident #007's SDM had shared video footage they recorded. The video showed resident #006 exhibiting identified responsive behaviours towards resident #008.

A second CIR was submitted to the Director on a specified date. According to the CIR, the SDM of resident #007 informed the DOC of an incident of resident to resident abuse involving residents #006 and #007, which had occurred approximately one month prior. The CIR indicated that on the specified date, the SDM had observed resident #006 exhibiting identified responsive behaviours towards resident #007. The SDM indicated they intervened to stop the identified responsive behaviour and did not report the incident to RPN #123, who was the nurse on duty at the time.

Inspector #672 reviewed an identified internal policy which provided definitions and examples of resident abuse.

Inspector #672 reviewed another identified internal policy which indicated how and when staff were to assess residents possibly involved in incidents of resident to resident abuse, and what assessment tool to utilize to complete the assessment.

During an interview, the Administrator indicated the purpose of the identified assessment tool was to ensure that any resident observed exhibiting or being involved in identified responsive behaviours was cognitively aware of their actions and had the ability to provide informed consent. The Administrator further indicated the assessment was to be completed by staff each time a resident was observed to be exhibiting or participating in the identified responsive behaviours, and staff had been educated on how and when to complete the assessment tool.

Inspector #672 reviewed resident #006's health care records, written plan of care, and progress notes from a specified time period. According to a progress note written on a specified date, resident #006 had been exhibiting identified responsive behaviours towards identified individuals for a specified period of time. The progress notes indicated that between a specified time period, resident #006 was observed exhibiting identified responsive behaviours towards identified individuals on a specified number of occasions. The progress notes further indicated that following the compliance date, resident #006 had been involved in a specified number of incidents of exhibiting identified responsive behaviours towards identified individuals.

Inspector #672 reviewed resident #006's health care record, and did not observe any completed identified assessment tools during a specified time period.

Inspector reviewed resident #007's health care records and did not observe any completed identified assessment tools during a specified time period.

Inspector #672 then reviewed resident #008's health care records and did not observe any completed identified assessment tools during a specified time period.

During separate interviews, PSW #117, RPN #123, RPN #106, the Social Worker and the BSO nurse all indicated that residents #007 and #008 were unable to participate in the identified responsive behaviours for a specified reason. RPN #123 and the BSO nurse further indicated that they were not aware of how and when staff were to assess residents possibly involved in incidents of resident to resident abuse, and what assessment tool to utilize to complete the assessment.

During separate interviews with resident #006's regular staff members, PSW #117 and RPN #123 both indicated that resident #006 had a history of exhibiting the identified responsive behaviours, and staff had been directed to implemented a specified intervention for resident #006 to assist in managing the identified responsive behaviours. Both RPN #123 and PSW #117 further indicated that the intervention was not effective in preventing the resident from exhibiting the identified responsive behaviours for specified reasons. According to RPN #123, resident #006's identified responsive behaviours were "normalized" by staff, due to a lack of staff education and awareness. RPN #123 indicated that staff members normalizing resident #006's identified responsive behaviours led to staff not reporting incidents of exhibited identified responsive behaviours and not completing identified assessment tools related to the behaviours.

Inspector #672 reviewed resident #006's progress notes for a specified time period. During this time, the notes indicated resident #006 was observed exhibiting identified responsive behaviours towards identified individuals on a specified number of occasions. The progress notes did not indicate that any of the incidents had been reported.

During an interview, the DOC indicated that the first internal investigation conducted related to resident #006's identified responsive behaviours was on a specified date, after the incident between residents #006 and #008 had been reported. The DOC further indicated this was due to staff not reporting incidents of exhibited identified responsive behaviours from resident #006. The DOC indicated belief staff were not reporting the incidents as a result of the staff normalizing the resident's identified responsive behaviours, therefore registered staff had received education related to definitions and examples of resident abuse, how and when staff were to assess residents possibly involved in incidents of resident to resident abuse, and what assessment tool to utilize to complete the assessment.

During an interview, the Administrator indicated the expectation was that all residents were to be protected from abuse by anyone at all times. The Administrator further indicated that co-residents in the home had not been protected from resident #006's identified responsive behaviours due to staff normalizing the behaviours which led to staff not completing assessments or reporting the incidents.

A repeat Compliance Order was warranted related to the following:

1) The severity was considered to be a level 2 due to the potential for actual harm.

2) The scope was considered to be a level 2 due to resident #006 being involved in a specified number of incidents of exhibited identified responsive behaviours during a specified time period.

3) The licensee had a level 4 compliance history related to on-going non-compliance with section s. 19 (1) of the LTCHA which included:
A Voluntary Plan of Correction (VPC) issued on a specified date, during a Resident Quality Inspection;
A Compliance Order (#001) issued on a specified date, during a Critical Incident System Inspection, with an identified compliance due date.
Inspector #672 was unable to put the compliance order (CO#001) back into compliance at this time. (672)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 13, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 13th day of May, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Batten

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