Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

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


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

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

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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Mar 16, 2020 | 2020_643111_0007 | 001540-20, 002183-20 | Critical Incident System |

### 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

LYNDA BROWN (111)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): February 20, 21, 24, 25, March 2 and 3, 2020.**

**There were two critical incident reports (CIR) inspected concurrently as follows:**
**-Log #001540-20 (CIR) related to alleged improper care.**
**-Log #002183-20 (CIR) related to alleged resident to resident abuse.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RN), Personal Support Workers (PSW), Housekeeper (HSK), the Behaviour Support Ontario Nurse (BSO), the Scheduling Clerk and the Social Worker (SW),**

**During the course of the inspection, the inspector observed residents, reviewed health care records, reviewed the home's investigations, reviewed staffing schedules and reviewed the following policies: Responsive Behaviours and Prevention of Abuse and Neglect.**

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

**During the course of this inspection, Non-Compliances were issued.**
- **9 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 :**

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

the home.

A critical incident report (CIR) was submitted to the Director for a witnessed resident to resident abuse incident that occurred on a specified date and time, involving resident #005 towards resident #004.

In addition, there was a second CIR submitted to the Director on a specified date, for a resident to resident abuse incident that occurred on a specified date and time. The CIR indicated a PSW witnessed resident #005 being abusive towards resident #011 in a specified area.

Observation of the resident rooms indicated resident #004, #005 and #011 all resided in the same area and in close proximity. Observation of resident #004 indicated the resident was cognitively impaired and did not speak. Observation of resident #011 indicated the resident was cognitively impaired and was unable to communicate. Resident #005 was not in the home.

Review of the progress notes of resident #005 indicated that there were additional incidents involving resident #005 towards resident #004, #011, #012 and #013 during a specified period that were documented by either RPN #107 or #116 until resident #005 was transferred to hospital for assessment. After each of the CIR incidents, resident #005 was placed on one to one monitoring for a number of days. There was no documentation in resident #004, #011, #012 or #013’s progress notes regarding the incidents. In addition to these incidents, resident #005 was witnessed attempting to approach either resident #004, #011, #12 and #013 in a specified areas and staff intervened before any contact was made on a number of specified dates.

Observation of the video footage of the hallway where resident #004, #005 and #011 resided, confirmed the witnessed observations by the staff involving resident #005 towards resident's ( #004 and #011) in a specified area and stayed a specified period of time.

During separate interviews with the DOC, RN #108, RN #119, BSO RPN #117, RPN #107, RPN #118, PSW #109, PSW #113 and PSW #114 and HSK #105 by Inspector #111, all confirmed awareness that resident #005 demonstrated ongoing specified responsive behaviours towards resident #004 and #011. They indicated the incidents would occur in specified areas. They all confirmed that resident #004 and #011 were cognitively impaired and resident #005 was aware that their behaviour was inappropriate.

They all confirmed a specified intervention for resident #004 was ineffective in protecting the resident from resident #005. RPN #107 confirmed they did not complete an assessment or document the incidents on the recipient residents progress notes, or indicated that they notified anyone regarding the incidents that occurred on specified dates, involving resident #004 and #011. RPN #116 confirmed they did not complete an assessment, did not document the incidents on the recipient residents progress notes or indicated who they notified regarding the incidents that occurred on specified dates involving resident #004. The DOC also confirmed the SDMs, the police and the Director were not made aware of the incidents of suspected abuse involving resident #004 and #011 on those same dates and there were no documented head to toe assessments completed for resident #004 and #011, following the incidents.

The licensee failed to protect resident #004, #011, #012 and #013 from abuse. The victims were cognitively impaired. The aggressor was assessed to be aware of their actions and continued to abuse residents over an extended period of time. Staff were aware of the ongoing abuse from resident #005 to the victims and the interventions implemented were ineffective in preventing the abuse. There were no assessments conducted on the victims after the suspected abuse occurred, the licensee did not notify the Substitute Decision Makers (SDM) of the victims when the incidents occurred, there was no investigations completed and the Director and police were not informed of the suspected abuse. In addition, the final outcome of the incident that was reported to the Director was not provided to the Director within 21 days.

***Additional Required Actions:***

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

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**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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**Findings/Faits saillants :**

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

A critical incident report (CIR) was submitted to the Director for a witnessed resident to resident abuse incident that occurred on a specified date and time, involving resident #005 towards resident #004.

Observation of resident #004 indicated the resident was cognitively impaired and did not speak. Observation of resident #011 indicated the resident was cognitively impaired and did not speak English. Resident #005 was not in the home.

Review of the progress notes of resident #004, #005 and #011 indicated during a specified period, there were ongoing incidents when resident #005 was involved in suspected abuse towards resident #004 and/or #011, in a specified area. There was also an incident of suspected abuse by resident #005 towards resident #013, in a specified area. There were also ongoing incidents when resident #005 attempted to engage in specified responsive behaviours towards the same residents in another specified area.

Review of the current written plan of care for resident #005 indicated the resident demonstrated specified responsive behaviours due to specified triggers. There were a number of specified interventions that did not provide clear direction as to how or when the interventions were to used.There was also no clear direction related to the frequency of monitoring of resident #005 in specified areas.

Review of the current written plan of care for resident #004 indicated under safety, the resident was not to be within a number of feet from resident #005 in a specified area and a number of other interventions. There was no clear direction on how the staff would

prevent resident #005 from approaching resident #004 in a different specified area.

Review of the current written plan of care for resident #011, there was no documented evidence of the resident being at risk of specified responsive behaviours by resident #005, or interventions to manage the risk.

During separate interviews with the DOC, RN #108, RN #119, BSO RPN #117, RPN #107, RPN #118, PSW #109, #113 and #114 and HSK #105 by Inspector #111, all confirmed awareness that resident #005 demonstrated ongoing specified responsive behaviours towards both resident #004 and #011. They indicated the incidents would occur in specified areas. They all confirmed that resident #004 and #011 were cognitively impaired and the use of one specified intervention with resident #004 was not effective. They all confirmed that resident #005 was aware of their responsive behaviours were inappropriate.

The licensee failed to ensure the plan of care for resident #004, #005 and #011 provided clear directions to staff and others who provide direct care to the residents, as the plan of care was not clear for resident #005 as to how and when specified interventions were to be implemented and the frequency of monitoring resident #005 and when this was to occur. There were also interventions for resident #004 that were identified as ineffective in protecting the resident from resident #005 and there was no clear direction when the resident was in a specified area. There were also no clear directions on how to protect resident #011 from resident #005.

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**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 :**

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

A critical incident report (CIR) was submitted to the Director for a witnessed resident to resident abuse incident that occurred on a specified date and time, involving resident #005 towards resident #004.

Review of the licensee's policy "Zero Tolerance of Abuse and Neglect" indicated to document or write a brief actual note (not allegations or opinion) writing the details of the suspected, alleged or witnessed incident of abuse as soon as possible and conduct a head to toe physical assessment on the alleged victim and document findings.

Review of the progress notes during a specified period for resident #005, indicated that in addition to the above CIR, there were additional suspected incidents of resident to resident abuse by resident #005 towards resident #004 and/or #011 on specified dates. Review of the progress notes on the same dates for resident #004 and #011 had no documented evidence of the incidents or a head to toe assessment being completed.

During separate interviews with RPN #107 and #116 by Inspector #111, they confirmed they documented the incidents involving resident #005 towards resident #004 and/or #011 on specified dates and confirmed they did not document the incidents on resident #004 or #011's health record or completed a head to toe assessment and should have.

The licensee had failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with as RPN #116 and #107 did not complete an actual note (not allegations or opinions) writing the details of the suspected, alleged or witnessed incident of abuse as soon as possible for resident #004 and #011, or completed a head to toe physical assessment on the alleged victim and document the findings.

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints**

**Specifically failed to comply with the following:**

**s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).**

**Findings/Faits saillants :**

The licensee has failed to ensure that any written complaints that have been received concerning the care of a resident or the operation of the home is immediately forwarded to the Director.

A CIR was received by the Director on a specified date, for a written complaint that was received by the Social Worker(SW), from the family of resident #001. The CIR indicated the written complaint was received on a specified date and alleged improper care. An after hours call was received by the Director on a number of days later, regarding the written complaint.

During an interview with the Social Worker (SW) by Inspector #111, they confirmed they received the written complaint from the family of resident #001 on a specified date and was regarding alleged improper care. The SW indicated they forwarded the complaint to the DOC the same day. The SW confirmed they did not forward the written complaint to the Director.

During an interview with the DOC by Inspector #111, they confirmed the SW initially received the written complaint from the family of resident #001 on a specified date and they forwarded the written complaint to the DOC the same day. The DOC confirmed an after hours call regarding the written complaint alleging improper care was submitted to the Director a number of days later.

The licensee had failed to ensure that a written complaint from the family of resident #001, alleging improper care was immediately forwarded to the Director, as the written complaint was not provided to the Director until a number of days after the written complaint was received.

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated: (i) Abuse of a resident by anyone.

A critical incident report (CIR) was submitted to the Director for a witnessed resident to resident abuse incident that occurred on a specified date and time, involving resident #005 towards resident #004.

Review of the progress notes during a specified period for resident #005, indicated that in addition to the above identified incident, there were a number of additional suspected incidents of resident to resident abuse towards resident #004, #011 or #013 that were not investigated. The incidents were documented by either RPN #107 and RPN #116.

During separate interviews with RPN #107 and #116 by Inspector #111, they indicated awareness of a number of incidents of suspected abuse involving resident #005 towards resident #004 and #011. The RPN's indicated any dates when this occurred, they would have reported the incidents to the BSO RPN (#120) and the RN for follow up. The RPN's could not recall which RN they would have reported the incidents to and confirmed they did not always document this.

BSO RPN #120 was unavailable for interview.

During an interview with the DOC by Inspector #111, they indicated no awareness of suspected or witnessed resident to resident abuse incidents involving resident #005 towards other residents (resident #004 and #013) on specified dates and did not become aware of other incidents until they began the investigation related to the incident for the CIR. The DOC indicated their expectation was that any alleged, suspected or witnessed incidents of resident to resident abuse should have been immediately reported to the RN and DOC, to be immediately investigated.

The licensee failed to immediately investigate suspected abuse by resident #004 towards resident #004 or resident #013.

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**WN #6: 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 has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

A critical incident report (CIR) was submitted to the Director for a witnessed resident to resident abuse incident that occurred on a specified date and time, involving resident #005 towards resident #004.

Review of the progress notes during a specified period for resident #005, indicated that in addition to the above identified incident, there were a number of additional suspected incidents of resident to resident abuse towards resident #004, #011 and/or #013 that were not reported to the Director. The incidents were documented by either RPN #107 and RPN #116.

During an interview with RPN #116 by Inspector #111, they confirmed that they had documented incidents on specified dates, involving resident #005 towards resident #004 and/or #013. The RPN indicated they would have notified the RN, who would notify the Director and confirmed they did not document that the RN was notified. The RPN could not recall which RN they would have reported the incidents to and confirmed they did not

always document this.

During an interview with RPN #107 by Inspector #111, they confirmed that they had documented incidents on specified dates, involving resident #005 towards resident #004. The RPN indicated they would have notified the RN, who would notify the Director and confirmed they did not document that the RN was notified. The RPN could not recall which RN they would have reported the incidents to and confirmed they did not always document this.

During an interview with the DOC by Inspector #111, they indicated no awareness of suspected resident to resident abuse incidents involving resident #005 towards other residents (resident #004 and #013) on specified dates and did not become aware of these incidents until they began the investigation for CIR incident, a number of months later. The DOC indicated their expectation is that any alleged, suspected or witnessed incidents of resident to resident abuse should have been immediately reported to the RN and DOC, to be immediately reported to the Ministry of Long Term Care (MLTC).

The licensee failed to immediately report to the Director suspected abuse by resident #005 towards resident #004 and #013 on a number of dates.

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

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

A critical incident report (CIR) was submitted to the Director for a witnessed resident to resident abuse incident that occurred on a specified date and time, involving resident #005 towards resident #004.

Review of the progress notes during a specified period for resident #005, indicated that in addition to the above identified incident, there were a number of additional suspected incidents of resident to resident abuse towards resident #004, #011 and/or #013. The incidents were documented by either RPN #107 or #116 and had no documented evidence the SDM’s of either resident #004, #005, #011 or #013 were notified.

During an interview with RPN #116 by Inspector #111, they confirmed that they had documented incidents on specified dates, involving resident #005 towards resident #004 and/or #013. The RPN could not recall whether the SDMs were notified and confirmed they did not document that any of the SDMs were notified.

During an interview with RPN #107 by Inspector #111, they confirmed they had documented incidents on specified dates, involving resident #005 towards either resident #004 or #011. The RPN could not recall whether the SDMs were notified and confirmed they did not document that any of the SDMs were notified.

During an interview with the DOC by Inspector #111, they indicated their expectation was that any nurse who became aware of alleged, suspected or witnessed incidents of resident to resident abuse, they were to notify the SDM.  The DOC indicated no awareness that on specified dates, the SDMs of either resident's involved had not been notified within 12 hours of the incidents and should have been.

The licensee failed to notify the SDMs of resident #004, #005, #011 and #013 within 12 hours of becoming aware of suspected resident to resident abuse.

**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.**

**Findings/Faits saillants :**

The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

A critical incident report (CIR) was submitted to the Director for a witnessed resident to resident abuse incident that occurred on a specified date and time, involving resident #005 towards resident #004.

Review of the progress notes for a specified period for resident #005, indicated that in addition to the above identified incident, there were additional suspected incidents of resident to resident abuse documented by RPN #107 and #116, that had no documented evidence the police were notified on a number of specified dates.

During separate interviews with RPN #107 and #116 by Inspector #111, they confirmed they had documented incidents on the specified dates and did not inform the police.

During an interview with the DOC by Inspector #111, they indicated their expectation was that anyone who becomes aware of alleged, suspected or witnessed incidents of resident to resident abuse, are to notify the RN and the DOC, who will notify the police. The DOC confirmed the police were not notified of the incidents on the specified dates and should have been.

The licensee failed to notify the police of suspected incidents of resident to resident abuse by resident #005 towards resident #004 and #011.

**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act**

**Specifically failed to comply with the following:**

**s. 104. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).**

**Findings/Faits saillants :**

The licensee has failed to ensure that a final report was provided to the Director within 21 days.

A critical incident report (CIR) was submitted to the Director for a resident to resident abuse incident involving resident #005 towards resident #004. The CIR indicated the witnessed incident occurred on a specified date and time. A final report had not been provided to the Director.

During an interview with the DOC by Inspector #111, they confirmed the final report had not been provided to the Director within 21 days of the incident.

The licensee failed to ensure the final report was provided to the Director for a witnessed resident to resident abuse incident involving resident #005 towards resident #004 that occurred on a specified date and the final report had not been provided to the Director, approximately 30 days later.

**Issued on this 24th day of March, 2020**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## 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

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

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

## Public Copy/Copie du rapport public

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|---|---|
| **Name of Inspector (ID #) / Nom de l’inspecteur (No) :** | LYNDA BROWN (111) |
| **Inspection No. / No de l’inspection :** | 2020_643111_0007 |
| **Log No. / No de registre :** | 001540-20, 002183-20 |
| **Type of Inspection / Genre d’inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Mar 16, 2020 |
| **Licensee / Titulaire de permis :** | Unionville Home Society<br>4300 Highway #7, MARKHAM, ON, L3R-1L8 |
| **LTC Home / Foyer de SLD :** | Union Villa<br>4300 Highway #7, Unionville, ON, L3R-1L8 |
| **Name of Administrator / Nom de l’administratrice ou de l’administrateur :** | Julie Horne |

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 Long-Term Care**

**Ministère des Soins de longue durée**

## 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

## 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

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**Order # / No d'ordre :** 001

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

**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 shall comply with LTCHA, 2007, s.19(1).

Specifically the licensee shall develop, implement and submit a corrective action plan to address the following:
1. Ensure resident #004, #011, #102 and #013 are protected from abuse by resident #005.
2. The plan must include education to direct care staff on their roles and responsibilities for identifying and responding to potential and actual abuse, conducting assessments on victims and notifying the SDM.
3.Develop a monitoring process to ensure any alleged, suspected or witnessed incidents of resident to resident abuse is documented as per the home Prevention of Abuse policy, and reporting requirements are completed.

Please submit the written plan, quoting the inspection number and inspectors name by email to CentralEastSAO.MOH@ontario.ca by March 27, 2020.

Please ensure that the submitted written plan does not contain any PI/PHI.

**Grounds / Motifs :**

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

A critical incident report (CIR) was submitted to the Director for a witnessed resident to resident abuse incident that occurred on a specified date and time, involving resident #005 towards resident #004.

In addition, there was a second CIR submitted to the Director on a specified

date, for a resident to resident abuse incident that occurred on a specified date and time. The CIR indicated a PSW witnessed resident #005 being abusive towards resident #011 in a specified area.

Observation of the resident rooms indicated resident #004, #005 and #011 all resided in the same area and in close proximity. Observation of resident #004 indicated the resident was cognitively impaired and did not speak. Observation of resident #011 indicated the resident was cognitively impaired and was unable to communicate. Resident #005 was not in the home.

Review of the progress notes of resident #005 indicated that there were additional incidents involving resident #005 towards resident #004, #011, #012 and #013 during a specified period that were documented by either RPN #107 or #116 until resident #005 was transferred to hospital for assessment. After each of the CIR incidents, resident #005 was placed on one to one monitoring for a number of days. There was no documentation in resident #004, #011, #012 or #013's progress notes regarding the incidents. In addition to these incidents, resident #005 was witnessed attempting to approach either resident #004, #011, #12 and #013 in a specified areas and staff intervened before any contact was made on a number of specified dates.

Observation of the video footage of the hallway where resident #004, #005 and #011 resided, confirmed the witnessed observations by the staff involving resident #005 towards resident's ( #004 and #011) in a specified area and stayed a specified period of time.

During separate interviews with the DOC, RN #108, RN #119, BSO RPN #117, RPN #107, RPN #118, PSW #109, PSW #113 and PSW #114 and HSK #105 by Inspector #111, all confirmed awareness that resident #005 demonstrated ongoing specified responsive behaviours towards resident #004 and #011. They indicated the incidents would occur in specified areas. They all confirmed that resident #004 and #011 were cognitively impaired and resident #005 was aware that their behaviour was inappropriate. They all confirmed a specified intervention for resident #004 was ineffective in protecting the resident from resident #005. RPN #107 confirmed they did not complete an assessment or document the incidents on the recipient residents progress notes, or indicated that they notified anyone regarding the incidents that occurred on specified

dates, involving resident #004 and #011. RPN #116 confirmed they did not complete an assessment, did not document the incidents on the recipient residents progress notes or indicated who they notified regarding the incidents that occurred on specified dates involving resident #004. The DOC also confirmed the SDMs, the police and the Director were not made aware of the incidents of suspected abuse involving resident #004 and #011 on those same dates and there were no documented head to toe assessments completed for resident #004 and #011, following the incidents.

The licensee failed to protect resident #004, #011, #012 and #013 from abuse. The victims were cognitively impaired. The aggressor was assessed to be aware of their actions and continued to abuse residents over an extended period of time. Staff were aware of the ongoing abuse from resident #005 to the victims and the interventions implemented were ineffective in preventing the abuse. There were no assessments conducted on the victims after the suspected abuse occurred, the licensee did not notify the Substitute Decision Makers (SDM) of the victims when the incidents occurred, there was no investigations completed and the Director and police were not informed of the suspected abuse. In addition, the final outcome of the incident that was reported to the Director was not provided to the Director within 21 days.

The scope was a level 2, a pattern as there were two critical incidents involving resident #004 and #011. The severity was actual harm or risk of harm to resident #004, #011, #012 and #013. The compliance history was a level 3, as the home was previously issued s.19(1) on September 24, 2018 with a compliance date of December 31, 2018 during inspection #2018_685648_0011. (111)

**This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le :** Jul 31, 2020

## 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 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 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 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 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 16th day of March, 2020**

**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