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 sous la Loi de 2007 sur les foyers de soins de longue durée

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 10, 2018	2018_525596_0002	002900-18	Resident Quality Inspection

Licensee/Titulaire de permis

Friuli Long Term Care
7065 Islington Avenue Woodbridge ON L4L 1V9

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

Villa Leonardo Gambin
40 Friuli Court Woodbridge ON L4L 9T3

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

THERESA BERDOE-YOUNG (596), JANET GROUX (606), MATTHEW CHIU (565)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 6, 7, 8, 9, 12, 13, 14, 15, 16, 20, 21, 23, 26, 27, 28 and March 1, 2 and 5, 2018.

The following complaint logs were inspected concurrently with the Resident Quality Inspection (RQI): log #012394-17 related to resident care concerns, log #012440-17 related to resident to resident physical abuse, log #016735-17 related to resident care concerns, log #022220-17 related to allegation of resident to resident physical abuse, log #001739-18 related to resident to resident physical abuse.
The following critical incident (CI) reports were inspected concurrently with the RQI: log #012111-17 for CI 2947-000013-17 related to resident to resident physical abuse, log #017803-17 for CI 2947-000017-17 related to significant change in resident's health status, log #-024049-17 for CI 2947-000021--17 related to resident to resident sexual abuse, log #027226-17 for CI 2947-000026-17 and 2947-000027-17 related to resident to resident sexual abuse and log #001245-18 for CI 2947-000004-18 related to resident to resident physical abuse.
A follow up inspection log #011562-17 was completed concurrently with this RQI.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Physician, Nurse Manager/falls lead (NM), Director of Resident and Family Services (DRFS), Recreation and Volunteer Manager (RVM), Office Manager (OM), Resident Assessment Instrument (RAI) Coordinator, Physiotherapist (PT), registered nurse (RN), registered practical nurse (RPN), personal support worker (PSW), Residents' Council members, Family Council Co-chair, residents and family members.

During the course of this inspection, the inspectors toured the home, observed resident care, observed staff to resident interaction, reviewed resident health records, meeting minutes, schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

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

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

- **7 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Legendé 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.

A critical incident system (CIS) report submitted to the ministry of health and long term care (MOHLTC) indicated that on a specified date resident #004 was pushed by resident #010; as a result, resident #004 sustained injuries to identified body parts.

For the purposes of the definition of physical abuse in subsection 2 (1) of the O. Reg 79/10 physical abuse means the use of physical force by a resident that causes physical injury to another resident.

Residents #004 and #010's plan of care revealed both residents had cognitive impairment and were capable of ambulating independently at the time of the above mentioned incident. A review of an incident note indicated that on the above mentioned specified date registered practical nurse (RPN) #137 witnessed residents #010 push resident #004 while they were walking down the hallway. RPN #137 assessed resident #004, informed the registered nurse (RN) and the physician in charge. Resident #004 was ordered to be transferred to hospital and was later diagnosed with a particular injury.

Review of the home's video camera surveillance system confirmed that the above mentioned altercation between resident #004 and #010 had occurred.

Interview with RPN #137 indicated that they also witnessed the above mentioned altercation and attended to resident #004 who had sustained injuries and was complaining of pain. Resident #004 was transferred to hospital and diagnosed with a particular injury as a result of being pushed by resident #010. RPN #137 indicated they considered it to be physical abuse towards resident #004.

Interview with the Assistant Director of Care (ADOC) indicated that the above mentioned incident had occurred and the home had failed to protect resident #004 from physical abuse by resident #010. [s. 19. (1)]

2. The home submitted a CIS report to the MOHLTC related to resident to resident physical abuse that occurred on a specified date. The CIS report indicated resident #017 exhibited responsive behaviours towards resident #016. The home's video camera surveillance system captured resident #017 hitting resident #016 causing them to sustain injuries to identified body parts.

The MOHLTC infoline received a complaint about the same incident as mentioned above.

Record review of resident #017's progress notes revealed they had a history of responsive behaviours towards other residents and staff prior to and after the date of the CI mentioned above, as follows:

On a specified date resident #017 was exhibiting responsive behaviours, slapped resident #022 and bit RN #133.

Record review of resident #022's progress notes indicated the same as mentioned above.

The following day resident #017 wandered into another resident's room and punched resident #023 without provocation; no pain or injury noted and it was witnessed by a PSW staff.

Record review of resident #023's progress notes indicated the same as mentioned above.

Five days later, approximately half an hour before the physical altercation with resident #016, indicated in the CIS report, resident #017 scratched a PSW staff on an identified body part.

Twelve days later resident #017 hit the one to one staff, punched resident #021, and later pushed resident #020 to the floor; resident #017 then took up an identified sharp object in the dining room threatening any staff trying to stop them. A staff was successful at taking the sharp object away from the resident.

Record review of resident #017's medication administration record (MAR) revealed changes made to the resident's medication regimen.
Record review of one to one staffing schedule revealed that the home initiated one to one staff monitoring for resident #017 seven days after the third of three incidents of responsive behaviours occurred in one month.
A referral to the Ontario Shores Centre for Mental Health Sciences was not completed until after the three above incidents occurred earlier in the month.

Interview with RN #133 reported they worked on a specified date in June 2017, when resident #017 and #022 wandered into another residents room. A PSW staff was also in the room with the residents. Resident #017 bit the RN and slapped resident #022. RN

#133 eventually redirected resident #017 out of the room without further incident. RN #133 stated that resident #022 was not protected from abuse by resident #017.

Interview with RAI Coordinator #128 revealed that they reviewed the home's video camera surveillance system four days after the third incident mentioned above and saw resident #017 striking resident #016 multiple times to identified body parts. Resident #016 sustained multiple injuries as a result of the above mentioned physical altercation, and did not strike back at resident #017; there was no one else in the near the residents at the time. RAI Coordinator #128 acknowledged that resident #017 was physically abusive to resident #016.

Interview with RN #134 reported that resident #017 exhibited responsive behaviours and wandered around the unit independently using a walker. The RN stated that they worked on the specified date of the last incident in June 2017, mentioned above, and saw resident #017 walking in the hallway using a walker. Resident #021 was also walking with their family member. RN #134 heard resident #021's family member speak loudly asking resident #017 what they were doing. The family member then reported that resident #017 walked by them and struck resident #021 for no reason. Upon assessment resident #021 did not sustain any visible injuries and voiced no complaints. Later that same evening RN #134 was called to the dining room where she observed resident #020 on the floor. Staff reported that resident #017 had pushed resident #020 to the floor unprovoked, and other residents who saw what happened were all upset and yelling. RN #134 stated that they then observed resident #017 pick up a sharp object and left the room appearing to be very agitated and upset. One of the staff was able to take the object away from the resident without incident. RN #134 stated that resident #020 and #021 were physically abused by resident #017.

Interview with the ADOC indicated that resident #017's responsive behaviours towards resident #016 were abusive.

The Administrator stated that the home could have done more to protect resident #016 from abuse from resident #017 since resident #017 had exhibited a pattern of physically aggressive behaviours and altercations with co-residents prior to the date of the incident that involved resident #016 on a specified date in June 2017. The licensee has failed to protect resident #017 from abuse despite a known pattern of physically aggressive behaviour. [s. 19. (1)]

3. A CIS report submitted to the MOHLTC by the home indicated that on a specified date

residents #012 and #013 were in the activity room with a group of residents watching television. PSW #156 was assigned to resident #013 for one to one care at that time. At a specified time PSW #156 left resident #013 in the activity room with resident #012 and other co-residents unsupervised. Seven minutes later RPN #150 observed from the nursing station's video camera monitor that resident #013 was kissing resident #012. The staff responded and intervened. The CIS report stated resident #012 had a cognitive performance scale (CPS) score of four and resident #013 had a CPS score of one.

For the purposes of the definition of sexual abuse in subsection 2 (1) of the O. Reg 79/10 sexual abuse means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Review of the resident assessment instrument- minimum data set (RAI-MDS) assessments and plan of care for residents #012 and #013 revealed both residents had various degrees of cognitive and physical impairment at the time of the incident. Resident #012 was using a wheelchair as the primary mode of locomotion, whereas resident #013 was capable of walking on the unit using a walker.

Further review of resident #013's progress notes, one to one care records and plan of care revealed the resident had a history of demonstrating inappropriate identified behaviours towards residents or staff. The behaviours included kissing and touching other residents. Interventions were put in place for managing the resident's behaviours, which included the one to one care for monitoring the resident during the time of the above mentioned incident.

Interviews with PSWs #147, #156, and RPN #150 indicated resident #012 was cognitively impaired and incapable to express preferences most of the times. The PSWs stated resident #012 might resist care, such as food during meal services, if they did not like eating. The staff members stated resident #012 was incapable of consenting to identified touching or behaviour.

PSW #147 and RPN #150 stated they were at the nursing station doing paper work when the above incident happened. The staff members witnessed, from the nursing station's surveillance video camera monitor, resident #013 was standing next to resident #012, leaning over and kissing resident #012. Resident #012 was sitting in a wheelchair and pushed resident #013 away.

PSW #156 stated that on a specified date they were providing one to one care to resident #013. Near the end of the shift, PSW #156 left resident #013 with a few other residents in the activity room without staff supervision in the area. As soon as PSW #156 went back to the activity room, they saw resident #013 leaning towards resident #012, kissing and touching resident #012's face. PSW #147 further stated resident #012 was still pushing resident #013 away when they arrived at the activity room and the residents were separated immediately. The staff members indicated resident #012 did not sustain any injuries and was not in distress.

Interview with the DOC acknowledged the above mentioned incident happened. When considering resident #013's history of demonstrating identified behaviours towards residents, the behaviour towards resident #012 should be considered sexual in nature. Since resident #012 was cognitively impaired and putting up their hands indicating no to resident #013, the behaviour and touch were non-consensual. The DOC acknowledged the home failed to protect resident #012 from sexual abuse by resident #013. [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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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

The home submitted a CIS report to the MOHLTC indicating that on a specified date residents #012 and #013 were in an activity room with a group of residents watching television. PSW #156 was assigned to resident #013 for one to one care during that time. PSW #156 left resident #013 in the activity room with resident #012 and other co-residents unsupervised. Seven minutes later RPN #150 observed from the nursing station's video camera monitor that resident #013 was kissing resident #012 and the staff responded and intervened. The CI report stated resident #012 had a CPS score of four and resident #013 had a CPS score of one.

Review of resident #013's RAI-MDS assessments, progress notes and plan of care revealed the resident had a history of demonstrating inappropriate sexual behaviours. The behaviours included kissing and touching other residents in sexual nature. The plan of care indicated one to one care was initiated for resident #013 and the one to one care records indicated the care was given to the resident for an identified time period in 2017, daily between a thirteen hour time frame.

Interview with PSW #156 stated on the day shift of the above mentioned date they were providing one to one care to resident #013. Near the end of the shift, PSW #156 left resident #013 with a few other residents in the activity room and went to use the washroom near the nursing station. PSW #156 indicated they notified RPN #150 who was in the nursing station. While resident #013 was unsupervised by one to one staff in the activity room, they went over to resident #012 kissed and touched them. PSW #156 further indicated they should stay with resident #013 at all times and should not have left the resident unsupervised.

RPN #150 stated they did not recall PSW #156 notifying them that resident #013 was unsupervised in the activity room. RPN #150 and PSW #147 stated when resident #013 kissed and touched resident #012 in the activity room, there was no staff member providing one to one care to resident #013.

Interviews with RPN #150, #140 and the DOC indicated when a PSW is assigned to one to one care for a resident, the PSW should stay with the resident at all times. If the PSW has to leave the resident, they should communicate to the charge nurse before leaving the resident.

The DOC acknowledged that during the above mentioned incident between residents #012 and #013, one to one PSW #156 had left resident #013 unattended in the activity room, and therefore the one to one care set out in the plan of care for resident #013 was not provided to the resident. [s. 6. (7)]

2. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

A CIS report submitted to the MOHLTC indicated that on a specified date resident #010 was wandering in the hallway and pushed resident #004 when they were walking in the area. As a result, resident #004 fell and sustained two identified injuries.The CIS report indicated the immediate actions taken to prevent recurrence included one to one supplemental staff provided the next day, the resident was being monitored frequently and the dementia observation system (DOS) was initiated.

Resident #010's plan of care revealed the resident was cognitively impaired and exhibited responsive behaviours towards residents, staff and families. The plan of care, progress notes and one to one staffing records indicated the day following the incident mentioned above, one to one staff monitoring for the resident started. Further review of

the progress notes on two specified dates in 2018, revealed the resident continued on DOS monitoring, and staff should complete the DOS tracking sheet.

Interview with RN #136 indicated the DOS monitoring was started together with the one to one staff monitoring for the resident. The one to one PSWs assigned to the resident were responsible for completing the DOS tracking sheets during their shifts. For the shifts that the one to one PSWs were not scheduled, the primary PSWs assigned to the resident should document on the DOS tracking sheets so that the resident's behaviours could be evaluated.

The inspector reviewed the DOS tracking sheets together with RN #136 and confirmed there was no DOS tracking record until a specified date in 2018, and multiple half-hour time slots on each day during a 32 day period from were not completed.

Interview with the ADOC indicated the one to one PSW and the DOS tracking were the care initiated together for monitoring resident #010, and the home indicated this on the CIS report. The ADOC confirmed either the one to one PSWs or the primary PSWs for the resident should have completed the DOS tracking records for monitoring the resident's behaviours and they were not documented as required. [s. 6. (9) 1.]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

The home submitted a CIS report to the MOHLTC related to resident to resident physical abuse that occurred on a specified date. The CIS report indicated that resident #017 exhibited responsive behaviours towards resident #016. The home's video camera surveillance system captured resident #017 striking resident #016 on the body; and they sustained multiple injuries.

The MOHLTC infoline received a complaint about the same incident as mentioned above.

Record review of one to one care staffing schedule revealed that the home initiated one to one staff monitoring for resident #017 seven days after the third of three incidents of responsive behaviours towards three co residents occurred in one month.

Interview with RN #133 reported that they worked on the first specified date in the above

mentioned specified month, when resident #017 and #022 wandered into another residents room. A PSW staff was also in the room with the residents. Resident #017 bit the RN on the shoulder and slapped resident #022. RN #133 eventually redirected resident #017 out of the room without further incident.

Record review of resident #017's progress notes revealed they had a history of responsive behaviours of being physically and verbally aggressive towards other residents and staff prior to and after the date of the CIS report as follows:

On the first specified date resident #017 was agitated, verbally and physically aggressive. The resident slapped resident #022 and bit RN #133.

Record review of resident #022's progress notes indicated the same as mentioned above.

On the second specified date resident #017 wandered into another resident's room and punched resident #023 without provocation; no pain or injury and it was witnessed by a PSW staff.

Record review of resident #023's progress notes indicated the same as mentioned above.

On the third specified date approximately half an hour before the physical altercation with resident #016, indicated in the CIS report, resident #017 scratched a PSW staff on the cheek.

On a subsequent date resident #017 hit the one to one staff, PSW #146, punched resident #021 in front of the activity room, then later at pushed resident #020 to the floor, took up a sharp object threatening any staff trying to stop them. A staff was successful with taking the sharp object away from the resident.

Record review of resident #017's written plan of care related to responsive behaviours revealed it was updated late in the month, despite episodes of responsive behaviours towards resident #022, #023 and #016 on three specified dates earlier in the month.The interventions included: documenting summary of each episode, note cause and successful interventions, resident has one to one staff on days and evenings, document care being resisted in progress notes, document resident's whereabouts hourly on DOS sheet, encourage resident to wander on unit in the therapy and activity room.

During interview with RAI Coordinator #128 and the ADOC they stated that the home should have reviewed and revised the resident's plan of care and updated the care plan sooner, after resident had two episodes of responsive behaviours towards two co-residents earlier that month. [s. 6. (10) (b)]

4. The home submitted a CIS report to the MOHLTC reporting that on a specified date resident #035 had a fall resulting in transfer to the hospital with a diagnosis of a particular injury.

Review of resident #035's progress notes during the period of five and a half months, indicated resident #035 had a total of nine falls. The progress notes indicated that the resident had a total of six falls in one month. On a specified date the resident was observed with symptoms of infection and placed on isolation with infection control surveillance. The resident was assessed by the physician, diagnosed with a particular infection and treated with antibiotics. Review of the progress notes indicated the following:
-On a specified date the resident was found on the floor in their room. Then later that day the resident was found in their room on the floor of the washroom alert and confused, and was assessed with no injuries.
-The next day the resident was found on the floor beside their bed, conscious but confused, and assessed with no injuries.
-Nine days after the previous specified date the resident fell in the hallway outside their room as they were walking, was assessed and sustained a small injury. Later that same day the resident was found on the floor in their room, assessed and observed with two old injuries. The resident was transferred to hospital and returned.
-On the last specified date the resident fell while walking in the hallway and was assessed with an injury.

Further review of the progress notes between the above mentioned specified dates indicated staff were to continue to remind the resident to transfer and change positions slowly, to have the bed at the lowest position when they are in bed, to encourage participation in activities which encourage physical activity, to remind the resident to use call bell for assistance. In addition to the above mentioned interventions, staff were to ensure that resident #035 had proper footwear on, have the side rails up, have a falls mat on the floor beside their bed, to have a bed and wheelchair alarm, to monitor the resident and remind them to use their walker.
On a specified date prior to the date of the CIS report the resident was found in the

hallway on the floor. Upon assessment the resident was bleeding from two injuries and was transferred to hospital for further assessment, and returned with a particular treatment.

Review of the progress notes on a specified date a month later indicated resident #035 was found outside of their bedroom laying on the floor and was assessed with no injuries or verbalization of pain. The progress notes indicated that approximately three hours later resident #035 complained of severe pain and was transferred to hospital.
Review of resident #035's written plan of care revised in May 2017, did not indicate that the care plan was updated to reflect all the interventions as mentioned above until the resident had the fall and sustained and injury two months later.

Interview with PSW #107 indicated resident #035 was ambulatory and walked in their room and in the hallways. They indicated that the staff ensured that the resident was monitored and reminded to call for assistance, wore proper shoes, and reminded them to use their walker as they were forgetful.

Interview with RPN #108 indicated that the resident had six falls in one month, and that additional interventions were initiated to manage the risk of falling but their care plan was not updated to include the new interventions.

Interview with the home's falls prevention program lead #104 indicated that the resident had six falls in one month, one four months later, and the last one the following month, with injury. They indicated the home initiated additional interventions to manage the resident's risk of falling such as having a bed and chair alarm but confirmed that the care plan was not revised and updated to reflect the changes after the resident had the six falls in one month.

Interview with DOC #129 indicated the expectation was for staff to revise and update the care plan whenever a resident had a change in their needs or condition, and that resident #035's written care plan was not revised and updated. [s. 6. (10) (b)]

5. The licensee has 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 has not been effective.

The home submitted a CIS report to the MOHLTC reporting that on a specified date resident #010 was wandering in the hallway and pushed resident #004. As a result,

resident #004 fell and sustained two injuries.

Residents #004 and #010's plan of care revealed both residents were cognitively impaired and capable of walking independently at the time of the above mentioned incident. A review of the incident note indicated on the above mentioned specified date. RPN #137 witnessed resident #010 push resident #004 down to the floor. Subsequently, resident #004 was transferred to hospital and diagnosed with a particular injury.

Review of progress notes during a three and half month period and prior to the above mentioned incident, indicated resident #010 had demonstrated ongoing responsive behaviours towards residents, staff or families. During this period, 11 incidents were identified and five of them involved pushing co-residents. One of the incidents indicated that resident #010 pushed a co-resident to the floor and the resident was not injured.

Review of resident #010's responsive behaviour plan of care for the time of the above mentioned incident stated the goals were to reduce incidents of responsive behaviours and to ensure safety for residents and staff. The plan of care stated the following interventions that were revised six months earlier:
- The resident does not like when residents go near them or touch them,
- Remove other residents or prevent other residents from going near the resident,
- Knock on the resident's door before entering,
- When staff is with the resident and when the resident is accepting staff's assistance and attention, staff should only show interest to the
resident and not to other people, staff or resident,
- The resident gets agitated sometimes when family leaves after their visit. Staff should be more vigilant and anticipate behaviors as it is hypothesized that this is a trigger for the resident,
- The resident dislikes some disruptive and wandering residents in the home. Staff should take the resident to a quiet place away from residents that are loud and wandering into their space.

Interviews with PSW #122, PSW #135 and RN #136 revealed that resident #010 was cognitively impaired and demonstrated responsive behaviours towards residents, staff and families. The resident's behaviour was unpredictable and they could be calm then suddenly start pushing and hitting someone. Staff would redirect the resident or have the resident attending activity programs. The resident might not be engaging with the programs and wandering independently on the unit. Staff would monitor the resident when they saw them wandering. Since the resident wandered independently, staff stated

that it was ineffective to prevent co-residents from getting close to resident #010, monitor them and to ensure their safety. PSWs #122 and #135 indicated they were afraid that resident #010 might hit them while providing care to them.

Further interviews with RN #136 and the ADOC indicated resident #010 was followed up by the behavioural support services mobile support team last summer, and the behavioural plan of care was revised in July 2017; the resident's aggressive behaviours subsided and were manageable at that time. Near the end of 2017 and January 2018, the resident's physical aggressions had escalated and in early January 2018, resident #010 pushed another resident to the floor. The staff acknowledged the care set out for resident #010's behavioural plan of care was ineffective to ensure safety for residents and the behavioural plan of care had not been revised as required. [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 the care set out in the plan of care is provided to the resident as specified in the plan, that the provision of the care set out in the plan of care is documented, that the resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, and that the resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

The skin and wound IP triggered from stage one of the RQI related to altered skin integrity for resident #005.

Record review revealed resident #005 had developed area of altered skin integrity within 30 days of admission.

Review of resident #005's plan of care and progress notes revealed the resident was at risk for skin breakdown. A review of resident #005's assessment records indicated that on a specified date a skin and wound care assessment indicated the resident had an area of impaired skin integrity to a particular body part. The following day, a skin observation note in the resident's progress notes indicated the resident had two areas of impaired skin integrity. The areas were cleansed and dressed as ordered. Further review of the progress notes indicated seven days after the above mentioned skin and wound care assessment there were no new skin issues and the existing wound dressing was done on that day. There was no skin assessment records for one area of altered skin

integrity, and no other reassessment records for the other area of altered skin integrity.

Interviews with RPN #102 and #103 indicated when a resident has altered skin integrity, they should receive a skin assessment using the home's skin and wound care assessment instrument as soon as possible. The staff members acknowledged on the above mentioned specified date resident #005 received a skin assessment for one area of altered skin integrity. The staff members stated the progress notes on the next day indicated the resident had developed a new area of altered skin integrity and a skin assessment was not completed. They were unable to identify any details of the second area of altered skin integrity other than a progress note dated the following month, indicating the areas were healed.

Interview with the DOC indicated when a resident has altered skin integrity, the resident should receive a skin assessment. Registered staff could use the skin observation note or health status note to document a skin assessment, but the home's skin and wound care assessment instrument should be completed as soon as possible. The DOC indicated that resident #005 did not receive a skin assessment for the area of altered skin integrity using the skin and wound care assessment instrument. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The skin and wound IP triggered from stage one of the RQI related to altered skin integrity for resident #005.

Record review of the resident's clinical record revealed resident #005 had developed a new area of altered skin integrity within the 30 days of admission.

Review of resident #005's plan of care and progress notes revealed the resident was at risk for skin breakdown. A review of resident #005's assessment records revealed on a specified date a skin and wound care assessment indicated the resident had an area of altered skin integrity. The following day, a skin observation note in the resident's progress notes indicated the resident had two areas of altered skin integrity. The areas were cleansed and dressed as ordered. Further review of the progress notes indicated seven days after the above mentioned skin and wound care assessment, there was no new skin issues and the existing wound dressing was done on that day. There was no skin assessment records for one area of altered skin integrity and weekly skin reassessments

for not completed for both.

Interviews with RPN #102 and #103 indicated when a resident has altered skin integrity, they should be reassessed weekly by a registered staff using either the home's skin and wound care assessment instrument or the skin observation note. The staff members acknowledged that on the above mentioned specified date resident #005 received a skin assessment for one area of altered skin integrity. They stated the progress notes on the next day indicated the resident had developed a new area of altered skin integrity and a skin assessment was not completed. They were unable to identify any weekly skin reassessments for both areas of altered skin integrity other than a progress note dated the following month indicating the areas were healed.

Interview with the DOC indicated when a resident has altered skin integrity, the resident should receive a weekly skin reassessment by registered staff. The staff could use either the skin and wound care assessment instrument, the skin observation note or the health status note to document a skin reassessment. The DOC indicated resident #005's health status note of a specified date was not a skin reassessment for the above mentioned areas of altered skin integrity, and they should be healed by a specified date the following month, as stated in the progress note. The DOC confirmed resident #005's two areas of altered skin integrity were not reassessed weekly as required.
[s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, and that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home submitted a CIS report to the MOHLTC reporting that on a specified date resident #013 was observed kissing resident #012 in the activity room.

Review of the home's policy titled Prevention of Abuse and Neglect of a Resident, policy #VII-G-10.00, current revision date January 2015, revealed the following:
- If any employee or volunteer witnesses an incident, or has any knowledge of an incident, that constitute resident abuse or neglect; all staff are responsible to immediately take steps including immediately inform the Executive Director/Administrator and/or charge nurse in the home.
- The charge nurse will provide support to staff member reporting, in immediately reporting any of the following to the Ministry of Health and Long-Term Care Director (with Executive Director/Administrator or designate, if available): Abuse of a resident by anyone or neglect of a resident by the licensee or staff that result in harm or a risk of harm to the resident.

Review of the RAI-MDS assessments and the plan of care for resident #013 revealed the resident had a CPS score of one and was capable of walking on the unit using a walker at the time of the above mentioned incident. Further review of resident #013's plan of care revealed the resident had demonstrated responsive behaviours including physically affectionate/expressive behaviours with co-resident and other residents such as touching other co-residents, holding hands and arms, and kissing.

Review of resident #013's progress notes for a specified date one month prior to the

above mentioned date, indicated that staff observed resident #013 grabbing resident #011's buttocks as the resident stood near resident #013.

Review of the CIS for incidents that occurred over a two month timeframe revealed the home had not submitted a CIS report for the above incident.

Interviews with RPN #152 who witnessed and documented the above mentioned incidents stated the incident happened on the specified date mentioned above in the progress notes. The RPN stated resident #011 was cognitively impaired and might not be capable of giving or refusing consent to sexual touch. RPN #152 witnessed when resident #011 was standing next to resident #013, reached out and grabbed resident #011's buttock. RPN #152 intervened, told resident #013 to stop and separated both residents. RPN stated resident #013's behaviour was, to a certain extent, a sexually inappropriate behaviour, and they did not suspect that an abuse had happened. RPN #152 did not recall if it was reported to the ADOC, DOC or the Administrator.

Review of resident #013's progress notes for a specified date revealed that staff observed resident #013 touching resident #011's two body parts and attempting to kiss the resident. When staff stopped resident #013, the resident became verbally aggressive and attempted physical aggression. Subsequently a visitor of a co-resident had complained to RPN #152 that they had noticed resident #013's responsive behaviours including touching resident's inappropriately. The visitor was concerned for their family member and staff on the unit.

Review of the CIS for incidents that occurred for a two month timeframe revealed the home had not submitted a CIS report for the above mentioned incident.

Interviews with RPN #152 who witnessed and documented the above mentioned incidents stated the visitor had complained about resident #013's behaviours and verbalized they had witnessed resident #013 touching resident #011's body areas inappropriately when they visited previously. RPN #152 did not follow up with when the touching occurred and what the inappropriate body areas were. RPN further stated since it happened on a particular day of the week, they reported the incident to the manager on duty that day. The staff member did not recall who the manager was.

Interview with RVM #153 reported that on a specified date, they were the manager on duty in the building. RVM #153 recalled RPN #152 had reported the incident and the visitor's concerns about resident #013's aggressive behaviours, but the staff member did

not report the visitor's concerns about resident #013 touching resident's inappropriately. RVM #153 stated RPN #152 should report the inappropriate touching of residents' body parts so that the home can follow up on the incidents, but RPN #152 did not.

Interview with the DOC indicated the home's expectation for mandatory reporting of resident abuse when a charge nurse suspects an abuse has occurred, the nurse should report it to the management staff including ADOC, DOC or the Administrator. Only the DOC and the Administrator have access to submit a mandatory report to the MOHLTC using CIS. If the incident happened on the weekend, the charge nurse should immediately report it to the manager on duty in the building. The manager should report it to the DOC or the Administrator, and to the MOHLTC using the after-hour number when required.

The DOC stated that the above mentioned incidents that occurred on two specified dates required the home to follow up as there was reason to believe the behaviours were sexual in nature and that resident to resident sexual abuse may have occurred. The DOC confirmed that the first incident in October 2017, was not reported to them, the ADOC or the Administrator, and that the visitor's concerns regarding resident #013's inappropriate sexual behaviours on the second specified date of the same month, was not reported to RVM #153, as required by the home's policy. [s. 20. (1)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

A review of Residents' Council meeting minutes revealed on June 22, 2017, a concern was brought forward during the Residents' Council meeting that night staff were sometimes loud and noisy. Further review of the Council meeting records indicated no evidence the home had responded to the Council in writing.

Interviews with resident #008 and #009 revealed the home usually responds to the Residents' Council's concerns verbally during the Council's meetings, and they were not aware of the home responding in writing to their concerns in the past. Resident #008 further stated they recalled the above mentioned concern was brought to the home during the Residents' Council meeting and resident #008 was not aware that any written response was given to the Residents' Council.

Interview with the director of resident and family services (DRFS) revealed they usually address the Residents' Council concerns during the meetings. If follow up action required, they will bring the concerns to the home's management team for discussion and follow up actions. The DRFS would then get back to the corresponding resident who raised the concerns, and to the Residents' Council in the following meetings.

The DRFS further stated that the above mentioned concern was brought up during the Residents' Council meeting and the issues were discussed in the nursing practice meeting. The DRFS confirmed no response was given to the Residents' Council in writing as required. [s. 57. (2)]

WN #6: 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 :

1. 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 suspected may constitute a criminal offence.

The home submitted a CIS report to the MOHLTC related to resident to resident physical abuse that occurred on a specified date. The CIS report indicated that resident #017 exhibited responsive behaviour towards resident #016. The home's video camera surveillance system captured resident #017 hitting resident #016 causing them to sustain injuries to identified body parts.

Record review of resident #017's clinical record (risk management notes) revealed that four days after the specified date of the CIS report mentioned above, RAI coordinator #128 reviewed camera footage from the home's video camera surveillance system, and saw resident #017 striking resident #016 multiple times to the body. There were no witnesses and resident #016 did not hit back. Resident #016 sustained multiple injuries.

Interview with RAI coordinator #128 revealed the same as mentioned above. The RAI coordinator also stated that they discovered the injuries on resident #016's body four days prior to reviewing the camera footage but did not know the cause, as the incident between resident #017 and #016 was unwitnessed. Once they reviewed the home's video camera surveillance footage, then they became aware of what happened and notified the residents' families. Resident #016's family member did not want the home to contact the police, however the police were finally notified of the resident to resident physical abuse nine days after the incident occurred.

Record review of the home's investigation notes for this CIS report revealed that the police were notified nine days after the incident occurred.

Interview with the Administrator acknowledged that the police were not notified of the above mentioned incident of abuse from resident #017 towards resident #016 immediately when the home became aware of it; they should have been notified immediately but were notified a few days later. [s. 98.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to shall ensure that the Director was informed an incident of injury in respect of which a person was taken to hospital, no later than one business day after the occurrence of the incident, followed by the report required under subsection (4).

Review of a complaint received by the MOHLTC on a specified date revealed an allegation of abuse regarding resident #035. Resident #035 had a fall on a specified date three months earlier, sustained an injury to an identified body part, and was transferred to hospital for further assessment and medical treatment.

Review of resident #035's progress notes indicated that the resident had a fall four months earlier and was found on the floor in their room. Upon assessment the resident was observed with areas of old impaired skin integrity to two identified body parts and was transferred to the hospital for further assessment; the resident returned with no injury. Further review of resident #035's progress notes indicated on a specified date, the resident was found on the floor of the hallway. Upon assessment the resident was bleeding and sustained two injuries. The resident was transferred to hospital for further assessment with one of the injuries requiring treatment.

Review of resident #035's clinical records did not indicate that a CI report was submitted to the MOHLTC.

Interview with the DOC indicated the home did not report the above mentioned incidents to the director because based on the MOHLTC document titled report types submitted in the CIS, it was the home's understanding that the above mentioned incidents did not meet the criteria that required them to report to the MOHLTC. [s. 107. (3) 4.]

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 sous la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 18th day of April, 2018

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

Original report signed by the inspector.

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	THERESA BERDOE-YOUNG (596), JANET GROUX (606), MATTHEW CHIU (565)
Inspection No. / No de l'inspection :	2018_525596_0002
Log No. / No de registre :	002900-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 10, 2018
Licensee / Titulaire de permis :	Friuli Long Term Care 7065 Islington Avenue, Woodbridge, ON, L4L-1V9
LTC Home / Foyer de SLD :	Villa Leonardo Gambin 40 Friuli Court, Woodbridge, ON, L4L-9T3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Annette Zuccaro-Vanin

To Friuli Long Term Care, you are hereby required to comply with the following order (s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2017_378116_0005, 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 of the LTCHA.

The licensee shall prepare, submit and implement a plan to ensure that all residents are protected from abuse by resident #010, #013, #017 and any other residents with responsive behaviours that put others at risk of harm. The plan must include but is not limited to the following:

1. Ensure that any resident exhibiting sexually responsive behaviours are assessed for consent and interventions are implemented to ensure safety of co-residents.
2. Develop an on-going auditing process to ensure that resident #017 specifically, and any resident exhibiting responsive behaviours that put others at risk of harm, is reassessed, new interventions initiated and the plan of care reviewed and revised when necessary to minimize the risk of harm to other residents. Include the frequency of audits, who will be responsible for doing the audits and evaluating the results.

Please submit the written plan for achieving compliance for inspection 2018_525596_0002 to Theresa Berdoe-Young, LTC Homes Inspector, MOHLTC, by email to TorontoSAO.moh@ontario.ca by May 11, 2018, and implement the plan by June 30, 2018. Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to comply with CO #001 from inspection

2017_378116_0005 served on April 19, 2017, with a compliance date of June 30, 2017.

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

The licensee was ordered to do the following:
1. Develop and submit a plan that includes the following requirements and the person responsible for completing the tasks:
2. Provide re-education and training to all staff in the home on the home's policy to promote zero tolerance of abuse and neglect of residents.
3. Ensure all staff are educated on how to identify and report resident to resident abuse.
4. Ensure that any resident exhibiting sexual behaviour(s) is assessed for consent and interventions are implemented to ensure safety of co residents.
5. The policy review and training shall include all definitions of abuse, and not be limited to resident to resident abuse, as identified within the home's abuse policy and within the Long-Term Care Homes Act, 2007, Ontario Regulations 79/10.

The licensee completed steps 1,2,3 and 5.
The licensee failed to complete step 4. regarding ensuring that any resident exhibiting sexual behaviour(s) is assessed for consent and interventions are implemented to ensure safety of co residents.

The severity of this issue was determined to be level 3 as there was actual harm to residents #016 and #004. The scope of the issue was level 2 as it related to three out of five residents reviewed. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA that included:

- compliance order (CO) #001 issued April 19, 2017, with a compliance due date of June 30, 2017 (2017_378116_0005).

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

1. A critical incident system (CIS) report submitted to the ministry of health and long term care (MOHLTC) indicated that on a specified date resident #004 was pushed by resident #010; as a result, resident #004 sustained injuries to identified body parts.

For the purposes of the definition of physical abuse in subsection 2 (1) of the O. Reg 79/10 physical abuse means the use of physical force by a resident that causes physical injury to another resident.

Residents #004 and #010's plan of care revealed both residents had cognitive impairment and were capable of ambulating independently at the time of the above mentioned incident. A review of an incident note indicated that on the above mentioned specified date registered practical nurse (RPN) #137 witnessed resident #010 push resident #004 while they were walking down the hallway. RPN #137 assessed resident #004, informed the registered nurse (RN) and the physician in charge. Resident #004 was ordered to be transferred to hospital and was later diagnosed with a particular injury.

Review of the home's video camera surveillance system confirmed that the above mentioned altercation between resident #004 and #010 had occurred.

Interview with RPN #137 indicated that they also witnessed the above mentioned altercation and attended to resident #004, who had sustained injuries and was complaining of pain. Resident #004 was transferred to hospital and diagnosed with a particular injury as a result of being pushed by resident #010. RPN #137 indicated they considered it to be physical abuse towards resident #004.

Interview with the Assistant Director of Care (ADOC) indicated that the above mentioned incident had occurred and the home had failed to protect resident #004 from physical abuse by resident #010. [s.19. (1)] (565)

2. The home submitted a CIS report to the MOHLTC related to resident to resident physical abuse that occurred on a specified date. The CIS report indicated resident #017 exhibited behaviours towards resident #016. The home's video camera surveillance system captured resident #017 hitting resident #016 causing them to sustain injuries to identified body parts.

The MOHLTC infoline received a complaint about the same incident as mentioned above.

Record review of resident #017's progress notes revealed they had a history of responsive behaviours towards other residents and staff prior to and after the date of the CI mentioned above, as follows:

On a specified date resident #017 was exhibiting responsive behaviours, slapped resident #022 and bit RN #133.

Record review of resident #022's progress notes indicated the same as mentioned above.

The following day resident #017 wandered into another resident's room and punched resident #023 without provocation; no pain or injury noted and it was witnessed by a PSW staff.

Record review of resident #023's progress notes indicated the same as mentioned above.

Five days later, approximately half an hour before the physical altercation with resident #016, indicated in the CIS report, resident #017 scratched a PSW staff on an identified body part.

Twelve days later resident #017 hit the one to one staff, punched resident #021, and later pushed resident #020 to the floor in the dining room; resident #017 then took up a sharp object threatening any staff trying to stop them. A staff was successful at taking the sharp object away from the resident.

Record review of resident #017's medication administration record (MAR) revealed changes made to the resident's medication regimen.
Record review of one to one staffing schedule revealed that the home initiated one to one staff monitoring for resident #017 seven days after the third of three incidents of responsive behaviours occurred in one month.

A referral to the Ontario Shores Centre for Mental Health Sciences was not completed until after the three above incidents occurred earlier in the month.

Interview with RN #133 reported they worked on a specified date in June 2017, when resident #017 and #022 wandered into another resident's room. A PSW staff was also in the room with the residents. Resident #017 bit the RN and slapped resident #022. RN #133 eventually redirected resident #017 out of the room without further incident. RN #133 stated that resident #022 was not protected from abuse by resident #017.

Interview with RAI Coordinator #128 revealed that they reviewed the home's video camera surveillance system four days after the third incident mentioned above and saw resident #017 striking resident #016 multiple times to identified body parts. Resident #016 sustained multiple injuries as a result of the above mentioned physical altercation, and did not strike back at resident #017; there was no one else near the residents at the time. RAI Coordinator #128 acknowledged that resident #017 was physically abusive to resident #016.

Interview with RN #134 reported that resident #017 exhibited responsive behaviours and wandered around the unit independently using a walker. The RN stated that they worked on the specified date of the last incident mentioned above, and saw resident #017 walking in the hallway using a walker. Resident #021 was also walking with their family member. RN #134 heard resident #021's family member speak loudly asking resident #017 what they were doing. The family member then reported that resident #017 walked by them and struck resident #021 for no reason. Upon assessment resident #021 did not sustain any visible injuries and voiced no complaints. Later that same evening RN #134 was called to the dining room where she observed resident #020 on the floor. Staff reported that resident #017 had pushed resident #020 to the floor unprovoked, and other residents who saw what happened were all upset and yelling. RN #134 stated that they then observed resident #017 pick up a sharp object and left the dining room appearing to be very agitated and upset. One of the staff was able to take the sharp object away from the resident without incident. RN #134 stated that resident #020 and #021 were physically abused by resident #017.

Interview with the ADOC indicated that resident #017's responsive behaviours towards resident #016 were abusive.

The Administrator stated that the home could have done more to protect resident #016 from abuse from resident #017 since resident #017 had exhibited a pattern of physically aggressive behaviours and altercations with co-residents prior to the date of the incident that involved resident #016 on a specified date. The licensee has failed to protect resident #017 from abuse despite a known pattern of physically aggressive behaviour. [s. 19. (1)] (596)

3. A CIS report submitted to the MOHLTC by the home indicated that on a specified date residents #012 and #013 were in the activity room with a group of residents watching television. PSW #156 was assigned to resident #013 for one

to one care at that time. At a specified time, PSW #156 left resident #013 in the activity room with resident #012 and other co-residents unsupervised. Seven minutes later RPN #150 observed from the nursing station's video camera monitor that resident #013 was kissing resident #012.The staff responded and intervened.
The CIS report stated resident #012 had a cognitive performance scale (CPS) score of four and resident #013 had a CPS score of one.

For the purposes of the definition of sexual abuse in subsection 2 (1) of the O. Reg 79/10 sexual abuse means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Review of the resident assessment instrument- minimum data set (RAI-MDS) assessments and plans of care for residents #012 and #013 revealed both residents had various degrees of cognitive and physical impairment at the time of the incident. Resident #012 was using a wheelchair as the primary mode of locomotion, whereas resident #013 was capable of walking on the unit using a walker.

Further review of resident #013's progress notes, one to one care records and plan of care revealed the resident had a history of demonstrating inappropriate identified behaviours towards residents or staff. The behaviours included kissing and touching other residents in sexual nature.
Interventions were put in place for managing the resident's behaviours, which included the one to one care for monitoring the resident during the time of the above mentioned incident.

Interviews with PSWs #147, #156, and RPN #150 indicated resident #012 was cognitively impaired and incapable to express preferences most of the times. The PSWs stated resident #012 might resist care, such as food during meal services, if they did not like eating.The staff members stated resident #012 was incapable of consenting to identified touching or behaviour.

PSW #147 and RPN #150 stated they were at the nursing station doing paper work when the above incident happened.The staff members witnessed, from the nursing station's surveillance video camera monitor, resident #013 was standing next to resident #012, leaning over and kissing resident #012. Resident #012 was sitting in a wheelchair and pushed resident #013 away.

PSW #156 stated on a specified date they were providing one to one care to resident #013. Near the end of the shift, PSW #156 left resident #013 with a few other residents in the activity room without staff supervision in the area. As soon as PSW #156 went back to the activity room, they saw resident #013 leaning towards resident #012, kissing and touching resident #012's face.
PSW #147 further stated resident #012 was still pushing resident #013 away when they arrived at the activity room and the residents were separated immediately. The staff members indicated resident #012 did not sustain any injuries and was not in distress.

Interview with the DOC acknowledged the above mentioned incident happened. When considering resident #013's history of demonstrating identified behaviours towards residents, the behaviour towards resident #012 should be considered sexual in nature. Since resident #012 was cognitively impaired and putting up their hands indicating no to resident #013, the behaviour and touch were non-consensual. The DOC acknowledged the home failed to protect resident #012 from sexual abuse by resident #013. [s. 19. (1)] (565)
(596)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 10th day of April, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Ministére 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

Name of Inspector / Nom de l'inspecteur : Theresa Berdoe-Young

Service Area Office / Bureau régional de services : Toronto Service Area Office