Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 22, 2019	2019_631210_0008	004037-17, 004525-17, 007899-17, 015368-17, 029656-17, 005794-18, 005796-18, 008870-18, 010035-18, 020216-18, 020246-18, 030841-18, 031244-18, 001607-19, 003012-19, 003223-19, 003611-19	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Woodbridge Vista Care Community
5400 Steeles Avenue West Woodbridge ON L4L 9S1

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

SLAVICA VUCKO (210), DEREGE GEDA (645), GORDANA KRSTEVSKA (600), NICOLE RANGER (189)

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): April 16, 17, 18, 23, 24, 25, 26, 29, 30, May 1, 2, 3, 6, 7, 8, 9, and 10, 2019.

-Intakes #004037-17, #007899-17, #010035-18, #003012-19 related to fall prevention and management
-Intakes #029656-17, #031244-18, #001607-19, #003611-19 related to incidents that caused injury to a resident,
-Intakes #005794-18 and #005796-18 related to infection prevention and control
-Intakes #008870-18, #020246-18, #030841-18, #020216-18, #004525-17, #015368-17 related to abuse prevention.

During the course of the inspection the following follow up intakes were inspected:
-Intake #003223-19 related to personal support services.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care, Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSW) and Physiotherapist (PT), Housekeeping staff, Behavioural Support Ontario (BSO) Lead, Resident Assessment Instrument (RAI) Coordinator, Physiotherapy Assistant (PTA), Director of Resident and Family Relation (DRFR) and residents.

The inspectors performed observations of staff and resident interactions, provision of care, reviewed residents' clinical records, staff training records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

8 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (11)	CO #001	2018_631210_0022	210

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure staff used safe transferring and positioning devices or techniques when assisting residents.

A Critical Incident Report (CIS) report was submitted to Ministry of Health and Long term

Care (MOHLTC) related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. According to the report on a specified date, resident #008 was diagnosed with an injury.
A review of resident #008's clinical record indicated the resident was admitted at the home on a specified date with multiple diagnoses. They had moderate cognitive performance. They used a walker for mobility and required extensive assistance by one person for activities of daily living (ADL) including transfer and toileting.

A review of resident #008's progress notes indicated on a specified date, Registered Practical Nurse (RPN) #112 sent a referral to the Physiotherapist (PT) for the resident to be assessed for toileting assistance. According to the referral a PSW reported to the RPN that resident #008 sometimes does not like to stand with one person and assistance of side bars in the washroom while toileting. According to the referral, the RPN #112 requested the resident to be assessed for two staff and/or sit/stand lift assistance while toileting. The PT acknowledged the referral and documented that the reason for referral was a decline in transfer ability. Interview with the PT indicated they assessed resident #008 on the next day, for assistance during toileting and documented that the resident required to be assisted by two people. The PT further documented that the resident required one person to support them in the washroom holding the bar, while the other staff can do pericare, and they discussed the assessment with registered staff.

A review of the written plan of care indicated resident #008 required one-person extensive assistance for toileting at admission. The care plan was updated eight days after the PT assessed the resident, that resident #008 required two-person total assistance for toileting.

According to the progress notes resident #008 complained of pain in a specified body area four days after the PT assessed the resident. The PT and the physician assessed the resident and ordered an X-Ray. Six days after the PT's assessment RPN #109 documented the resident was crying. The X-Ray result indicated resident #008 sustained a fracture.

Interview with the PT indicated that when they perform assessment for transfer of a resident, they document the assessment in progress notes and discuss with registered staff who would further update the written plan of care.

Interview with RPN #109 indicated resident #008's written plan of care for transfer and

assistance during toileting was not updated for eight days, and on the eight day the resident was diagnosed with a fracture.

A review of resident #008's POC flow sheets for the above mentioned period indicated no documentation about the type of transfer and assistance while toileting. Interview with ADOC #110 and RPN #109 indicated PSWs do not document ADL assistance provided however they are expected to provide the care according to the plan of care; in this case one person assistance for transfer from bed to wheelchair (and vice-versa) for five days and for toileting for eight days since the PT's assessment. According to the PT, ADOC #110 and RPN #109 if there is a change in the level of assistance required for transfer and toileting, the expectation is the PSWs should report to registered staff to assess the resident and update the care plan immediately if required for safety. They should also send referral to the PT for further assessment.

A review of resident #008's clinical record and interview with PT, ADOC #110, and RPN #109 acknowledged that resident #008's written plan of care was not updated on a specified date when their transfer ability during toileting deteriorated. The PSWs were expected to follow the care plan, therefore the resident was not transferred safely during toileting for eight days.

2. A CIS report was submitted to the MOHLTC, related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The report indicated that on a specified date, resident #010's body part got caught under the wheelchair. The resident was being transported towards their room by staff while in the wheelchair.

A review of resident #010's clinical record indicated the resident was admitted on a specified date, with multiple diagnoses. The primary mode of locomotion was the wheelchair, they were able to self-propel and other person to wheel. They had mild cognitive impairment.

Interview with PSW # 103 indicated that on a specified date, they assisted resident #010 with personal care. After the care was provided the resident was able to self-propel to certain distance of their room. Then they asked the PSW to assist them the rest of the way to their room. PSW #103 pushed the wheelchair from behind and did not notice that the resident's body part got caught backward under the wheelchair. RPN #104 was notified, assessed the resident and notified the physician. PSW #103 indicated that specified items were not attached on the wheelchair at the time of the incident. They did

not attempt to retrieve the items from the resident's room, but wheeled the resident the short distance to the room. PSW #103 further stated that the method how the resident was transported was not safe for the resident, because they did not check the front part of the wheelchair.

According to resident #010's progress notes, the physician ordered X-Ray and recommended the specified items to be used when resident is seated in the wheelchair. The resident was transferred to hospital for further assessment and returned.

A review of resident #010's written plan of care indicated on the date of the incident the care plan was updated that resident #010 required one staff limited assistance for locomotion with the wheelchair for most of their locomotion and the specified items to be applied when the resident was in the wheelchair.

Interview with RPN #104 indicated the expectation is when a resident requires assistance with locomotion of the wheelchair, staff should use the specified items for safety. After this incident the home implemented safety measures. When a resident requires assistance with locomotion in their wheelchair, staff would have the items handy to attach them on the wheelchair.

Interview with PT, RPN #104, and ADOC #110 acknowledged that resident #010 was not transported safely in their wheelchair on a specified date from the hallway to their room.

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 staff used safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #2: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

The licensee has failed to ensure that within 10 days of becoming aware of an incident under subsection (1), (3) or (3.1), they made a report in writing to the Director, which included a description of the events leading up to the incident.

1. A CIS report was submitted to the MOHLTC on a specified date related to alleged physical abuse that resulted in mild body injury from resident #017 to resident #022.

Another CIS report was submitted to the MOHLTC one year later related to an incident of alleged sexual abuse that happened on a specified date. It was reported that resident #009 was observed by staff to be touching resident #021 inappropriately.

A third CIS report was submitted to the MOHLTC for an incident related to alleged resident to resident physical abuse. Resident #009 was witnessed trying to pull resident #022 out of bed.

A review of the above mentioned CIS reports indicated that they did not include descriptions of what happened prior to residents #009, #017 exhibiting abusive behaviours towards residents #021 and #022.

An interview with the Administrator indicated that the staff are very committed and educated regarding responsive behaviour and they follow the home's Responsive Behaviour Management Program, but they may not have documented everything on the CIS reports.

Interviews with the Behavioural Support Ontario (BSO) lead RPN #106, both ADOCs and

the Director of Resident and Family Relations (DRFR) agreed that the CIS reports did not include a description of the events leading up to the incidents.

2. A CIS report was submitted to the MOHLTC on a specified date about an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. Resident #018 was diagnosed with a fracture of unknown cause.

A review of resident #018's clinical record indicated the health status of the resident changed and they were assessed by PT on a specified date. The PT recommended the transfer status to be upgraded to sit-stand lift by two persons because of deteriorating weight bearing status. Registered staff updated the written plan of care.

A review of resident #018's progress notes indicated the resident presented with signs of pain in a part of the body approximately three weeks after the PT assessed the resident. The Nurse Practitioner (NP) increased the dosage of the pain medication and ordered an X-Ray. The X-Ray result indicated the resident had a fracture and they were sent to hospital. They returned to the home with a prescription for pain management and comfort measures.

A review of resident #018's written plan of care indicated updates that on the date the PT assessed the resident the resident required two person assistance with sit-stand lift for transfer, bath and toileting. The level of assistance was discussed and confirmed at the multidisciplinary care conference.

A review of resident #018's Point of Care (POC) flow sheets for activities of daily living (ADL) for 24 days, from the date of PT's assessment, indicated documentation by PSWs that the resident was transferred 48 times from bed to wheelchair and vise-versa of which in 21 times were by one person. During the same period the resident was provided assistance with bath five times of which in three times were by one person. Toileting assistance during days and evenings was provided by one person on 28 occasions during the same time period.

Interview with the RAI Coordinator RPN #129, PSWs #125 and #136 indicated that the flow sheet documentation should reflect the level of support/assistance provided to residents during ADLs.

According to PSW#125's interview and review of resident #018's flow sheets for transfer,

they transferred the resident 16 times, and toileted them 17 times by one person from the moment the PT assessed the resident until the first signs of pain. Interview with PSW #136 and review of the flow sheets documentation indicated they provided bath to resident #018 by one person two days before the resident presented with signs of pain.

Another CIS report was submitted to the MOHLTC on a specified date related to an injury of unknown cause to resident #008.

Interviews with ADOC #110 and the Administrator indicated that for the home to determine the cause of the injuries of residents #008 and #018 and the events leading to the critical incidents they reviewed if the residents had previous falls, and referred the inspector to the residents' records such as the progress notes and the assessments after the above mentioned incidents happened. The Administrator and ADOC #110 were not able to demonstrate that the home investigated the events that led to body injuries of residents #008 and #018, such as if the appropriate level of care was provided according to the written plan of care.

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 enure that within 10 days of becoming aware of an incident under subsection (1), (3) or (3.1), they made a report in writing to the Director, which included a description of the events leading up to the incident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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).

Findings/Faits saillants :

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

A CIS report was submitted to the MOHLTC related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. According to the report on a specified date, resident #008 was diagnosed with a fracture of a specified body part.

A review of the written plan of care indicated resident #008 required one-person extensive assistance for toileting at admission. The care plan was updated on a specified date, that resident #008 required two-person total assistance for toileting.

A review of the Activity of Daily living (ADL) flow sheets indicated no documentation related to self-performance and support provided for toileting during a period of three months. The ADL section for toileting which included the self-performance and support provided by staff such as how the resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter and adjusting clothes was documented for one week, during the mandatory quarterly weekly observation period.

Interview with the DOC and ADOC #110 indicated that the PSWs do not document the level of assistance they provide to residents for ADLs on everyday basis. They document by exception and the expectation is the PSWs to provide care according to the written plan of care that they have access to. Further, if there is a health status change and the resident requires a higher level of care than described in the care plan, they have to report to the registered nurse. They have an option to notify the nurse by creating an alert documentation in Point of care (POC) or to report it verbally and the nurse to document the exempted care. The registered nurse would then assess the resident, send appropriate referrals for further assessment and update the care plan accordingly. They indicated this process was implemented since August 2018. The DOC and ADOC #110 were not able to retrieve PSW's documentation for the period from February 3 until 12, 2019, and confirm if resident #008 was assisted during toileting according to the PT recommendation.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Two CIS reports were submitted to the MOHLTC, for incidents that happened on identified dates related to alleged resident #009 to residents #021 and #022 abuse. In one case resident #009 touched resident #021 inappropriately and in the other case resident #009 pulled resident #022 out of bed.

A review of resident #009's Minimum Data Set (MDS) assessment record prior the incident on a specified date indicated that the resident had been identified to have memory problem, with moderately cognitive impairment. The resident was identified to have exhibited responsive behaviour towards the staff and other residents.

A review of resident #009's assessment record indicated that the resident had been monitored on admission and each time after responsive behaviour had been identified or medication had been changed. For monitoring the staff used the Dementia Observation System (DOS) record that had been reviewed and discussed among the interdisciplinary team members and the BSO lead-RPN #106.

A review of resident #009's written plan of care prior to the incident indicated that the resident was identified to exhibit responsive behaviour related to cognitive impairment. The trigger had been identified and goal set up to minimize the responsive behaviour. Interventions were added or adjusted according to the outcome of the DOS record.

A review of the home's policy titled "Responsive Behaviours-Management" # VII-F-10.20 revised November 2018, on page two indicated that the registered staff would conduct and document an assessment of the resident experiencing responsive behaviour that may include completing behavioural assessment based on the resident needs, including but not limited to Behavioural Assessment Tool, Depression scale, Mini-mental, and Cohen-Mansfield Aggression Inventory.

A review of resident #009's clinical record indicated that the staff had not completed a behavioural assessment when the resident presented with responsive behaviours based on the resident needs, and to determine the triggers for the behaviour on admission and after, up until the resident was sent to another institution for further assessment.

In an Interview, the BSO lead-RPN #106 acknowledged that they used the DOS tool for monitoring, BSO referral, and BSO weekly rounds to evaluate the interventions implemented to manage the resident's responsive behaviour, however the BSO lead-RPN #106 stated that they did not use the tools for assessment of resident #009 as per the policy, and identify the triggers in order to manage the behaviour.

Interviews with the two ADOCs and DRFR staff #117, who is a member of the BSO team, confirmed that resident #009 was not assessed for responsive behaviours as per the policy and the available tools.

WN #5: 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 the resident #022 was protected from abuse by others in the home.

A CIS report was submitted to the MOHLTC on a specified date, related to physical abuse resident to resident. According to the report resident #022 sustained a minor injury from resident #017 during an altercation.

A review of resident #022's clinical record indicated that the resident had moderate cognitive impairment, with no history of responsive behaviour. A DOS record initiated right after the incident indicated that the resident had not experienced responsive behaviours within the seven day observation period.

A review of resident #017's MDS assessment record prior to the incident indicated that the resident had been identified to have a short and long term memory problem and moderate cognitive impairment. The resident was identified to have responsive behaviors. A review of resident #017's written plan of care indicated that the resident was identified to have a responsive behaviour and had interventions in place.

An interview with staff #106 indicated the staff were aware of resident #017's responsive behaviour. They indicated they were monitoring the resident however when the resident was walking around the unit the staff was not able to keep an eye on the resident at all times. One of the triggers for their responsive behaviour was when staff tried to redirect the resident.

A review of resident #022's progress notes indicated that on a specified date, resident #017 entered resident #022's room and caused a minor body injury to the resident. Resident #017 was redirected immediately by staff. Resident #022 was assessed with no visible injury. On another specified date, resident #022 sustained laceration on the body while in the dining room. According to RPN #106 the notes indicated that the resident sustained the injury in an abuse/altercation with resident #017. The PSW who reported the incident to registered staff is no longer in the home to be interviewed. Interview with RPN #106 and record review indicated the registered staff who documented the incident did not obtain details from the PSW about how the altercation happened.

Interview with BSO lead-RPN #106 indicated that usually the staff redirect resident #017 when they see them entering into other residents' rooms. RPN #106 further indicated that when the altercation happened, they did not notice when resident #017 entered resident #022's room. They also stated that during the second altercation, the staff had not reacted quickly enough to redirect resident #017 before they caused a body injury to resident #022. RPN #106 recognized that resident #017 had been abusive towards resident #022.

During interviews with both ADOCs they acknowledged that resident #022 was not protected from abuse from resident #017 on the specified date as mentioned above, despite the strategies that were in place to manage resident #017's responsive behaviour.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse by anyone that the licensee knows of, or that is reported was immediately investigated.

A CIS report was submitted to the MOHLTC on a specified date related to an alleged sexual abuse incident that happened on a specified date, from resident #009 towards resident #013. According to the report resident #009 touched resident #013's body part in their room while asleep and tried to take a piece of cloth off.

A review of resident #013's clinical record prior to the incident indicated that the resident had been identified to have a memory problem, with moderate cognitive impairment. The resident did not have a history of responsive behaviour. At the time of the incident

resident #013 had been in their room and was not aware of the other resident being in their room.

A review of resident #009's MDS assessment record prior to the incident indicated that the resident had been identified to have a memory problem, moderate cognitive impairment, with mental function that varied over the course of the day. The resident was identified to have exhibited responsive behaviour towards staff and residents that was not easily altered. A review of the resident's record indicated that the resident had been monitored on admission and each time after the responsive behaviour had been identified or medication had been changed.

A review of the home's investigation record indicated that the home did not immediately investigate the incident between the two residents witnessed by PSW #116. A review of the record revealed a communication note between staff and the manager on duty, ADOC #111 when the incident report was submitted.

In an Interview, the BSO lead acknowledged that they were not working the identified weekend and completed a referral on the following day, upon return to work. They also indicated that when they received the referral they did not investigate the incident about how it happened but reinforced the interventions regarding managing resident #009's responsive behaviour. The BSO lead also stated that the resident had been considered for referral to an institution for further assessment of their responsive behaviour, but the referral was on hold because the Substitute Decision Maker (SDM) refused to sign the consent.

Interviews with both ADOCs indicated that the incident happened during weekend when management staff were not available. Both ADOCs acknowledged that the incident was not investigated immediately upon finding out about the witnessed sexual abuse.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who requires continence care products had sufficient changes to remain clean, dry and comfortable.

A CIS report was submitted to the MOHLTC on a specified date, related to an allegation of staff to resident neglect. According to the CIS report on a specified date and time, the Director of Resident Programs staff #117 overheard a conversation between PSW #115 and RPN #116. PSW #115 informed the staff that on the above mentioned date PSW #113 had left the floor 10 minutes before the end of their shift and left resident #019 incontinent.

Interview with PSW #113 revealed that they were assigned to provide care to resident #019 on their shift of the above mentioned date. PSW #113 stated that they provided the care to the resident twice, and changed the resident's incontinent product after the meal. PSW #113 further indicated that they left the unit at some time before the end of the shift to arrange some administrative work. According to PSW #113 the expectation is that they should check residents prior to the end of their shift, however PSW #113 indicated they did not check on resident #019 prior to leaving the unit.

Interview with evening RPN #116 revealed they arrived on the unit earlier on the above mentioned date. According to RPN #116 they were called by PSW #115 to come into resident #019's room where they found the resident sitting in their wheelchair with their incontinent product heavily soiled. The resident appeared not to be changed in a long time. RPN #116 informed the day RPN #114 who was still on the unit about the incident.

Interview with the ADOC #110 revealed that an investigation was conducted and acknowledged that resident #019 did not receive assistance to remain clean, dry and comfortable.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

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

A CIS report was submitted to the MOHLTC on a specified date, regarding physical abuse between resident #017 and #022. According to the CIS report resident #017 caused a minor body injury to resident #022 during an altercation.

A review of resident #017's MDS assessment record prior to the incident indicated that the resident had been identified to have memory problem, moderate cognitive impairment, with mental function that varied over the course of the day. These behaviours were not easily altered. The resident was also had responsive behaviours. These behaviours occurred one to three days per week in the observation period, and in general their behavioural status deteriorated as compared to the previous status.

A review of resident #017's written plan of care revised prior to the incident indicated that the resident was identified to have a behaviour problem related to cognitive impairment. The interventions planned to manage their behaviour and determine the underlying cause were: gentle persuasions, monitoring, safety checks, redirection, engagement in activities and conversations.

A review of resident #017's clinical record indicated that on a specified date, resident #017 entered resident #022's room and caused minor body injury to the resident. The resident was referred to the BSO lead-RPN #106 and the recommendation for the staff was to continue to review, adhere and follow the interventions outlined in the care plan under the "behaviour problem" focus as they remained effective in the intervention of the resident's responsive behaviour.

A review of resident #017's plan of care after the incident indicated that there were no steps taken to minimize the risk of altercations and potentially harmful interactions between the residents by identifying and implementing interventions.

A review of resident #017's clinical record indicated that on a specified date, resident #017 caused minor body injury to resident #022 while in the common area.

Interview with BSO lead-RPN #106 acknowledged that the team should have worked on identifying the potential triggers for altercations between resident #017 and #022.

Issued on this 22nd day of May, 2019

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

Original report signed by the inspector.