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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 17, 2016	2016_168202_0011	010530-16	Resident Quality Inspection

Licensee/Titulaire de permis

THE MENNONITE HOME ASSOCIATION OF YORK COUNTY
123 Weldon Road Stouffville ON L4A 0G8

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

PARKVIEW HOME LONG-TERM CARE
123 Weldon Road Stouffville ON L4A 0G8

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

VALERIE JOHNSTON (202), JANET GROUX (606), MATTHEW CHIU (565), SHIHANA RUMZI (604)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 13, 14, 15, 18, 19, 20, 21, 22, 27, 28, 2016.

During the course of the inspection the following Critical Incident System (CIS) intakes were inspected: 017535-15, 020490-15, 00442-16, 011866-16.
During the course of the inspection the inspectors: reviewed clinical records, conducted a tour of the home, observations of meal services, medication administration, staff and resident interactions, provisions of care, reviewed staff training records, reviewed home's policies related to abuse and neglect of residents, medication administration, continence management and responsive behaviours.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Director of Nutritional Services and Property Resources, Director of Programs and Services, Resource Nurse, Registered Nurses (RNs), Personal Support Workers (PSWs), Dietary Aides, Presidents of Residents' Council and Family Council, residents, families.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

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

6 WN(s)
1 VPC(s)
2 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 all residents are protected from sexual abuse.

The Long-Term Care Homes Act, 2007, O. Reg 79/10, defines "sexual abuse" as any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a person other than a licensee or staff member.

Record review of an identified Critical Incident System (CIS) report and progress notes revealed on an identified date, RPN #115 observed resident #011 in resident #010's room touching resident #010 on an identified area over his/her clothing. The staff member immediately separated the residents.

Record review of the Resident Assessment Instrument Minimum Data Set (RAI-MDS) assessment revealed resident #010 and #011 were cognitively impaired and both had a higher than average Cognitive Performance Scale (CPS) score.

Interview with RPN #115 indicated on another identified date, in resident #010's room, he/she observed resident #011 sitting behind resident #010 and touching an identified area of resident #010's body over his/her clothing. When the staff member intervened, resident #011 pulled away. The staff member took resident #011 back to his/her room. Resident #010 did not sustain an injury or demonstrate any distress after the incident.

Interviews with the DOC and RPN #115 confirmed resident #010 was unable to give consent and the home failed to protect resident #010 from abuse. [s. 19. (1)]

2. The home submitted a CIS on an identified date, to the MOHLTC, notifying that an incident of resident to resident abuse had occurred two days prior on an identified date

and time. The report revealed that resident #021 had pulled back resident #025's blanket while the resident had been in bed and had been observed by staff touching an identified area of resident #025's body.

Resident #021 was admitted to the home on an identified date in 2014, to an identified home area and relocated to another identified home area in the past year. A review of resident #021's progress notes from the time of his/her admission revealed that on nine different occasions resident #021 was observed by staff members touching co-residents inappropriately.

Interviews with direct care staff from all three shifts on both identified home areas revealed that resident #021 targets residents with cognitive impairment and waits until he/she believes staff are not watching to touch co-residents.

A review of the clinical records for the above mentioned residents revealed that all of these residents had been diagnosed with cognitive impairment. The most recent RAI-MDS assessments for the above mentioned residents were reviewed and revealed that they all had a Cognitive Performance Scale (CPS) that ranged from three to six which indicated moderate to severe cognitive impairment.

The DOC indicated in an interview that sexual abuse is any non-consensual touching and confirmed that the residents involved in the incidents were cognitively impaired and some were sleeping at the time, therefore, the residents could not have consented and sexual abuse occurred. Furthermore, the DOC revealed that she had been unaware of the incidents mentioned above and only learned that an incident occurred through reading the progress notes at random times.

Interviews with RPNs #121, #123 and PSW #125 revealed that resident #021's identified responsive behaviours had been escalating. The staff indicated that the resident is no longer hiding his/her actions and has become more aggressive, placing residents that are unable to speak for themselves at risk. The staff further indicated that the resident had recently targeted residents at shift change when staff are unavailable to monitor his/her whereabouts. A review of the progress notes for resident #021 confirmed that the most recent incidents of abuse occurred at the start of shift while staff are getting report. The three most recent incidents were observed at the beginning of a shift.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

Resident #021 was admitted to the home on an identified date in 2014. From the time of the resident's admission, there have been 10 incidents of abuse towards co residents. Direct care staff indicated that resident #021 "knows what he/she is doing" and will seek out residents who are sleeping or unable to speak for themselves. The staff further indicated the resident knows when he/she is being watched and when he/she believes he/she is not being monitored will exhibit identified inappropriate behaviours toward other residents. The staff indicated that they have been directed to monitor the resident and document any further incidents. The staff confirmed that monitoring resident #021 at all times is not possible and that co residents remain at risk.

The scope of the non-compliance is isolated to an identified home area.

A review of the compliance history revealed the following non-compliance related to the Long-Term Care Homes Act, 2007, c.8. s. 19 (1).: A voluntary plan of correction (VPC) was previously issued for section 19 (1) during a Resident Quality Inspection on May 04, 2015, under Inspection #2015_334565_0009.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone.

The Long-Term Care Homes Act, 2007, O. Reg 79/10, defines "sexual abuse" as any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a person other than a licensee or staff member.

Interviews with RPNs #120, #121, #123, #126 and PSWs #119, #122, #124, and #125 indicated that resident #021 had displayed responsive behaviours and had targeted residents that are cognitively impaired and/or are unable to speak for themselves. The staff indicated that resident #021 had been observed to touch other resident's who had been unable to provide consent, in identified areas of their bodies while residents had been sleeping. Staff indicated that the untoward touching of one resident to another would be considered sexual abuse.

Interviews with RPNs #120, #123 and #121 revealed that all abuse incidents are reported to the charge nurse and documented on Point Click Care (PCC) for the DOC or ADOC to read. The staff further revealed that this is the home's process for reporting incidents of

abuse.

A review of resident #021's clinical records revealed that he/she had been admitted to the home on an identified date in 2014. A review of resident #021's progress notes from the time of his/her admission revealed ten documented incidents of abuse that had occurred on identified dates.

An interview with the DOC indicated that the ten above mentioned dates had been identified as sexual abuse and confirmed that only two out of the ten sexual abuse incidents had been reported to the Director. The DOC confirmed that the two submissions had been submitted late and not immediately as required by the legislation as follows:

-An identified CIS had been submitted to MOHLTC Director on an identified date and time, the witnessed incident of abuse had occurred two days prior.

-An identified CIS had been submitted to the MOHLTC Director on an identified date and time, and the witnessed incident of abuse had occurred three days prior.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

Resident #021 was admitted to the home on an identified date in 2014. From the time of the resident's admission, there have been 10 incidents of abuse towards co residents. A review of the Critical Incident Report (CIS) submissions to the MOHLTC Director, only two of the 10 incidents had been reported and had been reported late and not immediately as required. Interviews with direct care staff revealed that with any incident of abuse, the incident is to be documented in Point Click Care (PCC) in order to be reviewed by the DOC or ADOC.

The scope of the non-compliance is widespread.

A review of the compliance history revealed the following non-compliance related to the Long-Term Care Homes Act, 2007, c.8. s. 24 (1).: A voluntary plan of correction (VPC) was previously issued for section 24 (1) during a Resident Quality Inspection on May 04, 2015, under Inspection #2015_334565_0009. [s. 24. (1)]

2. Record review of an identified CIS report and progress notes revealed on an identified

date, RPN #115 observed an incident of abuse involving resident #010 and #011. The incident was reported to the Director on one day later.

An interview with RPN #115 indicated when he/she observed the above mentioned incident he/she had reasonable grounds to suspect abuse had occurred to resident #010. The RPN did not report the incident to the Director but documented it in the progress notes. Interview with the DOC confirmed that he/she became aware of the incident the next morning and reported it to the Director in the afternoon, but not immediately as required. [s. 24. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with 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,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who is incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstance of the resident require, and assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

The home had previously been issued a written notification, under O.Reg. 79/10, s. 51 (2), on May 15, 2015, within report # 2015_334565_0009, of a Resident Quality

Inspection (RQI).

Resident #001 was admitted to the home on an identified date in 2008. A review of resident #001's RAI-MDS assessment records revealed that the resident had been assessed as continent of urine on admission, the RAI-MDS assessment of an identified date years later, indicated that the resident had a change in urinary status and had been assessed as occasionally incontinent of urine, and in a subsequent assessment of an identified date, indicated that the resident had been frequently incontinent of the same.

Resident #003 was admitted to the home on an identified date in 2008. A review of resident #003's RAI-MDS admission assessment records revealed that the resident had been incontinent of urine upon admission.

A review of the home's Continence Management, policy, #RC-11-05, dated October 2015, directed registered staff to "conduct a bowel and bladder continence assessment on admission and after a significant change in condition that may affect bladder or bowel continence".

Interviews with RN #105 and RPN #100 indicated that residents are assessed for incontinence on admission, or with any change in health status, using a three day tracking tool and if required a continence management system form is completed. The staff indicated that this form is used for the identification of product type and size.

An interview with RPN #102 co-lead of the home's continence care program confirmed that staff are to use the above mentioned forms for continence assessment. When asked if the forms were a clinical tool that would identify causal factors, patterns, type of incontinence and potential to restore function with specific interventions, as required in the legislation, the RPN confirmed that these assessments did not and that the home currently did not have a clinical assessment tool specifically designed for continence assessment. The RPN further confirmed that no resident in the home would have received a continence assessment as required. [s. 51. (2) (a)]

2. Resident #004 was admitted to the home on an identified date in 2013. A review of the resident's RAI-MDS admission assessments, revealed the resident had been occasionally incontinent in bowel and frequently incontinent in bladder. A review of assessment records indicated the resident received the assessments using a three day tracking tool on three identified dates, and a completed continence management system form. The assessments did not include the identification of causal factors, types of

incontinence, and potential to restore function with specific interventions.

Interviews with RPN #108 and the Resource Nurse indicated the resident was incontinent. The Resource Nurse confirmed the above mentioned assessment forms did not include the identification of causal factors, types of incontinence, and potential to restore function with specific interventions and that the resident did not receive the assessment as required. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstance of the resident require, and assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

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 :

1. The licensee has failed to ensure that the home's Dietitian Referral policy, #FS-10-85, dated May 2015, is complied with.

Review of resident #009's written plan of care indicated under "Nutritional Status": resident #009 needs a minimum eight servings fluid/day at meals, snacks, and med passes, encourage fluids intake at meals. Nursing to monitor weight and intake and inform RD as needed.

Review of resident #009's "Nutritional Intake Record" for two identified months, identified resident #009 had between 437.5-875 millilitres (ml) of fluids equaling 3.5-7 serving of fluid a day.

An interview conducted with RPN #126 indicated the nutritional intake records are reviewed by registered staff each Monday and when resident #009's fluid intake was consistently lower than recommended a dietary referral should have been carried out and documented on PCC progress notes, as directed in the home's above mentioned policy.

Interviews conducted with the Director of Nutritional Services & Property Resources (DNSPR) and the DOC confirmed resident #009 had not received the minimum fluid requirement and nursing did not collaborate with the DNSPR informing that resident #009 had not received his/her recommended fluid intake per day and no dietary referral had been sent as in accordance with the home's policy. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the home's Self Administration of PRN Medications policy, #RC-12-40, dated December 2015, is complied with.

The above mentioned policy directs staff and/or physician to complete the Competency Screen for Self-Administration of Medications #RC-12-4-01 with the resident.

An interview with resident #024 revealed that he/she had self-administered an identified medication when necessary and will either keep the medication in his/her pocket or by the bedside in his/her room.

A review of resident #024's clinical records revealed that on an identified date, the physician had authorized the resident to self-administer an identified medication when necessary. The review revealed and had been further confirmed by RPN #102, that a Competency Screen for Self-Administration of Medications as directed in the home's above mentioned policy had not been completed for resident #024. [s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following are developed to meet the needs of residents with responsive behaviours: 3. Resident monitoring and internal reporting protocols.

A review of resident #021's written plan of care indicated that the resident had identified responsive behaviours that had been directed toward co-residents as well as staff.

A review of resident #021's progress notes from admission, revealed 13 documented

incidents of responsive behaviours directed towards co-residents.

Interviews with RPN #121 and #120 revealed that resident #021 had exhibited responsive behaviours from the time of his/her admission and indicated that the resident's responsive behaviours had escalated. When asked if there are monitoring and reporting protocols to respond to residents identified with responsive behaviours, the RPN's indicated that there was and stated that they are to contact the responsive behaviour lead identified as the Director of Programs and Support Services (DPSS) by calling or sending a form to him/her for any escalating behaviours. RPN #120 revealed that all incidents of responsive behaviours toward others are documented in the progress notes and the DOC would read the information and respond accordingly. The RPN's further stated that although they are to document and contact the DPSS regarding escalating behaviours, they felt that nothing is rectified and that they are left to manage the responsive behaviours on their own.

An interview with the DPSS revealed that he/she was not the responsive behaviour lead and that staff had only been directed to send a responsive behaviour debriefing form to him/her for statistical purposes only. The DPSS further revealed that he/she is not involved in resident care and that nursing were responsible for addressing all resident care, including those with identified responsive behaviours.

An interview with the DOC indicated that the staff are to document all responsive behaviour incidents in the progress notes and that either herself or the ADOC will read the notes and determine if more information is required from the registered staff. The DOC confirmed that the DPSS is only responsible for tracking statistical information regarding residents with responsive behaviours and that the responsive behaviour debriefing form is only used for residents displaying physical incidents of aggression with injury.

The DOC confirmed that there is a lack of internal reporting and monitoring of residents identified with responsive behaviours and that there is no specific response time for either herself or the ADOC to read the progress notes and respond accordingly. [s. 53. (1) 3.]

2. The licensee has failed to ensure that strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

The home submitted a CIS on an identified date, to the MOHLTC, notifying that an incident of resident to resident abuse had occurred. The report revealed that resident #021 had pulled back resident #025's blanket while he/she had been in bed and had been observed by staff touching resident an identified areas of resident #025's body.

Resident #021 was admitted to the home on an identified date in 2014. The plan of care for resident #021 identified the resident as having identified responsive behaviours toward co residents and staff.

Interviews with RPNs #121, #120, #123, #126, and PSWs #122, #124 and #125 revealed that resident #021 is cognitively impaired and had been identified with responsive behaviours that included identified inappropriate interactions towards co–residents and staff since admission. The staff indicated that resident #021 will seek out opportunity to elicit identified responsive behaviours on to other residents and had been successful in doing so. The staff further indicated that although the resident had been identified with a cognitive impairment, all staff stated that the resident "knows what he/she is doing", has manipulated residents, is aware of when staff are watching him/her and will target residents that are unable to speak for themselves. The staff indicated that they have observed resident #021 enter co resident rooms and has touched other residents inappropriately. Staff identified the resident #021's responsive behaviours as abuse and that residents residing on the identified home area are at risk of being abused by the resident.

When asked of direct care staff which included, RPNs #121, #120, #126, and PSWs #119, #122, whether strategies had been developed and implemented to respond to resident #021's identified responsive behaviours, the staff indicated that they currently monitor the resident as much as possible and attempt to keep identified at risk residents away from resident #021. RPN #120 further indicated that staff must make sure that resident #021 is not watching them when moving identified at risk residents away from him/her as he/she will follow them. PSW #122 revealed that in an identified time of day, he/she will move identified at risk residents close to the nursing station in order for them to monitor resident #021 more closely. The above mentioned staff further indicated that the monitoring of resident #021 is not always possible and there had been no further strategies developed or implemented to ensure that there is no risk to other residents.

A review of the written plan of care for resident #021 identified that he/she has exhibited responsive behaviours toward identified co–residents. The interventions within the written plan of care directed staff to monitor for responsive behaviours toward identified co

residents and remove the co resident if risk is observed. Staff are directed to use a behavior tracking tool and inform the physician and to continue to monitor when the resident enters co resident rooms.

An interview with the DOC indicated that resident #021 had been identified with having identified responsive behaviours that have posed a risk to other residents residing on the identified home area. The DOC further indicated that staff have been directed to monitor the resident as much as possible. When asked whether strategies had been developed and implemented to respond to resident #021's responsive behaviours, the DOC confirmed that this had not occurred. [s. 53. (4) (b)]

3. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments and reassessments.

Record review of resident #011's progress notes and assessment records revealed the resident was cognitively impaired and demonstrated identified responsive behaviours. The assessment records indicated the resident had been referred to the Behavioural Supports Ontario Mobile Support Team (BSO-MST) in an identified year, and a behavior support plan had been recommended.

Further review of progress notes indicated the resident continued to demonstrate the identified responsive behaviours in 2015 and 2016. There was no assessment or reassessment conducted for the resident's behaviours after the initial assessment.

Interviews with PSW #117, RPN #108 and the DOC confirmed the resident had ongoing identified responsive behaviours. RPN #108 and the DOC further confirmed the behavioural interventions had not been effective to manage the resident's responsive behaviours and no assessment or reassessment had been taken in response to the needs of the resident's behaviours since the initial assessment. [s. 53. (4) (c)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (7) The licensee shall ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except,
(a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and O. Reg. 79/10, s. 131 (7).
(b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. O. Reg. 79/10, s. 131 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except, (a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and (b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. O. Reg 79/10, s. 131 (7).

An interview with resident #024 revealed that he/she self-administers an identified medication when necessary and will either keep the medication in his/her pocket or by the bed in his/her room.

A review of resident #024's physician orders revealed that an order had been issued on an identified date, which had permitted the resident to self-administer the identified medication when necessary. The review did not reveal authorization by a physician or registered nurse in the extended class which would have permitted resident #024 to keep the above mentioned medication on his or her person or in his or her room.

Interviews with RPN #102 and the ADOC confirmed that a physician, registered nurse in the extended class or other prescriber who attends the resident had not authorized resident #024 to keep the above medication on his or her person or in his or her room. [s. 131. (7)]

Issued on this 17th day of June, 2016

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) :	VALERIE JOHNSTON (202), JANET GROUX (606), MATTHEW CHIU (565), SHIHANA RUMZI (604)
Inspection No. / No de l'inspection :	2016_168202_0011
Log No. / Registre no:	010530-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 17, 2016
Licensee / Titulaire de permis :	THE MENNONITE HOME ASSOCIATION OF YORK COUNTY 123 Weldon Road, Stouffville, ON, L4A-0G8
LTC Home / Foyer de SLD :	PARKVIEW HOME LONG-TERM CARE 123 Weldon Road, Stouffville, ON, L4A-0G8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Solange Taylor

To THE MENNONITE HOME ASSOCIATION OF YORK COUNTY, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

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

Order # / Ordre no : 001

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

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 :

Upon receipt of this order:

1. The licensee shall develop, implement and submit a plan, that will ensure that all residents are protected from resident #021's identified responsive behaviours placing identified residents at risk of abuse. The plan shall include, but not be limited to residents residing on the identified home area home area.

2. Within one week of receipt of this order, conduct a meeting between management and direct care staff from the identified home area.

3. The meeting shall allow direct care staff opportunities to collaborate for the development and implementation of written strategies, including techniques and interventions to meet the needs of resident #021's identified responsive behaviours. The written strategies must include strategies, techniques and interventions, to prevent, minimize or respond to the risks associated with the identified area of abuse to other residents residing on the identified home area.

4. The plan is to include the required tasks, the person responsible for completing the tasks and the time lines for completion. The plan is to be submitted to valerie.johnston@ontario.ca by June 15, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that all residents are protected from sexual abuse.

The home submitted a CIS on an identified date, to the MOHLTC, notifying that an incident of resident to resident abuse had occurred two days prior on an

identified date and time. The report revealed that resident #021 had pulled back resident #025's blanket while the resident had been in bed and had been observed by staff touching an identified area of resident #025's body.

Resident #021 was admitted to the home on an identified date in 2014, to an identified home area and relocated to another identified home area in the past year. A review of resident #021's progress notes from the time of his/her admission revealed that on nine different occasions resident #021 was observed by staff members touching co-residents inappropriately.

Interviews with direct care staff from all three shifts on both identified home areas revealed that resident #021 targets residents with cognitive impairment and waits until he/she believes staff are not watching to touch co-residents.

A review of the clinical records for the above mentioned residents revealed that all of these residents had been diagnosed with cognitive impairment. The most recent RAI-MDS assessments for the above mentioned residents were reviewed and revealed that they all had a Cognitive Performance Scale (CPS) that ranged from three to six which indicated moderate to severe cognitive impairment.

The DOC indicated in an interview that sexual abuse is any non-consensual touching and confirmed that the residents involved in the incidents were cognitively impaired and some were sleeping at the time, therefore, the residents could not have consented and sexual abuse occurred. Furthermore, the DOC revealed that she had been unaware of the incidents mentioned above and only learned that an incident occurred through reading the progress notes at random times.

Interviews with RPNs #121, #123 and PSW #125 revealed that resident #021's identified responsive behaviours had been escalating. The staff indicated that the resident is no longer hiding his/her actions and has become more aggressive, placing residents that are unable to speak for themselves at risk. The staff further indicated that the resident had recently targeted residents at shift change when staff are unavailable to monitor his/her whereabouts. A review of the progress notes for resident #021 confirmed that the most recent incidents of abuse occurred at the start of shift while staff are getting report. The three most recent incidents were observed at the beginning of a shift.

The severity of the non-compliance and the severity of the harm and risk of

further harm is actual.

Resident #021 was admitted to the home on an identified date in 2014. From the time of the resident's admission, there have been 10 incidents of abuse towards co residents. Direct care staff indicated that resident #021 "knows what he/she is doing" and will seek out residents who are sleeping or unable to speak for themselves. The staff further indicated the resident knows when he/she is being watched and when he/she believes he/she is not being monitored will exhibit identified inappropriate behaviours toward other residents. The staff indicated that they have been directed to monitor the resident and document any further incidents. The staff confirmed that monitoring resident #021 at all times is not possible and that co residents remain at risk.

The scope of the non-compliance is isolated to an identified home area.

A review of the compliance history revealed the following non-compliance related to the Long-Term Care Homes Act, 2007, c.8. s. 19 (1).: A voluntary plan of correction (VPC) was previously issued for section 19 (1) during a Resident Quality Inspection on May 04, 2015, under Inspection #2015_334565_0009. (202)

2. The Long-Term Care Homes Act, 2007, O. Reg 79/10, defines "sexual abuse" as any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a person other than a licensee or staff member.

Record review of an identified Critical Incident System (CIS) report and progress notes revealed on an identified date, RPN #115 observed resident #011 in resident #010's room touching resident #010 on an identified area over his/her clothing. The staff member immediately separated the residents.

Record review of the Resident Assessment Instrument Minimum Data Set (RAI-MDS) assessment revealed resident #010 and #011 were cognitively impaired and both had a Cognitive Performance Scale (CPS) score of four.

Interview with RPN #115 indicated on another identified date, in resident #010's room, he/she observed resident #011 sitting behind resident #010 and touching an identified area of resident #010's body over his/her clothing. When the staff member intervened, resident #011 pulled away. The staff member took resident

#011 back to his/her room. Resident #010 did not sustain an injury or demonstrate any distress after the incident.

Interviews with the DOC and RPN #115 confirmed resident #010 was unable to give consent and the home failed to protect resident #010 from abuse. (565)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 29, 2016

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee shall upon receipt of this order:

1. Review the home's policy, titled, Zero Tolerance of Abuse/Neglect, #AD-03-05/RC-02-05, dated August 2013, with all staff in the home.

2. The policy review shall include, mandatory reporting of abuse under section 24 (1) of the Act and all areas of abuse, including corresponding definitions as identified within the home's abuse policy and within the Long-Term Care Homes Act, 2007, Ontario Regulations 79/10.

3. At the end of the review, staff shall be able to recognize and define all forms of abuse under the legislation, including sexual abuse, and the immediate reporting of such.

4. The licensee shall develop, implement and submit a plan, that includes all above three requirements, the person responsible for completing the tasks and the time lines for completion. The plan is to be submitted to valerie.johnston@ontario.ca by June 15, 2016.

Grounds / Motifs :

1. The licensee failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone.

Record review of an identified CIS report and progress notes revealed on an identified date, RPN #115 observed an incident of abuse involving resident #010 and #011. The incident was reported to the Director on one day later.

An interview with RPN #115 indicated when he/she observed the above mentioned incident he/she had reasonable grounds to suspect abuse had occurred to resident #010. The RPN did not report the incident to the Director but documented it in the progress notes. Interview with the DOC confirmed that he/she became aware of the incident the next morning and reported it to the Director in the afternoon, but not immediately as required. (565)

2. The Long-Term Care Homes Act, 2007, O. Reg 79/10, defines "sexual abuse" as any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a person other than a licensee or staff member.

Interviews with RPNs #120, #121, #123, #126 and PSWs #119, #122, #124, and #125 indicated that resident #021 had displayed inappropriate behaviours and had targeted residents that are cognitively impaired and/or are unable to speak for themselves. The staff indicated that resident #021 had been observed to touch other resident's who had been unable to provide consent, in identified areas of their bodies while residents had been sleeping. Staff indicated that the untoward touching of one resident to another would be considered sexual abuse.

Interviews with RPNs #120, #123 and #121 revealed that all abuse incidents are reported to the charge nurse and documented on Point Click Care (PCC) for the DOC or ADOC to read. The staff further revealed that this is the home's process for reporting incidents of abuse.

A review of resident #021's clinical records revealed that he/she had been admitted to the home on an identified date in 2014. A review of resident #021's progress notes from the time of his/her admission revealed ten documented incidents of abuse that had occurred on identified dates.

An interview with the DOC indicated that the ten above mentioned dates had been identified as sexual abuse and confirmed that only two out of the ten sexual abuse incidents had been reported to the Director. The DOC confirmed that the two submissions had been submitted late and not immediately as required by the legislation as follows:

-An identified CIS had been submitted to MOHLTC Director on an identified date and time, the witnessed incident of abuse had occurred two days prior.

-An identified CIS had been submitted to the MOHLTC Director on an identified date and time, and the witnessed incident of abuse had occurred three days prior.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

Resident #021 was admitted to the home on an identified date in 2014. From the time of the resident's admission, there have been 10 incidents of abuse towards co residents. A review of the CIS submissions to the MOHLTC Director, only two of the 10 incidents had been reported and had been reported late and not immediately as required. Interviews with direct care staff revealed that with any incident of abuse, the incident is to be documented in Point Click Care (PCC) in order to be reviewed by the DOC or ADOC.

The scope of the non-compliance is widespread.

A review of the compliance history revealed the following non-compliance related to the Long-Term Care Homes Act, 2007, c.8. s. 24 (1).: A voluntary plan of correction (VPC) was previously issued for section 24 (1) during a Resident Quality Inspection on May 04, 2015, under Inspection #2015_334565_0009.

(202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 29, 2016

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

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 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 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 17th day of May, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Valerie Johnston

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