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 sions 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 18, 2016	2016_391603_0006	000823-14	Critical Incident System

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

BRADFORD VALLEY
2656 6th Line Bradford ON L3Z 3H5

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

SYLVIE LAVICTOIRE (603), LINDSAY DYRDA (575), TIFFANY BOUCHER (543)

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): March 7-11, 14-18, 2016

This Critical Incident inspection is related to 12 critical incidents (Log #000823-14, 005077-14, 007492-14, 005554-15,024406-15, 027342-15, 030432-15, 032033-15, 032502-15, 002369-16, 022503-15, 035908-15) the home submitted related to allegations of abuse to a resident.

A complaint inspection related to 20 complaints submitted to the Director regarding the care of residents, allegations of abuse to a resident and failure to comply, was conducted concurrently with this inspection. For details, see inspection #2016_391603_0005.

During the course of the inspection, the inspector(s) directly observed the delivery of care and services to residents, resident to resident interactions, conducted a tour of resident home areas, reviewed resident health care records, reviewed various home policies, procedures, and programs, and reviewed staff education attendance records.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Director of Programs/Admissions, Director of Environmental Services, Pharmacist, Director of Dietary Services, Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI)-Coordinator, Human Resources Manager, Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Physiotherapist, Physiotherapist Assistants, Housekeeping Staff, Food Service Assistants, Residents, and Family Members.

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

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

6 WN(s)
4 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. 6. Plan of care

Specifically failed to comply with the following:

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 resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan was not effective.

Inspector #603 reviewed a Critical Incident Report (CI) submitted to the Director. The CI indicated that on a certain date, resident #025 struck resident #024 because resident #024 was bothering resident #025. Resident #024 sustained an injury.

A review of resident #024's care plan revealed that they independently wheeled themself in their wheelchair, on the unit. They would wander and staff were to encourage them to wander/wheel themself on the unit, within specified boundaries. These specified boundaries were not identified.

Inspector #603 reviewed resident #024's progress notes. On three different dates, resident #024 repeatedly wandered towards resident #025. On these three dates, an altercation broke out between resident #024 and #025, leading to resident #025 striking out at resident #024. Finally, on a certain date, resident #025 struck resident #024, causing an injury.

An interview with RPN #131 revealed that resident #024 had a tendency to wander towards resident #025 and make noise around them. The staff had to watch resident #024 closely and keep them away from the resident #025. RPN #131 later explained that "We try and monitor resident #024 as best as we can with the staff that we have, unfortunately, we can't watch them all the time". [s. 6. (10) (c)]

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. 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 and free from neglect by the licensee or staff.

The Long-Term Care Homes Act, 2007, defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

Inspector #543 reviewed a Critical Incident Report(CI) submitted to the Director. The CI was related to alleged staff to resident abuse. According to the CI, a staff member was rough with residents in the home.

Inspector #543 reviewed the home's internal investigation related to the alleged staff to resident abuse that occurred on the specific date. Documentation revealed that the home was unable to conclusively determine that the staff member was rough with residents in the home.

A review of the staff member's personnel file, revealed a significant pattern of performance concerns in relation to allegations and actual incidents of staff to resident abuse and/or neglect and compromising residents safety.

In an interview with the Administrator and the Director of Care, they stated that the staff member was terminated on a specific date. However, their employment was reinstated, as a result of the home not following the Collective Agreement's timelines.

In summary, the staff member received numerous disciplinary measures related to poor performance yet remains an employee in the home. As a result, residents were not protected from abuse and/or neglect by the licensee. [s. 19. (1)]

2. Inspector #603 reviewed a Critical Incident Report(CI) submitted to the Director. The CI indicated that on a certain date, resident #025 struck resident #024 because resident #024 bothered resident #025. Resident #024 sustained an injury.

A review of resident #024's care plan revealed that they independently wheeled themself in their wheelchair, on the unit. Resident #024 would wander and staff were to encourage them to wander/wheel themself on the unit, within specified boundaries. These specified boundaries were not identified.

Inspector reviewed resident #024's progress notes. On three different dates, resident #024 repeatedly wandered towards resident #025. On these three dates, altercations broke out between resident #024 and #025. Finally on one specific date, resident #025 struck resident #024, causing an injury.

An interview with RPN #131 revealed that resident #024 had a tendency to wander towards resident #025 and make noise around them. The staff had to monitor resident #024 closely and keep them away from resident #025. RPN #131 later explained that "We try and monitor resident #024 as best as we can with the staff that we have, unfortunately, we can't watch them all the time". [s. 19. (1)]

3. The Long-Term Care Homes Act, 2007, defines the meaning of neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Inspector #603 reviewed a Critical Incident Report(CI) submitted to the Director. The CI indicated that on a certain date, resident #014 was sitting in the dining room and stood up to walk with their walker. When they started to walk, the bar of the walker unlatched and the resident fell on the floor, hitting their face, and sustained an injury.

A review of the resident's progress notes revealed that earlier, on that day, PSW #114 reported to RN #115 that the walker had a broken piece (curbed part of the front bar). Both PSW #114 and RN #115 allowed the resident to continue using the walker even

though, the bar was broken. At the end of their day shift, RN #115 reported the broken walker to the oncoming RN #116, who was going to make a report to maintenance to have it fixed. The resident continued to use the walker until they fell and sustained an injury.

An interview with ADOC #106 revealed that the staff should have removed the resident's walker until it was fixed. ADOC #106 also explained that since this CI, the home had inserviced all staff regarding the proper usage of the walkers and this included, adding an walker checklist for every time a resident would use it.

A review of the inservicing revealed that up to the inspection dates, only 41% of the staff had been inserviced on usage of walkers. [s. 19. (1)]

4. The Long-Term Care Homes Act, 2007, defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident. Physical abuse is described as the use of physical force by anyone other than a resident that causes physical injury or pain.

Inspector #543 reviewed a Critical Incident Report(CI) submitted to the Director. The CI related to alleged staff to resident abuse when resident #020 was grabbed by a staff member and resident #021 was heard yelling down the hall, that the same staff allegedly bit them.

Inspector #543 reviewed the home's critical incident report for each resident and the following was described:

Resident #020: At an approximate time, a nurse saw the resident was struggling with a certain staff member. Resident appeared to be trying to get away from the staff member. The staff member was grabbing the resident. The nurse ran out to stop the attending staff member. The staff member stated that they were trying to get resident take their walker, but the resident refused. The nurse instructed the staff member not to force the resident and noted the resident as being tearful.

Resident #021: A nurse heard screaming from the hallway and went to resident #021's room. The nurse saw a certain staff member with the resident in the dark, with no light on. The nurse went to the resident and tried to calm them down. The resident indicated that they were hurt and that they wanted a doctor. The nurse noted a new bruise on a

specific body part of the resident.

Inspector reviewed the home's internal investigation related to alleged abuse towards residents #020 and #021 and documentation revealed the following:

1. The nurse stated that they observed a staff member grab resident #020, at that time, the nurse went to the staff member and told them not to force the resident. The nurse observed the resident pulling away from the staff member. After the incident, the nurse identified a bruise to the resident's specific body part.

2. A nurse stated that they were notified of an alleged abuse of two residents by the same staff. The nurse did a head to toe assessment on both residents and observed that resident #020 was visibly upset and crying and resident #021 stated that the staff member had bitten them.

3. The nurse stated that resident #021 was agitated and observed an injury that was bluish in colour.

Inspector #543 reviewed resident #020’s skin assessment completed after the incident of alleged abuse which indicated that the resident had another bruise to another part of the body.

Inspector #543 reviewed resident #021’s skin assessment completed after the incident of alleged abuse which indicated that the resident had a bruise to a part of the body.

The home's internal investigation related to two alleged incidents of staff to resident abuse determined that the staff member had inappropriate interactions with residents. In an interview with the Administrator, they confirmed that a written warning was served to this staff member confirming that they had inappropriate interactions with residents. They stated that "inappropriate interactions" indicated that they were unable to substantiate that abuse had occurred. [s. 19. (1)]

5. Inspector #603 reviewed a Critical Incident Report (CI) submitted to the Director. The CI revealed that resident #023 displayed inappropriate sexual behaviours towards 3 different residents. Resident #023 was aggressive and struck staff who were intervening. The resident was sent to the hospital accompanied by police officers. According to the CI, there were no ill effects to the residents involved.

A review of the resident's health care records revealed that the resident had a history of inappropriate sexual behaviours with other residents on two different dates, and 2 other incidents with sexual remarks towards staff on two different dates.

A review of the resident's care plan revealed a focus for inappropriate sexual behaviour. The staff were to reduce incidents of inappropriate sexual behaviours and protect other residents who are unable to protect themselves. The care plan offered no interventions for these goals.

An interview with ADOC #106 confirmed that the care plan had no interventions to reduce incidents of inappropriate sexual behaviours and protect other residents who were not able to protect themselves. [s. 19. (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 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 that the licensee knows of, or that is reported 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.

Inspector #575 reviewed a Critical Incident Report (CI) submitted to the Director. The CI alleged resident to resident abuse when resident #017 entered resident #018's room, became angry and pushed resident #018, causing the resident to fall and sustain an injury. The incident was not witnessed.

The Inspector requested the results of the investigation of the alleged incident, however, the DOC indicated that no investigation was completed. [s. 23. (1) (a)]

2. Inspector #603 reviewed a Critical Incident Report (CI) sumbitted to the Director. The CI indicated that on a certain date, resident #023 was found inappropriately touching resident #029 and asked for kisses from resident #012 and resident #028. Resident #023 was then seen walking while holding resident #028's hand. When staff intervened, resident #023 struck the staff, who then called 911. The resident was then transferred to the hospital for assessment and returned with a change in medication.

A review of resident #023's health records revealed no investigation notes for the CI. An interview with ADOC #106 confirmed that there was no investigation completed for the incident involving resident sexual abuse.

A review of the home's current Prevention of Abuse & Neglect of a Resident Policy #VII-G-10.00 revealed that with any knowledge of an incident that constitutes resident abuse, the ED/Administrator or designate, at the time of immediate notification by staff, will initiate the investigation by requesting written statements from anyone aware or involved in the situation, interview the residents, or persons who may have knowledge of the situation, and all investigation information would be kept in a separate report from the resident's record. [s. 23. (1) (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 ensuring that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated. This includes abuse of a resident by anyone, neglect of a resident by the licensee or staff, or anything else provided for in the regulations, to be implemented voluntarily.

WN #4: 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 factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations.

Inspector #603 reviewed a Critical Incident Report (CI) submitted to the Director. The CI indicated that resident #025 struck resident #024 because resident #024 had bothered resident #025. Resident #024 sustained an injury.

During the inspection, Inspector observed resident #025 laying in their bed. Resident #024 was in the hallway, close by resident #025's room and there was no staff in the vicinity.

A review of resident #025's progress notes revealed increased behaviours towards resident #024 on three different dates, leading to another date where resident #025 struck resident #024.

A review of resident #025's care plan revealed no specific triggers or interventions such as close monitoring related to resident #024 who had a history of bothering resident #025 leading to altercations between the two residents.

An interview with PSW #127 confirmed that resident #024 had a history of "annoying" resident #025 and ADOC #103 explained that the home had decided that it was best to move resident #025 to another unit, however, this was still not done. [s. 54. (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 ensuring that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff received annual retraining related to the home's policy to promote zero tolerance of abuse and neglect of residents.

Inspector #543 reviewed the home's tracking sheets related to annual retraining for the home's policy Prevention of Abuse & Neglect of a Resident. The Inspector identified that only 97.93% of staff completed retraining for year 2015.

Inspector interviewed the Administrator regarding the home's tracking sheets for annual retraining related to their abuse policy who confirmed that only 97.93% completed training for the year 2015.

In an interview with the Administrator and Director of Care, they explained that the home offered a lot of education related to the prevention of abuse to residents. They also confirmed that the annual retraining was an expectation of all staff. [s. 76. (4)]

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 ensuring that all staff receive annual retraining relating to the home's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff receive the required Responsive Behaviour training annually.

Inspector #603 reviewed the home's audit for annual training on Responsive Behaviour for 2015. The audit revealed that only 85.47% of all staff received the required training.

An interview with the Administrator confirmed that the total amount of direct care staff who received the annual Responsive Behaviour training was only 85.47%. [s. 221. (2)]

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 ensuring that all direct care staff receive the required Responsive Behaviour annual retraining, to be implemented voluntarily.

Issued on this 19th day of May, 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 sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SYLVIE LAVICTOIRE (603), LINDSAY DYRDA (575), TIFFANY BOUCHER (543)
Inspection No. / No de l'inspection :	2016_391603_0006
Log No. / Registre no:	000823-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 18, 2016
Licensee / Titulaire de permis :	The Royale Development GP Corporation as general partner of The Royale Development LP 302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	BRADFORD VALLEY 2656 6th Line, Bradford, ON, L3Z-3H5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LUANNE CAMPEAU

To The Royale Development GP Corporation as general partner of The Royale Development LP, 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) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall ensure that resident #024 is reassessed and her plan of care reviewed and revised to reflect her care needs including but not limited to her safety.

The licensee shall also review the new plan of care in 2 weeks and then again at any other time when the care set out in the plan has not been effective.

Grounds / Motifs :

1. 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 the care set out in the plan was not effective.

Inspector #603 reviewed a Critical Incident Report (CI) submitted to the Director. The CI indicated that on a certain date, resident #025 struck resident #024 because resident #024 was bothering resident #025. Resident #024 sustained an injury.

A review of resident #024's care plan revealed that they independently wheeled themself in their wheelchair, on the unit. They would wander and staff were to encourage them to wander/wheel themself on the unit, within specified boundaries. These specified boundaries were not identified.

Inspector #603 reviewed resident #024's progress notes. On three different dates, resident #024 repeatedly wandered towards resident #025. On these three dates, an altercation broke out between resident #024 and #025, leading to resident #025 striking out at resident #024. Finally, on a certain date, resident #025 struck resident #024, causing an injury.

An interview with RPN #131 revealed that resident #024 had a tendency to wander towards resident #025 and make noise around them. The staff had to watch resident #024 closely and keep them away from the resident #025. RPN #131 later explained that "We try and monitor resident #024 as best as we can with the staff that we have, unfortunately, we can't watch them all the time".

The decision to issue this compliance order was based on the scope which showed a pattern, the severity which indicated actual harm, and the compliance history which showed previous non-compliance in similar areas of the legislation.

(603)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit, and implement a plan for ensuring that every resident in the home, is protected from abuse by anyone. The plan shall address, but is not limited to the following:

1. That the plan of care for resident #014 and #024 are reviewed and updated with clear directions for managing these resident's wandering behaviours.
2. That the plan of care for resident #025 is reviewed and updated with clear directions for managing this residents' responsive behaviours.
3. The home must keep appropriate documentation with every incident of resident abuse involving anyone.
4. Retraining for all staff on the home's policy to promote zero tolerance of abuse and neglect of residents.
5. Continuous monitoring of the above steps to ensure that the plan is relevant if/when contributing factors change.

This plan shall be submitted in writing to Sylvie Lavictoire, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564 3133 or email sylvie.lavictoire@ontario.ca. This plan must be submitted by June 1, 2016, with full compliance by June 15, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Inspector #603 reviewed a Critical Incident Report (CI) submitted to the Director.

The CI revealed that resident #023 displayed inappropriate sexual behaviours towards 3 different residents. Resident #023 was aggressive and struck staff who were intervening. The resident was sent to the hospital accompanied by police officers. According to the CI, there were no ill effects to the residents involved.

A review of the resident's health care records revealed that the resident had a history of inappropriate sexual behaviours with other residents on two different dates, and 2 other incidents with sexual remarks towards staff on two different dates.

A review of the resident's care plan revealed a focus for inappropriate sexual behaviour. The staff were to reduce incidents of inappropriate sexual behaviours and protect other residents who are unable to protect themselves. The care plan offered no interventions for these goals.

An interview with ADOC #106 confirmed that the care plan had no interventions to reduce incidents of inappropriate sexual behaviours and protect other residents who were not able to protect themselves. (603)

2. The licensee has failed to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

The Long-Term Care Homes Act, 2007, defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident. Physical abuse is described as the use of physical force by anyone other than a resident that causes physical injury or pain.

Inspector #543 reviewed a Critical Incident Report(CI) submitted to the Director. The CI related to alleged staff to resident abuse when resident #020 was grabbed by a staff member and resident #021 was heard yelling down the hall, that the same staff allegedly bit them.

Inspector #543 reviewed the home's critical incident report for each resident and the following was described:

Resident #020: At an approximate time, a nurse saw the resident was struggling

with a certain staff member. Resident appeared to be trying to get away from the staff member. The staff member was grabbing the resident. The nurse ran out to stop the attending staff member. The staff member stated that they were trying to get resident take their walker, but the resident refused. The nurse instructed the staff member not to force the resident and noted the resident as being tearful.

Resident #021: A nurse heard screaming from the hallway and went to resident #021's room. The nurse saw a certain staff member with the resident in the dark, with no light on. The nurse went to the resident and tried to calm them down. The resident indicated that they were hurt and that they wanted a doctor. The nurse noted a new bruise on a specific body part of the resident.

Inspector reviewed the home's internal investigation related to alleged abuse towards residents #020 and #021 and documentation revealed the following:

1. The nurse stated that they observed a staff member grab resident #020, at that time, the nurse went to the staff member and told them not to force the resident. The nurse observed the resident pulling away from the staff member. After the incident, the nurse identified a bruise to the resident's specific body part.

2. A nurse stated that they were notified of an alleged abuse of two residents by the same staff. The nurse did a head to toe assessment on both residents and observed that resident #020 was visibly upset and crying and resident #021 stated that the staff member had bitten them.

3. The nurse stated that resident #021 was agitated and observed an injury that was bluish in colour.

Inspector #543 reviewed resident #020's skin assessment completed after the incident of alleged abuse which indicated that the resident had another bruise to another part of the body.

Inspector #543 reviewed resident #021's skin assessment completed after the incident of alleged abuse which indicated that the resident had a bruise to a part of the body.

The home's internal investigation related to two alleged incidents of staff to

resident abuse determined that the staff member had inappropriate interactions with residents. In an interview with the Administrator, they confirmed that a written warning was served to this staff member confirming that they had inappropriate interactions with residents. They stated that "inappropriate interactions" indicated that they were unable to substantiate that abuse had occurred. (603)

3. The licensee has failed to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

The Long-Term Care Homes Act, 2007, defines the meaning of neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Inspector #603 reviewed a Critical Incident Report(CI) submitted to the Director. The CI indicated that on a certain date, resident #014 was sitting in the dining room and stood up to walk with their walker. When they started to walk, the bar of the walker unlatched and the resident fell on the floor, hitting their face, and sustained an injury.

A review of the resident's progress notes revealed that earlier, on that day, PSW #114 reported to RN #115 that the walker had a broken piece (curbed part of the front bar). Both PSW #114 and RN #115 allowed the resident to continue using the walker even though, the bar was broken. At the end of their day shift, RN #115 reported the broken walker to the oncoming RN #116, who was going to make a report to maintenance to have it fixed. The resident continued to use the walker until they fell and sustained an injury.

An interview with ADOC #106 revealed that the staff should have removed the resident's walker until it was fixed. ADOC #106 also explained that since this CI, the home had inserviced all staff regarding the proper usage of the walkers and this included, adding an walker checklist for every time a resident would use it.

A review of the inservicing revealed that up to the inspection dates, only 41% of the staff had been inserviced on usage of walkers. (603)

4. The licensee has failed to ensure that residents are protected from abuse by

anyone and free from neglect by the licensee or staff in the home.

Inspector #603 reviewed a Critical Incident Report(CI) submitted to the Director. The CI indicated that on a certain date, resident #025 struck resident #024 because resident #024 bothered resident #025. Resident #024 sustained an injury.

A review of resident #024's care plan revealed that they independently wheeled themself in their wheelchair, on the unit. Resident #024 would wander and staff were to encourage them to wander/wheel themself on the unit, within specified boundaries. These specified boundaries were not identified.

Inspector reviewed resident #024's progress notes. On three different dates, resident #024 repeatedly wandered towards resident #025. On these three dates, altercations broke out between resident #024 and #025. Finally on one specific date, resident #025 struck resident #024, causing an injury.

An interview with RPN #131 revealed that resident #024 had a tendency to wander towards resident #025 and make noise around them. The staff had to monitor resident #024 closely and keep them away from resident #025. RPN #131 later explained that "We try and monitor resident #024 as best as we can with the staff that we have, unfortunately, we can't watch them all the time". (603)

5. The licensee has failed to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

The Long-Term Care Homes Act, 2007, defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

Inspector #543 reviewed a Critical Incident Report(CI) submitted to the Director. The CI was related to alleged staff to resident abuse. According to the CI, a staff member was rough with residents in the home.

Inspector #543 reviewed the home's internal investigation related to the alleged staff to resident abuse that occurred on the specific date. Documentation revealed that the home was unable to conclusively determine that the staff member was rough with residents in the home.

A review of the staff member's personnel file, revealed a significant pattern of performance concerns in relation to allegations and actual incidents of staff to resident abuse and/or neglect and compromising residents safety.

In an interview with the Administrator and the Director of Care, they stated that the staff member was terminated on a specific date. However, their employment was reinstated, as a result of the home not following the Collective Agreement's timelines.

In summary, the staff member received numerous disciplinary measures related to poor performance yet remains an employee in the home. As a result, residents were not protected from abuse and/or neglect by the licensee.

The decision to issue this compliance order was based on the scope which was isolated, the severity which indicated actual harm/risk and the compliance history which had previous unrelated non compliance. (543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 15, 2016

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 sions 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 sions 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 18th day of May, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sylvie Lavictoire

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