Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 28, 2022	2022_946111_0008	014545-21, 014664-21, 017861-21, 019392-21, 000059-22, 001211-22, 001335-22, 001393-22, 001394-22, 001395-22, 001396-22, 001397-22, 001398-22, 001907-22, 002079-22, 003084-22, 003783-22	Critical Incident System

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue Woodstock ON N4S 3V9

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

Caressant Care Lindsay Nursing Home
240 Mary Street West Lindsay ON K9V 5K5

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

LYNDA BROWN (111), BRITNEY BARTLEY (732787), CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 14 to 18, 21 to 22, 2022.

The following critical incident (CI) inspections were completed concurrently during this inspection:
-CI related to an unexpected death.
-Three CI's related to falls with an injury for which the resident was taken to hospital
-Four CI's related to alleged staff to resident abuse and/or neglect.
-Three CI's related to responsive behaviours.
-CI related to missing/unaccounted controlled substances.
-CI related to a disease outbreak.

Follow-up (F/U) inspections to Compliance Orders were also completed concurrently during this inspection:
-F/U related to labelling of personal items.
-F/U related to proper positioning during meal times.
-F/U related to following one of the home's policies.
-F/U related to continence care products.
-F/U related to duty to protect residents from abuse and/or neglect.
-F/U related to infection, prevention and control (IPAC) practices.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Assistant Director of Care (ADOC), Environmental Services Manager (ESM), maintenance staff, Resident care Coordinator (RCC), Scheduler, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping (HSK) and residents.

During the course of the inspection, the inspector(s): toured the home, observed meal service, reviewed resident health records, staff training records, reviewed IPAC audits, screening and testing records, maintenance logs, staff records, home's investigations, and the following policies: Infection prevention and control (IPAC), Suicide, Preventative Maintenance procedures/schedules, Zero Tolerance of Abuse and Neglect, continence care, medication management policies, public health line listing, medication incidents and falls prevention management.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Infection Prevention and Control
Medication
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **21 WN(s)**
- **11 VPC(s)**
- **4 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #003	2021_673672_0040	194
O.Reg 79/10 s. 229. (4)	CO #003	2021_673672_0039	111
O.Reg 79/10 s. 37. (1)	CO #002	2021_673672_0039	111
O.Reg 79/10 s. 73. (1)	CO #001	2021_673672_0040	111
LTCHA, 2007 S.O. 2007, c.8 s. 91. (1)	CO #001	2021_673672_0039	111

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

WN #1: The Licensee has failed to comply with 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).

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse by resident #004 towards other residents, was immediately investigated.

Three residents had complained to staff that resident #004 had alleged abused them. The Administrator confirmed that there was no immediate investigation into the incidents to determine whether or not the incidents were confirmed as abuse, despite submitting a report to the Director as such. Failing to immediately investigate the suspected abuse minimizes the ability of the home to obtain concise and accurate information related to the abuse.

Source: CI and interview with staff.

2. The licensee has failed to ensure that every suspected incident of staff to resident #001 neglect, that was reported, was immediately investigated.

A PSW reported to an RN, a suspected incident of staff to resident #001 neglect. The RN reported the allegation to the manager. The DOC provided the Inspector with an investigation that had not occurred until a number of weeks after the allegation was

reported. Failing to immediately investigate an allegation of staff to resident neglect increased the risk for resident harm.

Source: CI, clinical health records of resident #001 and interview with staff.

3. The licensee failed to ensure that every alleged incident of staff to resident #002 neglect, was immediately investigated.

The home reported an alleged staff to resident neglect incident involving resident #002. The Administrator confirmed that there was no investigation completed into the incident. Failing to immediately investigate an allegation of neglect of care for resident #002, placed the resident at additional risk of neglect.

Source: CI, health records for resident #002 and interview with staff.

4. The licensee has failed to ensure that the results of the alleged resident to resident abuse investigation involving resident #004 were reported to the Director.

The home reported to the Director suspected abuse by resident #004 towards a number of residents and the results of the abuse investigation were not provided to the Director. The Administrator confirmed that the results of the investigation had not been reported to the Director. There is minimal risk to the resident for results of the abuse investigation not being reported to the Director.

Source: CI, health records for a number of residents and interview with staff.

5. The licensee has failed to ensure that the results of an alleged staff to resident #001 neglect investigation were reported to the Director.

The home reported an allegation of staff to resident neglect involving resident #001 and the report to the Director did not provide the results of the investigation. The Administrator confirmed that the results of the investigation had not been reported to the Director. There is minimal risk to the resident for results of the neglect investigation not being communicated to the Director.

Source: CI and interview with staff.

6. The licensee failed to ensure that the results of the alleged staff to resident #002

neglect investigation was reported to the Director.

A report was submitted to the Director for an alleged staff to resident neglect incident involving resident #002 and the report did not include the results of the investigation. The Administrator confirmed that the results of the homes investigation concluded that the allegations of neglect of resident #002 were founded and the results had not been provided to the Director. There was minimal risk to the resident for results of the neglect investigation not being reported to the Director.

Source: CI and interview with staff.

Additional Required Actions:

CO # - 001, 003 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 :

The licensee has failed to ensure that the person who had reasonable ground to suspect abuse of a number of residents by resident #004 were immediately reported to the Director.

There was an alleged resident to resident abuse by resident #004 toward a number of residents that was not reported to the Director until 24 hours later.. The DOC and the Administrator both confirmed that the incident was not immediately reported to the Director. There is minimal risk to the resident for the home failing to immediately report the suspicion of sexual abuse to the Director.

Source: CI and interview with staff.

2. The licensee has failed to ensure that the person who had reasonable ground to suspect that neglect of resident #001 by the licensee or staff that resulted in harm or a risk of harm to the resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A PSW reported an incident of suspected staff to resident #001 neglect to an RN, who reported the allegation to the DOC. The DOC confirmed that they had forgotten to notify the Director until a number of days later. Failing to immediately report an allegation of neglect of a resident, increases the risk of neglect to continue.

Sources: CI and interview with staff.

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure the pain policy was complied with for resident #013.

A compliance order (CO) under report #2021_673672_0040 was issued for LTCHA, 2007 s. 8(1)(b) on January 20, 2022 and the order was to be complied with on February 28, 2022. This incident occurred prior to the compliance due date.

Under O.Reg. 79/10, s.51(1)2, the home was required to have a pain management program developed and implemented in the home that identified and managed pain in residents.

Pain Management Program Policy indicated the Registered staff would initiate a 72-hour pain monitoring tool (including methods for residents unable to self-report pain) and if pain was noted, an electronic pain assessment tool would be completed. The registered staff were to also develop a care plan using the pain assessment results, along with pharmacological and non-pharmacological interventions.

Two RPNs had discovered that resident #013 was missing their narcotic pain medication and there was no documented evidence to indicate the resident was reassessed for pain until a number of days later. The resident also had their pain medications increased a number of times and there were no other pain assessments completed. There was also no written plan of care related to pain developed until a number of months later. An RPN confirmed that all residents were to be assessed with a pain assessment tool at specified times, using specified pain assessment tools and confirmed the appropriate pain assessments were not being completed for resident #013, despite the resident having pain, when the resident was found missing the narcotic pain medication and when the their pain medications were increased. They were unaware that the resident had not

had written care plan for pain until a number of months later. Failing to ensure the pain policy is complied with for resident #013 may result in the resident having pain unmanaged.

Sources: CI, health record of resident #013, observations of resident #013, Pain Management Program Policy and interview of staff.

2. The licensee has failed to ensure that a specified responsive behaviour policy was complied with for resident #014.

A compliance order (CO) under report #2021_673672_0040 was issued for LTCHA, 2007 s. 8(1)(b) on January 20, 2022 and the order was to be complied with on February 28, 2022. This incident occurred prior to the compliance due date.

Under O.Reg. 79/10, s. 55(a) procedures and interventions were to be developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours.

Resident #014 was admitted to the home with a history of specified responsive behaviours. The resident continued to demonstrate those high risk responsive behaviours on a number of dates. The BSO confirmed they were aware of the residents previous history with the specified responsive behaviours, they had notified the physician, completed a referral to Ontario Shores and new medication changes were ordered. The psycho geriatric referral completed for the resident recommended the staff have increased monitoring of the resident due to the high risk responsive behaviours and additional interventions to protect the resident which were implemented for a short period of time. The resident continued to demonstrate the high risk responsive behaviour a number of times after the interventions were discontinued and a follow up from the psycho geriatric referral completed with additional interventions added. items. The resident continued to demonstrate those high risk responsive behaviours on a number of dates and the had an incident that resulted in a near miss injury to the resident and the resident was not placed on increased monitoring and was not transferred to hospital for assessment until the following day, as required by the home's policy. The home was to complete a suicide risk assessment tool (SRAT) upon admission for all residents with a known history, upon a resident expressing desire to commit suicide, and upon return from a psychiatric leave for suicide attempt. The residents care plan was also to be updated based on the SRAT. When the resident has vocalized or attempted suicide, the staff were to immediately notify the DOC and/or ED, immediately investigate, complete

the suicidal intervention checklist and implement any safety measures. If the resident attempted suicide, the staff were to call 911.The resident's plan also directed staff to refer to a social worker as needed. RPN #129 confirmed they had not completed any SRAT when the resident had express suicidal thoughts and indicated there were no SRAT ever completed for the resident and were not available on PCC to complete. The RPN also indicated no awareness of the home’s policy at the time related to suicide. RPN #119 no longer worked in the home. RPN #104 (BSO) confirmed the resident was not immediately transferred to hospital following a suicide attempt until the next day and should have been. They also confirmed that no SRAT or suicide intervention checklist had been completed for the resident. There was also no indication that the social worker had been contacted. Failing to follow the home's suicide policy for resident #014, who had previous history of expressed and demonstrated suicide, resulted in a suicide attempt and may lead to further incidents of self harm.

Sources: CI, health record for resident #014, the home's policy on a specified responsive behaviour and interview of staff.

3. The licensee has failed to ensure that their secified responsive behaviour policy had been complied with for resident #017.

A compliance order (CO) under report #2021_673672_0040 was issued for LTCHA, 2007 s. 8(1)(b) on January 20, 2022 and the order was to be complied with on February 28, 2022.

Under O.Reg. 79/10, s. 55(a) procedures and interventions were to be developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours.

Resident #017 had a prior history of a specified responsive behaviour. The resident also demonstrated other responsive behaviours that placed other residents and staff at risk for harm or injury, including resident #018. There were a number of incidents when resident #0017 had displayed the specified repsonsive behaviour towards resident #018 before the resident was relocated. On a specified date, the resident had reported they had displayed a specified responsive behaviour and no further actions were taken as the incident was not witnessed. On another specified date, the resident was found by a PSW displaying the same specified responsive behaviour that caused a risk for injury to them self, the resident was upset as a result of the incident and was not transferred to hospital for an assessment until the following day. The day after the resident returned from

hospital, the resident was relocated to an area of the home where they could be closely monitored and other safety interventions were implemented. A number of days later, the resident again demonstrated the specified behaviour, the physician was notified, discouraged the staff from transferring the resident to hospital and recommended calling the police instead. Later the same day, the resident's responsive behaviours became unmanageable and the police were not called. The resident was placed on increased monitoring for the remainder of the shift. The following day, the BSO staff determined the resident had an infection, notified the doctor who ordered an antibiotic and indicated that increased monitoring of the resident would only be used as needed. A few days later, the resident was given a device that placed them at risk for injury, despite the residents risk for injury and were not to be provided to the resident. A number of days later, the resident began demonstrating responsive behaviours towards a staff member that caused an injury to the staff member and the police were not called. The resident was placed on increased monitoring at that time and was then later discovered demonstrating a responsive behaviour that caused an injury to the resident, with the use of the device that was provided to the resident. The resident was transferred to hospital at that time. The home's specified responsive behaviour policies indicated that staff were to call the police when the resident's responsive behaviours became violent or unamangeable and was not implemented when this occurred towards resident #018 and other staff. The resident also displayed another ongoing responsive behaviours that placed them at risk for self injury and the policies strategies to be used where not implemented. An RPN and the BSO staff confirmed the specified policies had not been implemented in the home and strategies that were identified to be used to manage those responsive behaviours were inconsistently used. Failing to ensure the home's responsive behaviour policies were complied with to address the residents risk for injury towards other residents and staff, and towards them self, placed resident #017, resident #0018 and staff at risk for injury and harm.

Sources: CI, health record of resident #017 and #018, observation and interview of resident #017, home's responsive behaviour policies, and interview of staff.

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The licensee failed to ensure that the written plan of care for resident #002 set out clear directions to staff and others who provide direct care to the resident related to responsive behaviours, dressing and continence care.

An allegation of staff to resident neglect was reported involving resident #002, and had occurred over a number of days. Two PSWs confirmed resident #002 had been found neglected on a specified date and time. One PSW reported that resident #002 was not provided specified care as required on a specified shift, due to direction from the registered staff. Another PSW reported that they had provided care to resident #002 on a specified date and shift, but was unable to recall if all of the required care was provided. Another PSW reported resident #002 demonstrated responsive behaviours that did not allow the staff to complete their care as required and as per the directions provided by the registered staff due to risk for falls. An RPN confirmed that the staff were encouraged to provide specified care to the resident on specified shifts, to ensure the residents safety and due to complaints of pain. The plan of care did not set out clear directions for resident #002 related to which shift was responsible for ensuring the resident was provided the appropriate care and interventions to be used when the resident demonstrated responsive behaviours, or had pain. Failing to ensure that resident #002's plan of care set out clear direction to staff and others who provide direct care to the resident, resulted in the resident being neglected.

Sources: CI, resident #002's clinical health records and interview with staff.

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

resident #001 as specified in the plan related to continence care.

A PSW was assisting resident #001 with their care and discovered alteration in the residents skin that resulted in pain and treatment. The resident's plan of care set out the care that was to be provided to the resident related to continence care. The electronic documentation completed by the PSWs for a specified period, indicated the resident was not provided with the continence care as indicated in the plan. A staff member confirmed that they had been responsible for resident #001's care on a specified date, was not aware of the residents care requirements related to continence care and had not provided the resident with continence care as set out in the plan. Two additional PSWs also confirmed the resident had not been provided continence care as set out in the residents plan. Failing to ensure that the care set out in the plan was provided as specified, resulted in skin breakdown and pain for resident #001.

Source: CI, resident #001's clinical health record and interview with staff.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written plan of care set out clear directions to staff and others who provide direct care to the resident, and that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with for resident #002.

The home was to ensure that all staff who suspected neglect of care of a resident, were to immediately inform their suspicion to the Registered Nurse (RN) in charge, who will notify the Manager. A PSW reported suspected neglect of resident #002 to an RPN. The RPN confirmed that the PSW reported the alleged neglect of the resident and did not report the allegation to the RN. Failing to immediately report suspected incidents of neglect of care as per the home's policy, increased the risk of further neglect.

Source: CI, the home's prevention of Abuse and Neglect policy and interview with staff.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).
3. The type and level of assistance required relating to activities of daily living. O. Reg. 79/10, s. 24 (2).
4. Customary routines and comfort requirements. O. Reg. 79/10, s. 24 (2).
5. Drugs and treatments required. O. Reg. 79/10, s. 24 (2).
6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions. O. Reg. 79/10, s. 24 (2).
7. Skin condition, including interventions. O. Reg. 79/10, s. 24 (2).
8. Diet orders, including food texture, fluid consistencies and food restrictions. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the admission care plan for resident #007 identified any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks.

Resident #007 was admitted to home and sustained a number of falls within a number of days of admission. Their last fall resulted in an injury for which the resident was transferred to hospital and the resident later died in hospital. The resident admission care plan had no falls interventions to mitigate the risks until after the resident's last fall. An RPN confirmed the resident's admission care plan should have included interventions to prevent falls or mitigate risks associated with falls. Failing to develop an admission care plan for resident #007 with interventions to mitigate risks for falls, placed the resident at further risk for falls and/or injuries.

Sources: CI, clinical record review of resident #007, the home's falls prevention and management policy, and interview with staff.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the admission care plans identify any risks the resident may pose to himself or herself, including any risk of falls, and interventions to mitigate those risks, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

The licensee has failed to ensure that when resident #007 sustained a fall, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Resident #007 sustained an unwitnessed fall and their was no post-fall assessment completed.An RPN confirmed they were working when the resident fell but refused to answer whether they had completed the post-fall assessment. Another RPN confirmed registered staff were to complete the specified electronic post-fall assessment tool after each fall and confirmed there was no post-fall assessment tool completed for a specified date that resident #007 sustained a fall. Failing to complete the clinically appropriate post fall assessment instrument placed resident #007 at risk for an additional falls and injury.

Sources: CI, clinical record of resident #007, the home's falls prevention and management policy, and interviews with staff.

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 when a resident sustains a fall, a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #8: 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,
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

The licensee failed to ensure that there was a range of continence care products available and accessible to resident #015 and staff at all times, and in sufficient quantities for all required changes.

Resident #015's plan of care related to toileting, directed staff to provide the resident with a specified incontinence product to promote continence. A PSW confirmed the resident was to be provided the same specified product, but the home provided them with a different incontinence product. The PSW also indicated that the staff were only allocated

one incontinence product per resident, per shift and any additional products required them to locate the Registered staff and sign for another product. An RPN confirmed that the resident and family had expressed their preference for the use of a specified incontinence product to maintain continence, and confirmed that the specified product was not made available to the resident. The RCC also confirmed that the residents were only provided one incontinence product per shift and resident #015 was supplied with a different incontinence product then as per the residents preference, as the home did not supply any of the specified incontinence product for any of the residents. Failing to provide resident #015, with a range of continence care products and in sufficient quantities for necessary changes reduced the residents ability to maintain continence and may lead to skin breakdown. did not ensure continence care products were available and accessible to residents, which reduced the residents ability to maintain continence and may lead to skin breakdown.

Sources: resident #015's clinical health record, continence product worksheet and interview with staff.

2. The licensee failed to ensure that there was a range of continence care products available and accessible to resident #003 and staff at all times, and in sufficient quantities for all required changes.

Resident #003's plan of care for toileting, directed that the resident required assistance and the use of a specified incontinence product. A PSW reported that the resident required assistance with toileting a number of times per shift, the resident was allocated one incontinence product per shift and any additional products that were required, they had to locate the registered staff on the unit and sign out an additional product. The continence product worksheet indicated that the resident was provided one incontinence product per shift. The RCC confirmed that staff were only provided one incontinence product per resident, per shift. Failing to ensure continence care products were accessible to staff for resident #003, increased the risk of skin breakdown.

Sources: Resident #003's clinical health record, continence product worksheet and interview with staff.

3. The licensee failed to ensure that there was a range of continence care products available and accessible to resident #002 and staff at all times, and in sufficient quantities for all required changes.

Resident #002' plan of care for toileting, directed staff to provide assistance with toileting and the use a specified incontinence product. A PSW reported that the resident was assisted with toileting a number of times per shift. The continence product worksheet indicated that the resident was provided one specified incontinence product per shift and any additional products required locating the registered staff on the unit and signing for an additional product. Failing to ensure continence care products were accessible to staff as required, may result in resident #002 having increased risk of skin breakdown.

Sources: Resident #002's clinical health record, continence product worksheet and interview with staff.

4. The licensee failed to ensure that there was a range of continence care products available and accessible to resident #016 and staff at all times, and in sufficient quantities for all required changes.

Resident #016's plan of care for toileting, directed that the resident was able to perform the task independently and required staff assistance with their specified incontinence product at different times of the day. A PSW confirmed that the resident used the specified incontinence product and the product was available in the clean utility room in the residents room. The continence product worksheet identified that the resident was provided with a different incontinence product that indicated in the plan of care and was provided one per shift. The RCC confirmed that the specified incontinence product identified in the residents plan of care was not provided by the home. Failing to ensure that a range of continence care products were available for resident #016, reduced the resident's ability to maintain their level of continence independently.

Sources: Resident #016's clinical health record, continence product worksheet and interview with staff.

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 there is a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

The license has failed to ensure that resident #007's pain was assessed using a clinically appropriate assessment instrument specifically designed for pain, when their pain was not relieved by initial interventions.

Resident #007 sustained a fall and complained of pain to a specified area. The resident had received routine pain medication but continued to complain of pain for the remainder of the day. The following day, the resident continued to complain of pain to the specified area,the physician was contacted and a new narcotic pain medication was ordered and not administered to the resident until later the same day. The following day, the resident continued to complain of pain to the specified area and the resident was assessed by the Nurse Practitioner (NP) who ordered the resident sent to hospital for assessment, two days after the fall occurred. The resident was diagnosed with an injury to a specified area and subsequently died in hospital. An RN confirmed staff were to use the electronic pain assessment tool as the clinically appropriate assessment tool to assess for pain. Both the RN and an RPN confirmed that no pain assessment tool was completed for resident #007, despite the residents ongoing complaints of pain post fall. Failing to assess resident #007's pain, when their pain was not relived, resulted in the resident having unrelieved pain.

Sources: clinical record review of resident #007 and interviews with staff.

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 when a residents pain in not relieved by initial interventions, the resident is reassessed using a clinically appropriate assessment instrument, specifically designed for pain, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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 :

The licensee shall ensure that for resident #004 who demonstrated responsive behaviours, that strategies were developed and implemented to respond to these behaviours.

Resident #003, #005 and #006 had reported that resident #004 had alleged abused them on a specified date and shift. An RN and a PSW confirmed that resident #004 demonstrated specified responsive behaviours during a specified shift. The plan of care for resident #004 identified that the resident demonstrated the specified responsive behaviour but there were no strategies identified for managing the behaviour when it impacted other residents on a specified shift or another responsive behaviour that they demonstrated placing residents at risk for abuse. Failing to develop and implement strategies to respond to resident #004's responsive behaviours, increased the risk harm and impacted other residents quality of life.

Source: Clinical health record for resident #004 and interview with staff.

2. The licensee failed to ensure that resident #003 who demonstrated responsive behaviours, that strategies were developed and implemented to respond to those behaviours.

Two PSWs reported observing an injury to resident #003’s and suspected staff to resident abuse. Both PSWs then reported the suspected abuse to an RPN. The RPN confirmed that the resident had a history of demonstrating specified responsive behaviours that resulted in injury to them self and the plan of care did not identify strategies that were to be implemented related to this identified responsive behaviour of self harm. Failing to ensure resident #003 who demonstrated responsive behaviours that resulted in injuries to the resident, had strategies developed and implemented to respond to the behaviour, resulted in an injury to the resident that was incorrectly identified as abuse.

Sources: CI, resident #002’s clinical health record and interview with staff.

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 residents who demonstrate responsive behaviours, that strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

The licensee has failed to ensure that the Infection Prevention and Control program include daily monitoring of infections in residents.

The home was declared in a disease outbreak by Public Health (PH). The report to the Director indicated there were a number of confirmed resident cases and a number of resident deaths during the outbreak. The home was requested to provide a their daily surveillance of infections for a specified period prior to outbreak being declared and was not provided. The IPAC lead indicated that the Registered nursing staff were to complete daily surveillance of infections using the specified tool for any residents having symptoms of infection, then submit the surveillance records to the management and/or the IPAC lead to determine if any trends of infections were detected. The IPAC lead later confirmed they were unable to locate the daily surveillance records prior to the outbreak. Failing to complete daily surveillance of infections of residents in the home can resulted in infections being undetected and lead to additional outbreaks of infections.

Sources: CI and interview of staff.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Infection, Prevention and Control program include daily monitoring of infections in residents, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

The licensee failed to ensure that the appropriate police force was immediately notified of an alleged incident of staff to resident abuse, that the licensee suspects may constitute a criminal offence.

There was an allegation of staff to resident abuse towards resident #003, when the resident was found with an injury to a specified area. The incident was reported to the RCC and they confirmed that they did not report the allegations to the police. The home later determined that the allegation was unfounded. Failing to notify police of an allegation of staff to resident abuse, increases the risk of abuse to continue at the home.

Source: CI, resident #003 health record, home's investigation, and interview with staff.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incidents of abuse and or neglect of residents, that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

The licensee has failed to ensure that every medication incident involving resident #013 was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, if any,

the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Two RPNs had discovered at shift change that resident #013 was missing their transdermal narcotic. There was no medication incident report completed for this incident and there was no documented evidence the physician, medical director, the resident's SDM, the pharmacy, or the police were notified. One of the RPNs involved in the incident confirmed no medication incident was completed and they did not inform the resident's for SDM, the physician and/or medical director, the police or the pharmacy. The RPN also confirmed they had no documented evidence that the resident was assessed pain. The DOC also confirmed there was no medication incident report completed that would have notified the pharmacy and any actions taken as required. Failing to complete a medication incident following a missing narcotic for resident #013, may result in further medications incidents as no actions were taken.

Sources: CI, health record for resident #013, home's policy for medication incidents and interview with staff.

2. The licensee failed to ensure that every medication incident involving resident #002 was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

There was an alleged staff to resident #002 neglect incident that included a medication incident, when the residents medications were not administered as prescribed. The DOC and Administrator confirmed that an agency RPN was involved in the medication incident and no longer worked in the home. The medication administration record for resident #002 confirmed the agency RPN had signed for specified medications as given but had not administered the medications, as the medication packaging had not been opened on the specified date. There was no documented assessment of the resident or immediate actions taken. Failing to ensure that every medication incident involving a resident is documented with a record of the immediate actions taken to assess and maintain the resident health, increased the risk of injury to the resident.

Sources: CI, clinical health records of resident #002 and interview with staff.

3. The licensee has failed to ensure that every medication incident involving resident #013 was documented, reviewed and analyzed,, corrective action is taken as necessary,

and a written record kept.

Two RPNs discovered at shift change that resident #013 was missing their transdermal narcotic pain medication. There was no medication incident report completed for this incident and there was no documented evidence the incident was reviewed, analyzed or correct actions taken as necessary. One of the RPns involved in the missing narcotic confirmed there was no medication incident completed for the medication incident that occurred and was not aware of any corrective actions taken. The DOC also confirmed they had no documented medication incident report completed or any corrective actions taken. Failing to document a medication incident, that should be reviewed, analyzed and corrective actions taken, may lead to additional medications incidents involving resident #013.

Sources: CI, health record for resident #013and interview with staff

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 every medication incident involving residents is documented, together with a record of the immediate actions taken to assess and maintain the residents health; and reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the residents attending physician or the registered nurse in the extended class attending the resident and the pharmacy provider, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

The licensee has failed to ensure that staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The home was declared in a disease outbreak by Public Health (PH) on a specified date. The PH line listing identified resident #010, #011 and #012 as placed on isolation on a specified date and only resident #010 was symptomatic. Resident #010's health record had no indication why the resident was placed on isolation, had no indication of any symptoms, which type of precautions were to be used and the family was not informed until a number of days later. The resident was tested positive for the disease outbreak and was not monitored on every shift for the duration that they remained on isolation and had no indication when the isolation was discontinued or if their symptoms were resolved.
The PH line listing indicated resident #011 was placed on isolation and later tested positive for the disease. There was no indication in the residents health record that they were monitored for symptoms of infection until a number of days later. There was no further documentation to indicate the resident was monitored on every shift or when the resident's isolation was discontinued and the resident died a number of days later. . The PH line listing indicated resident #012 was placed on isolation and later tested positive for the disease. There was no indication the in the resident's health record that they were identified as being on isolation until a number of days later, when the test results returned positive. The resident was also not monitored on every shift when placed on isolation and there isolation was discontinued a week later. The IPAC lead confirmed all three residents were placed on isolation on the date identified in the PH line listing, despite the home not being declared in outbreak until the following day. The IPAC lead indicated the expectation was for the Registered nursing staff to document on the residents progress notes every shift, the assessment of the resident for symptoms while on isolation and for the during of the isolation. Failing to monitor residents on each shift for symptoms of infection can lead to symptoms being undetected, residents remaining on isolation unnecessarily and further transmission of infections in the home.

Sources: CI, Public Health Line listing, health records of resident #010, #011 and #012 and interview of staff.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that resident #002 was free from neglect by the staff in the home.

Under s. 5 of O. Reg 79/10, Neglect of care is defined 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 pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A compliance order (CO) under report #2021_673672_0040 was issued for LTCHA, 2007 s. 19(1) on January 20, 2022 and the order was to be complied with on February 1, 2022. This incident occurred prior to the compliance due date.

There was a suspected incident of staff to resident #002 neglect that occurred over a number of days. A number of PSWs confirmed they had suspected the resident had been neglected over a period of days and reported the allegation to an RPN. Two of the PSWs reported that they were directed by the registered staff not to provide specified care to the resident, at specified times, due to the resident's responsive behaviours, risk for falls and pain. One RPN confirmed that they did not report feel that the lack of care reported by PSW #121 on January 29, 2022, was neglect of care and did not report to incident to the RN. The Administrator confirmed the investigation determined the allegation was founded, as resident #002 had been neglected when they had been left in their wheelchair for an extended period and was also not provided their evening medication on January 28, 2022. Failing to ensure that resident#002 was free from neglect of care by staff at the home, resulted in resident #002 not being provided with toileting care, not being administered their medications, and not being provided the opportunity to return to bed.

Source: CI, clinical health record for resident #002 and interviews with staff.

WN #16: 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. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

The licensee has failed to ensure that staff receive training on the home policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities

There were multiple incidents of suspected or alleged abuse of residents by resident #004. An RN and an RPN were involved in the incidents. There were no training records to verify that the same RN or RPN had received training on the home's zero tolerance of abuse and neglect policy. A staff educator confirmed that both of the registered staff involved were agency staff and had not completed the required abuse prevention education prior to performing their responsibilities. Failing to ensure that staff receive training on the home's policy to promote zero tolerance abuse and neglect of residents prior to performing their responsibilities, increases the risk of abuse of residents not being investigated, reported or corrective actions taken to prevent a recurrence.

Source: CI, the home's prevention of abuse and neglect policy and interview with staff.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

The licensee has failed to ensure that the home's prevention of abuse and neglect policy identified the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation, and who will be informed of the investigation.

There were four incidents of alleged abuse submitted to the Director. The home's Zero Tolerance of Abuse and Neglect policy did not provide a manner in which allegations of abuse and neglect would be investigated, including who will undertake the investigation and who will be informed of the investigation, as required. The Executive Director confirmed the policy did not provide the required information. Several of the reported allegations of abuse did not have any investigation completed. Failing to ensure that the home's abuse policy identified the manner for completing abuse and neglect investigations, resulted in several abuse and/or neglect not being investigated and may result in additional abuse and/or neglect of residents.

Sources: four CI's, the home's prevention of abuse and neglect policy, and interview with staff.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the resident and resident's Substitute Decision Maker (SDM) were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

The home reported an alleged staff to resident neglect involving resident #002. The report to the Director indicated that the resident's SDM requested to be informed of the outcome of the investigation but there was no indication that this occurred. There was no documented evidence to indicated the SDM was informed of the results of the investigation upon its completion. The Executive Director and DOC both confirmed the notification to the resident's SDM of the results of the investigation would be indicated in the residents progress notes and confirmed there was no documented evidence this occurred. Failing to notify the resident's SDM of the results of the abuse investigation, results in poor communication with family members.

Sources: CI, clinical health records for resident #002 and interview with staff.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

The licensee has failed to ensure that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it and at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.

Inspector #194 inspected four separate critical incidents related to alleged, suspected or witnessed incidents of abuse and/or neglect. The homes Zero Tolerance of abuse and neglect Policy indicated the Director of Care (DOC) and/or designate, would ensure an analysis of every incident of abuse or neglect of a resident at the home was undertaken after the licensee becomes aware of it. The results would be considered in the annual Program Evaluation. The Program Evaluation template was to be used to identify what changes and improvements were required to prevent further occurrences. Changes and improvements that had been identified would be implemented and documented consistently.

The Administrator confirmed that the home had not been completing an analysis of every incident of abuse and/or neglect that the licensee became aware of and had not completed an annual evaluation for the effectiveness of the policy for prevention of abuse and neglect. Failing to ensure that an analysis of every incident of abuse and neglect was completed, increases the risk of further abuse and failing to ensure that an annual evaluation of the Policy was completed, contributed to incomplete investigations and reporting of abuse and/or neglect. compliance with investigation and reporting process at the home.

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Source:four CI'S, home's policy on prevention of abuse and neglect, and interview with staff.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

The licensee has failed to ensure that the Director was informed of a missing or unaccounted for controlled substance for resident #013 no later than one business day after the occurrence of the incident, followed by the report.

Two RPNs, discovered that resident #013 did not have their transdermal narcotic medication in place as required. There was no after-hours call received regarding the incident and a report was submitted to the Director, five days after the incident occurred. The ED confirmed the Director was notified five days after the occurrence. .

Sources: CI, health record of resident #013 and interview of staff.

2. The licensee has failed to ensure the Director was notified within one business day of an incident that caused an injury to a resident for which the resident was taken to hospital.

Resident #017 had a high risk responsive behaviour incident that resulted in an injury to the resident. The resident was transferred to hospital the following day for assessment. An RN confirmed they had the resident transferred to hospital when they became aware of the resident's incident. Both the RN and the Executive Director confirmed the incident was not reported to the Director.

Sources: health record of resident #017 and interview of staff .

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the medication management written policy for transdermal narcotics was evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Two RPNs discovered that resident #013 did not have their transdermal narcotic medication in place as required. There was no documented evidence the resident was assessed for pain or to indicate the police had been notified. The home's policies on medication incidents and the use of transdermal narcotics did not include that the resident was to be assessed for pain when the transdermal narcotic pain medication was unaccounted for, or indicated that the police were to be immediately notified of the missing or unaccounted for narcotic, as per evidence based practice. The report to the Director indicated the police had been notified, but the report had not been completed until five days after the incident occurred. One of the RPNs involved in the medication incident confirmed they had not documented whether the resident was assessed for pain when they discovered the pain medication was unaccounted for and confirmed they did not report the missing transdermal narcotic to the police, as required. The Executive Director was unable to provide evidence of when the police had been notified of the medication incident involving a missing narcotic.. Failing to ensure written policies are developed and implemented in accordance with evidence-based practices or with prevailing practices, may result in further medication incidents involving missing or unaccounted for narcotics, not being reported to the police and the resident's pain not being managed appropriately.

Sources: CI , health record of resident #013, home's policies, and interview of staff.

Issued on this 6th day of May, 2022

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	LYNDA BROWN (111), BRITNEY BARTLEY (732787), CHANTAL LAFRENIERE (194)
Inspection No. / No de l’inspection :	2022_946111_0008
Log No. / No de registre :	014545-21, 014664-21, 017861-21, 019392-21, 000059-22, 001211-22, 001335-22, 001393-22, 001394-22, 001395-22, 001396-22, 001397-22, 001398-22, 001907-22, 002079-22, 003084-22, 003783-22
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 28, 2022
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, Woodstock, ON, N4S-3V9
LTC Home / Foyer de SLD :	Caressant Care Lindsay Nursing Home 240 Mary Street West, Lindsay, ON, K9V-5K5
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Lisa Green

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To Caressant-Care Nursing and Retirement Homes Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 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. 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;
(b) appropriate action is taken in response to every such incident; and
(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).

Order / Ordre :

The licensee shall comply with LTCHA, 2007, s.23(1)(a).

Specifically, the licensee shall ensure:
1. All alleged, suspected or witnessed incidents of abuse and/or neglect are immediately investigated and a documented record kept of the investigation.
2. All managers to be retrained on their responsibilities related to investigating and reporting requirements of any alleged, suspected or witnessed incidents of abuse and/or neglect, and keep a documented record.

Grounds / Motifs :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse by resident #004 towards other residents, was immediately investigated.

Three residents had complained to staff that resident #004 had alleged abused them. The Administrator confirmed that there was no immediate investigation into the incidents to determine whether or not the incidents were confirmed as abuse, despite submitting a report to the Director as such. Failing to

immediately investigate the suspected abuse minimizes the ability of the home to obtain concise and accurate information related to the abuse.

Source: CI and interview with staff. (194)

2. The licensee has failed to ensure that every suspected incident of staff to resident #001 neglect, that was reported, was immediately investigated.

A PSW reported to an RN, a suspected incident of staff to resident #001 neglect. The RN reported the allegation to the manager. The DOC provided the Inspector with an investigation that had not occurred until a number of weeks after the allegation was reported. Failing to immediately investigate an allegation of staff to resident neglect increased the risk for resident harm.

Source: CI, clinical health records of resident #001 and interview with staff. (194)

3.
3. The licensee failed to ensure that every alleged incident of staff to resident #002 neglect, was immediately investigated.

The home reported an alleged staff to resident neglect incident involving resident #002. The Administrator confirmed that there was no investigation completed into the incident. Failing to immediately investigate an allegation of neglect of care for resident #002, placed the resident at additional risk of neglect.

Source: CI, health records for resident #002 and interview with staff.

A compliance order was considered by taking the following into account:

The severity was a risk of harm to residents when there were three incidents of alleged and/or suspected staff to resident neglect and/or suspected incident of resident to resident abuse by another resident towards three other residents, that were not immediately investigated.

The scope was widespread as there were three out of three incidents of abuse

and /or neglect of residents reviewed that were not immediately investigated.

The compliance history indicated the same subsection was issued to LTCHA, 2007, s.23(2) was issued as a Written Notification (WN) on November 16, 2020. (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2022

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 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 comply with OTCHA, 2007, s. 24(1).

Specifically, the licensee shall ensure that any alleged, suspected or witnessed incidents of abuse and/or neglect are immediately reported to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that the person who had reasonable ground to suspect abuse of a number of residents by resident #004 were immediately reported to the Director.

There was an alleged resident to resident abuse by resident #004 toward a number of residents that was not reported to the Director until 24 hours later.. The DOC and the Administrator both confirmed that the incident was not immediately reported to the Director. There is minimal risk to the resident for the home failing to immediately report the suspicion of sexual abuse to the Director.

Source: CI and interview with staff. (194)

2. The licensee has failed to ensure that the person who had reasonable ground to suspect that neglect of resident #001 by the licensee or staff that resulted in

harm or a risk of harm to the resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A PSW reported an incident of suspected staff to resident #001 neglect to an RN, who reported the allegation to the DOC. The DOC confirmed that they had forgotten to notify the Director until a number of days later. Failing to immediately report an allegation of neglect of a resident, increases the risk of neglect to continue.

Sources: CI and interview with staff.

A compliance order (CO) was issued by taking the following into account:

The severity was a risk of harm to residents when incidents of abuse and/or neglect are not reported to the Director immediately.

The scope was a pattern as there were two out of three incidents of abuse and/or neglect that were inspected that were not immediately reported to the Director.

The compliance history was ongoing non-compliance issued to the same subsection as follows: a Voluntary Plan of Correction (VPC) was issued on June 4, 2019 and November 16, 2020. (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 06, 2022

Order # / No d'ordre : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Order / Ordre :

The licensee is to be compliant with LTCHA, 2007, s. 23(2).

Specifically, the licensee shall ensure:
1. Immediately upon completion of all investigations of alleged, suspected or witnessed incidents of abuse and/or neglect, the results of the investigation are reported to the Director of the conclusion of the investigations to indicate whether they were determined to founded or unfounded, and the reasons for such.
2. All managers to retrained on their responsibilities related to reporting requirements of any alleged, suspected or witnessed incidents of abuse and/or neglect, and keep a documented record.

Grounds / Motifs :

1. The licensee has failed to ensure that the results of the alleged resident to resident abuse investigation involving resident #004 were reported to the Director.

The home reported to the Director suspected abuse by resident #004 towards a number of residents and the results of the abuse investigation were not provided to the Director. The Administrator confirmed that the results of the investigation had not been reported to the Director. There is minimal risk to the resident for results of the abuse investigation not being reported to the Director.

Source: CI, health records for a number of residents and interview with staff. (194)

2.

5. The licensee has failed to ensure that the results of an alleged staff to resident #001 neglect investigation were reported to the Director.

The home reported an allegation of staff to resident neglect involving resident #001 and the report to the Director did not provide the results of the investigation. The Administrator confirmed that the results of the investigation had not been reported to the Director. There is minimal risk to the resident for results of the neglect investigation not being communicated to the Director.

Source: CI and interview with staff. (194)

3. 6. The licensee failed to ensure that the results of the alleged staff to resident #002 neglect investigation was reported to the Director.

A report was submitted to the Director for an alleged staff to resident neglect incident involving resident #002 and the report did not include the results of the investigation. The Administrator confirmed that the results of the homes investigation concluded that the allegations of neglect of resident #002 were founded and the results had not been provided to the Director. There was minimal risk to the resident for results of the neglect investigation not being reported to the Director.

Source: CI and interview with staff.

A compliance order was considered by taking the following into account:

The severity was a risk of harm to residents when there were a number of incidents of alleged and/or suspected staff to resident neglect and suspected incidents of resident to resident abuse by another resident to wards three other residents that were not immediately investigated.

The scope was widespread as there were three out of three incidents of abuse and /or neglect of residents reviewed that were not immediately investigated.

The compliance history indicated the same subsection was issued to LTCHA, 2007, s.23(2) was issued as a Written Notification (WN) on November 16, 2020. (194)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : May 31, 2022

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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 # / No d'ordre : 004

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

Linked to Existing Order / Lien vers ordre existant: 2021_673672_0040, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall comply with O.Reg. 79/10, s. 8(1)(b).

Specifically, the licensee shall ensure:
1. All staff are trained on the home's suicide policy to ensure that they are aware of their roles and responsibilities for residents at risk of suicide. Keep a documented record of the training.
2. Review and revise the plan of care for resident #014 and #017, and any other residents at risk for suicide, to ensure the plan is developed based on the assessment tools provided in the home's suicide policy.

Grounds / Motifs :

1. The licensee has failed to ensure that a specified responsive behaviour policy was complied with for resident #014.

A compliance order (CO) under report #2021_673672_0040 was issued for LTCHA, 2007 s. 8(1)(b) on January 20, 2022 and the order was to be complied with on February 28, 2022. This incident occurred prior to the compliance due date.

Under O.Reg. 79/10, s. 55(a) procedures and interventions were to be developed and implemented to assist residents and staff who are at risk of harm

or who are harmed as a result of a resident's behaviours, including responsive behaviours.

Resident #014 was admitted to the home with a history of specified responsive behaviours. The resident continued to demonstrate those high risk responsive behaviours on a number of dates. The BSO confirmed they were aware of the residents previous history with the specified responsive behaviours, they had notified the physician, completed a referral to Ontario Shores and new medication changes were ordered. The psycho geriatric referral completed for the resident recommended the staff have increased monitoring of the resident due to the high risk responsive behaviours and additional interventions to protect the resident which were implemented for a short period of time. The resident continued to demonstrate the high risk responsive behaviour a number of times after the interventions were discontinued and a follow up from the psycho geriatric referral completed with additional interventions added. items. The resident continued to demonstrate those high risk responsive behaviours on a number of dates and the had an incident that resulted in a near miss injury to the resident and the resident was not placed on increased monitoring and was not transferred to hospital for assessment until the following day, as required by the home's policy. The home was to complete a suicide risk assessment tool (SRAT) upon admission for all residents with a known history, upon a resident expressing desire to commit suicide, and upon return from a psychiatric leave for suicide attempt. The residents care plan was also to be updated based on the SRAT. When the resident has vocalized or attempted suicide, the staff were to immediately notify the DOC and/or ED, immediately investigate, complete the suicidal intervention checklist and implement any safety measures. If the resident attempted suicide, the staff were to call 911.The resident's plan also directed staff to refer to a social worker as needed. RPN #129 confirmed they had not completed any SRAT when the resident had express suicidal thoughts and indicated there were no SRAT ever completed for the resident and were not available on PCC to complete. The RPN also indicated no awareness of the home's policy at the time related to suicide. RPN #119 no longer worked in the home. RPN #104 (BSO) confirmed the resident was not immediately transferred to hospital following a suicide attempt until the next day and should have been. They also confirmed that no SRAT or suicide intervention checklist had been completed for the resident. There was also no indication that the social worker had been contacted. Failing to follow the home's suicide policy for resident #014,

who had previous history of expressed and demonstrated suicide, resulted in a suicide attempt and may lead to further incidents of self harm.

Sources: CI, health record for resident #014, the home's policy on a specified responsive behaviour and interview of staff.

3. The licensee has failed to ensure that their specified responsive behaviour policy had been complied with for resident #017.

A compliance order (CO) under report #2021_673672_0040 was issued for LTCHA, 2007 s. 8(1)(b) on January 20, 2022 and the order was to be complied with on February 28, 2022.

Under O.Reg. 79/10, s. 55(a) procedures and interventions were to be developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours.

Resident #017 had a prior history of a specified responsive behaviour. The resident also demonstrated other responsive behaviours that placed other residents and staff at risk for harm or injury, including resident #018. There were a number of incidents when resident #0017 had displayed the specified repsonsive behaviour towards resident #018 before the resident was relocated. On a specified date, the resident had reported they had displayed a specified responsive behaviour and no further actions were taken as the incident was not witnessed. On another specified date, the resident was found by a PSW displaying the same specified responsive behaviour that caused a risk for injury to them self, the resident was upset as a result of the incident and was not transferred to hospital for an assessment until the following day. The day after the resident returned from hospital, the resident was relocated to an area of the home where they could be closely monitored and other safety interventions were implemented. A number of days later, the resident again demonstrated the specified behaviour, the physician was notified, discouraged the staff from transferring the resident to hospital and recommended calling the police instead. Later the same day, the resident's responsive behaviours became unmanageable and the police were not called. The resident was placed on increased monitoring for the remainder of the shift. The following day, the BSO

staff determined the resident had an infection, notified the doctor who ordered an antibiotic and indicated that increased monitoring of the resident would only be used as needed. A few days later, the resident was given a device that placed them at risk for injury, despite the residents risk for injury and were not to be provided to the resident. A number of days later, the resident began demonstrating responsive behaviours towards a staff member that caused an injury to the staff member and the police were not called. The resident was placed on increased monitoring at that time and was then later discovered demonstrating a responsive behaviour that caused an injury to the resident, with the use of the device that was provided to the resident. The resident was transferred to hospital at that time. The home's specified responsive behaviour policies indicated that staff were to call the police when the resident's responsive behaviours became violent or unamangeable and was not implemented when this occurred towards resident #018 and other staff. The resident also displayed another ongoing responsive behaviours that placed them at risk for self injury and the policies strategies to be used where not implemented. An RPN and the BSO staff confirmed the specified policies had not been implemented in the home and strategies that were identified to be used to manage those responsive behaviours were inconsistently used. Failing to ensure the home's responsive behaviour policies were complied with to address the residents risk for injury towards other residents and staff, and towards them self, placed resident #017, resident #0018 and staff at risk for injury and harm.

Sources: CI, health record of resident #017 and #018, observation and interview of resident #017, home's responsive behaviour policies, and interview of staff.

A Compliance Order (CO) was issued by taking the following into account:

The severity was actual risk, as resident #017 had demonstrated ongoing incidents of responsive behaviours towards them self , resident #018 and staff that resulted in injury toward them self and others, due to the responsive behaviour policy not been followed for any of the incidents.

The scope was isolated as, although their were two residents who were at risk for injury, only resident #017's incident had an incident that occurred after the compliance due date of February 28, 2022.

The compliance history had ongoing non-compliance with O.Reg. 79/10, s. 8(1)(b) and was issued a CO on January 20, 2022 during inspection #2021_673672_0040 with a compliance date of February 28, 2022. (111)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 28th day of April, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lynda Brown

Service Area Office /
Bureau régional de services : Central East Service Area Office