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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l’inspection	Log # / No de registre	Type of Inspection / Genre d’inspection
Jan 22, 2019	2018_591623_0023	031666-18	Critical Incident System

Licensee/Titulaire de permis

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

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

Case Manor Care Community
28 Boyd Street P.O. Box 670 BOBCAYGEON ON K0M 1A0

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

SARAH GILLIS (623)

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): November 27, 28, 29, 30, December 4, 5 and 6, 2018

Also present during the course of this inspection for the purpose of training observation was inspector #747.

The following intake was inspected:
Log #031666-18 for Critical Incident Report related to alleged resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), Assistant Director of Care (ADOC), Resident Care Coordinator (RCC), Registered Nurse(s) (RN), Registered Practical Nurse(s) (RPN), Personal Support Worker(s) (PSW), and residents.

In addition, the inspector toured the home, observed staff to resident and resident to resident interactions. The following records were reviewed: clinical medical records, the licensees internal investigation, and related policies.

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

During the course of this inspection, Non-Compliances were issued.
3 WN(s)
3 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

A call was received by Centralized Intake Assessment Triage Team (CIATT) on a specified date, from an OPP constable who indicated that they had been notified of an alleged abuse that had occurred in the home. The constable indicated that a complaint was received related to an allegation of abuse towards resident #001, the OPP constable indicated that the complainant had witnessed the resident being absused by a co-resident #002. The OPP constable indicated to CIATT that they had completed an investigation which included speaking with the licensee.

Related to log # 031666-18 for CIR

A Critical Incident Report (CIR) was submitted to the Director on a specified date for an allegation of resident to resident abuse that occurred 26 days prior. The CIR indicated that on a specified date, the substitute decision maker (SDM) for resident #001 reported to RN #100, that they were walking with resident #001 when they were approached by resident #002. Resident #002 was witnessed abusing resident #001's. The CIR indicated that this incident was not reported to the ADOC until eight days later, when the ADOC received a phone call from the SDM for resident #001.

Observation of resident #002 by Inspector #623 were completed on a specified date. Resident #002 was unable to respond to the Inspector when attempts were made to communicate.

On a specified date and time, during an interview with Inspector #623, PSW #101 indicated that resident #002 exhibits specific identified responsive behaviours towards staff but not typically towards other residents. The PSW indicated that there has been instances of resident #002 exhibiting a specified responsive behaviour towards other residents but they have not personally witnessed this and could not provide any specific details. PSW #101 indicated that staff can usually tell before resident #002 begins to experience specific responsive behavoiurs. PSW #101 indicated that resident #002 required specific safety checks and has for many months. The safety checks are documented in the Point of Care (POC). PSW #101 indicated that they review the care plan in Point Click Care (PCC) or the Kardex to see if there are any specific behaviours that they need to be aware of before providing care. Resident #002 has specified

interventions for staff to follow when providing care for staff safety.

On a specified date and time, during an interview with Inspector #623, PSW #105 indicated that they are familiar with resident #002 and have worked with them for a long time. The PSW indicated that the resident has been on a steady decline since admission. Resident #002 exhibits specific identified responsive behavoiurs towards other residents and staff, and spent some time at an external support facility. Once the resident returned, their specified responsive behavoiurs were improved. PSW #105 indicated that staff are getting good at recognizing the signs that resident #002 potentially could exhibit specified responsive behavoiurs. Resident #002 will exhibit specific behavoiurs as an indication that they could escalate. The majority of staff that work in the home area know these signs, the regular staff will try to keep consistency for care. There are specific interventions in place for resident #002 that are required when providing care. PSW #105 indicated that they were unaware of any incidents involving resident #002 exhibiting specific identified responsive behaviours. The PSW indicated that there is one resident in the same home area who believes that resident #002 is their spouse. That information is not in the Kardex or care plan and would be helpful for staff. PSW #105 indicated that the two residents have exhibited specific identified responsive behaviours on one occasion, but could not recall any specific details with dates or times. Most of the information regarding care needs, is passed from shift to shift verbally and is not written in the plan of care for resident #002. PSW #105 indicated that resident #002 requires safety monitoring, staff are required to visualize the resident and document in the POC. Resident #002 is always moving throughout the home area. Resident #002 also requires specific interventions at meal time. It is difficult to keep the resident focused. PSW #105 indicated that the current Kardex identifies that resident #002 goes to bed at a specified time, and this is not accurate. The Kardex also does not identify that resident #002 requires specific interventions for identified personal care. PSW #105 indicated that the current Kardex and plan of care do not provide enough detailed information regarding specific identified responsive behaviours that resident #002 is known to exhibit, along with triggers and interventions to assist staff to manage the behaviours or specific interventions to meet the care needs of the resident.

On a specific date and time, during an interview with Inspector #623, RPN #103 indicated that it was the responsibility of the nursing staff on the floor to create care plans for residents who display responsive behaviours. The physicians, Nurse Practitioner (NP) and Ontario Shores were all available for support. RPN #103 indicated that they were only familiar with resident #002 from hearing about concerns brought forwards at the morning report meetings. RPN #103 indicated that they were aware that at times resident

#002 was exhibiting specific identified responsive behaviours towards staff and co-residents. The plan of care for resident #002 indicated they require specific interventions at all times for staff safety, when care was provided. Resident #002 also requires specific identified interventions for personal care. RPN #103 indicated that when speaking to the staff last week for a BSO update on resident #002, nursing staff indicated the resident was managing better but was now exhibiting new responsive behaviours. Staff are to initiate one to one staffing with resident #002 when the resident is exhibiting signs of specific identified responsive behaviours. Resident #002 has exhibited specific identified responsive behaviours towards other residents that caused injury. The RPN indicated that when resident #002 approaches a person, they will reach out to take your hand. The RPN was unaware of the incident that occurred on a specified date, when resident #002 displayed specific identified responsive behaviours towards resident #001. RPN #103 indicated that they review the Incident notes, BSO, and Risk management notes in PCC at the beginning of the shift. They do not review all regular progress notes, therefore, if the staff documented the incident as a regular progress note, it would not have been flagged for review by RPN #103. The RPN indicated that when they recently began their role as BSO support nurse. The RPN indicated they have requested new specific assessments be completed for all resident that require monitoring. The RPN indicated that the most recent specific assessment that is currently on file for resident #002, was 10 months old and does not reflect resident #002's specific identified responsive behaviours.

On a specific date and time, during an interview with Inspector #623, RPN #104 who is also the RAI Coordinator, indicated that the PSW's are able to access through the POC, the support actions (required care needs for the day), the Kardex and the written care plan for all residents. These three documents together should provide all of the information that staff need to care for any resident. RPN #104 indicated that all registered staff are required to update these documents in the moment, for any changes that have occurred. Quarterly the plan of care is formally reviewed by the RAI Coordinator. If there is information that needs to be brought forward, it is done at that time, the support actions can be customized to appear in the Kardex for each specific resident. The plan of care includes everything, support actions, the Kardex, the written care plan and the digital chart and the paper chart. RPN #104 indicated that if the resident is displaying a behaviour that is not identified in the plan of care, the PSW should ask the registered staff if it expected behavoiur. RPN #104 indicated that it is expected for resident #002 to exhibit specific identified responsive behavoiurs and this should be noted in the plan of care. RPN #104 indicated that all specific identified responsive behaviours should be identified in the plan of care for resident #002, as well as any specific care needs that are

unique to resident #002 for all activities of daily living.

On a specific date and time, during an interview with Inspector #623, ADOC indicated that resident #002 was seen at an external support facility for inpatient assessment due to specific identified responsive behavoiurs that the resident was experiencing. The ADOC indicated that at the end of the stay, the resident returned to the home with a plan in place that the support facility assisted in creating. The ADOC indicated that the resident was not exhibiting the same behaviours when in the facility, that they did in the home. The ADOC indicated that specific responsive behaviours were never identified on the plan of care because they were never a problem. The ADOC was unaware of any incidents that involved resident #002 exhibiting specific responsive behaviours towards co-residents. The external support facility continues to be available to consult for medication suggestions. The ADOC indicated that the plan of care should identify any specific responsive behaviours, triggers and interventions to assist staff to manage the care needs for all residents.

Review of the current plan of care for resident #002 was completed by Inspector #623, which identified some specified responsive behavoiurs and interventions.

Review of the current Kardex for resident #002 was completed by Inspector #623, which identified some specific interventions.

The licensee failed to ensure that the plan of care sets out clear directions to staff and others who would provide direct care to resident #002, when known specific identified responsive behaviours as well as specific consideration when providing personal care, including triggers, and specific interventions were not identified. [s. 6. (1) (c)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated:
(i) Abuse of a resident by anyone
(ii) Neglect of a resident by the licensee or staff ,or
(iii) Anything else provided for in the regulations

Log #031666-18

A Critical Incident Report (CIR) was submitted to the Director on a specific date and time for an allegation of abuse that occurred on a specified date. The CIR indicated that on a specified date, the SDM for resident #001 reported to RN #100, that they were walking with resident #001 when they were approached by resident #002. Resident #002 was observed abusing resident #001. The CIR indicated that this incident was not reported to the ADOC until eight days later, when the ADOC received a phone call from the SDM.

On a specific date and time, during an interview with Inspector #623, the DOC indicated that they were off work at the time were not familiar with an alleged incident of abuse towards resident #001.

On a specific date and time, during an interview with Inspector #623, the ADOC indicated that the alleged incident of abuse, was reported to them on a specified, when they received a call from the SDM for resident #001. The SDM indicated that they were walking with resident #001 in the hallway on a specified date, resident #002 approached exhibited a specific responsive behaviour towards resident #001. The SDM indicated they felt that was inappropriate. The ADOC indicated that once they became aware of the alleged incident, they met with resident #001, who indicated that they didn't feel the incident was inappropriate. The SDM mentioned to the ADOC that resident #002 had entered resident #001's room on different occasions and made them feel uncomfortable. The ADOC then spoke to the staff and initiated specific monitoring so staff would be aware of resident #002's location, which was implemented for two days. The ADOC indicated that once they became aware of the incident, they spoke to the nurse who was on duty at the time. The ADOC indicated that it was determined that abuse did not occur, based on the interview with resident #001, who indicated that they understood that resident #002 was cognitively impaired and therefore did not understand what they were doing, therefore the incident was not reported. The ADOC indicated that a few days later they followed up with the SDM for resident #001 to update them on the measures that were put into place and the SDM seemed satisfied. The SDM also informed the ADOC at that time, they had reported the alleged incident to the police. The ADOC recalled receiving a phone call from the police constable inquiring about the alleged incident. The focus of the questions was on resident #002 and not resident #001. The ADOC indicated at that time, the RCC updated resident #002's SDM about what had occurred. There was no documentation in the progress notes to support this. The ADOC indicated that when an incident of alleged, suspected or witnessed abuse is reported, the expectation is that it would be reported to the RN Charge Nurse and they would notify the manager. The manager would notify the Ministry of Health and Long-term Care (MOHLTC). The ADOC indicated that they did not report this alleged incident to the MOHLTC because when they reviewed the reporting algorithm they did not feel it met the reporting requirements. The ADOC indicated that they reviewed the algorithm after they had done their own internal investigation and not before.

On a specified date and time, during an interview with Inspector #623, RN #100 indicated that on a specified date, the RN received a phone call from the SDM for resident #001. The SDM described incident that occurred earlier on that day when resident #002 exhibited specific identified responsive behaviours towards resident #001's. The SDM indicated that they intervened between the residents, and tried to leave with resident #001, but resiident #002 continued to follow. The SDM indicated that they were eventually able to leave the home area. The SDM indicated that they were upset by the

situation, it made them uncomfortable and had weighed on their mind all day, so they felt that they needed to report it. RN #100 indicated that they explained to the SDM that resident #002 was not aware of what they were doing, and the action was innocent. The RN assured the SDM that staff monitor resident #002 closely and would monitor to ensure that this did not happen again. The RN indicated that when they received the call from the SDM, resident #001 was out of the home on an LOA, and RN #100 did not see the resident before the shift was over to assess their emotional state. RN #100 indicated that they passed on the information to the next shift, but did not ask for resident #001 to be assessed upon return. RN #100 also indicated that they did not document the incident in resident #002's medical records and did not notify resident #002's SDM. RN #100 could not recall if they reported the alleged incident to the ADOC or DOC regarding resident #002 exhibiting specific identified behaviours towards resident #001. The RN indicated that the DOC was off at the time so if it was reported, it would have been to the ADOC. RN #100 indicated that when the RN spoke to the SDM, they didn't get the feeling that the SDM believed that the resident had been abused. The RN indicated that from the SDM's tone of voice on the phone, it was determined that the SDM was letting the RN know what was happening because they felt "weird" about it and not as a complaint. The RN indicated that the SDM did not mention an allegation of abuse.

On a specific date and time, during an interview with Inspector #623, the DOC indicated that the expectation of the licensee is when an allegation of resident abuse is reported, the RN would contact the DOC or the ED, and an investigation would immediately begin. The DOC indicated that they were not notified on a specified date, by RN #100, when the SDM for resident #001 initially reported their concerns. The DOC indicated that the licensee was made aware on a specified date, when the ADOC received a phone call from the SDM for resident #001.

The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that is reported, is immediately investigated, when the SDM for resident #001 reported to RN #100 on a specified date, the witnessed incident of abuse involving resident #002 and resident #001. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Log #031666-18

A Critical Incident Report (CIR) was submitted to the Director on a specific date and time, for an allegation of abuse that occurred on a specified date. The CIR indicated that on a specified date, the SDM for resident #001 reported to RN #100, that they were walking with resident #001 when they were approached by resident #002. Resident #002 exhibits a specific responsive behaviour towards resident #001's. The CIR indicated that this incident was not reported to the ADOC until eight days later, when the ADOC received a phone call from the SDM for resident #001.

On a specific date and time, during an interview with Inspector #623, the DOC indicated that they were off work when the alleged incident occurred were not familiar with it.

On a specific date and time, during an interview with Inspector #623, the ADOC indicated that the alleged incident of abuse was reported to them on a specified date, when they spoke to the SDM for resident #001. The ADOC indicated that once they became aware of the incident, they spoke to the nurse who was on duty at the time. The ADOC then met with resident #001 to discuss the incident. The ADOC indicated that they determined that abuse did not occur, based on the interview with resident #001, who indicated that they understood that resident #002 did not understand what they were doing and would be unable to determine that it was inappropriate, therefore the incident was not reported to the Director. The ADOC indicated that when an incident of alleged, suspected or witnessed abuse is reported, the expectation is that it would be reported to the RN Charge Nurse, and they would notify the manager. The manager would notify the Director. The ADOC indicated that they did not report this alleged incident to the MOHLTC because when they reviewed the reporting algorithm, they did not feel it met the reporting requirements. The ADOC indicated that they reviewed the algorithm after they had done their own internal investigation and not before.

On a specified date and time, during an interview with Inspector #623, RN #100 indicated that on a specified date, they received a phone call from the SDM for resident #001. The SDM described an incident that occurred earlier on that day when resident #002 approached resident #001's and exhibited a specific identified responsive behaviour. The SDM indicated that they removed resident #001 from the situation, by attempting to leave but resident #002 continued to follow. The SDM indicated that they were eventually able to leave the home area. The SDM indicated to RN #100, that they were upset by the situation, it made them uncomfortable and had weighed on their mind all day, so they felt that they needed to report it. RN #100 indicated that they explained to the SDM that resident #002 was not aware of what they were doing, they often approached people to get their attention and the action was innocent. The RN assured the SDM that staff

monitor resident #002 closely and would monitor to ensure that this did not happen again. The RN indicated that if a resident approached another resident in the same manor, they would not necessarily treat this as a specific identified responsive behaviour, resident #002 does not know what they are doing and therefore could not intentionally exhibit the specified responsive behavoiur. RN #100 indicated that they are aware of their duty to report any alleged, suspected or witnessed incident of abuse of a resident. They indicated that the expectation of the licensee is that when a situation arises which requires reporting, the RN charge nurse is expected to notify the DOC or ADOC. The RN indicated that in this facility RN #100 would not call the MOHLTC Action Line unless instructed to do so by the ED, DOC or ADOC. RN #100 could not recall if they reported the incident to the ADOC or DOC regarding resident #002 exhibiting specific identified responsive behaviours towards resident #001. RN #100 indicated that when they spoke to the SDM for resident #001, they didn't get the feeling that the SDM believed that the resident had been abused. The RN indicated that from the SDM's tone of voice on the phone, it was determined that the SDM was letting the RN know what was happening because they felt "weird" about it and not alleging abuse. The RN indicated that the SDM did not mention an allegation of abuse.

On a specific date and time, during an interview with Inspector #623, the Director of Care indicated that the expectation of the licensee is that when an allegation of resident abuse is reported, the RN would be expected to contact the DOC or the ED, the RN would also make the phone call to the MOHLTC after hours number to initiate reporting to the Director. The DOC indicated that RN #100 is aware of their responsibility to report. The DOC indicated that they were not notified on a specified date, by the RN when the SDM for resident #001 reported their concerns. The DOC indicated that licensee was made aware on a specified date, when the ADOC received the phone call from the SDM for resident #001, and a report should have been made to the Director at that time.

The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm, has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director. The SDM for resident #001 reported to RN #100 the witnessed incident of abuse that occurred on a specified date, involving resident #001 and #002. RN #100 did not immediately report the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

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 by ensuring that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

Issued on this 31st day of January, 2019

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

Original report signed by the inspector.