Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Sep 26, 2019	2019_640601_0011 (A1)	018462-18, 025279-18, 027939-18, 000904-19	Critical Incident System

Licensee/Titulaire de permis

Centennial Place Millbrook Inc.
307 Aylmer Street PETERBOROUGH ON K9L 7M4

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

Centennial Place Long-Term Care Home
2 Centennial Lane North MILLBROOK ON M5J 2G2

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

Amended by KARYN WOOD (601) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Licensee requested an extension to the compliance date. Compliance date has been changed to December 23, 2019.

Issued on this 26th day of September, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

Amended by KARYN WOOD (601) - (A1)

Amended 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): May 16, 17, 22, 23, 24, 28, 29, 30, 31, June 4, 5, 6, 10, and 11, 2019.

Log #018462-18 and log #025279-18 related to a fall resulted in an injury.

Log #027939-18 related to allegations of resident to resident abuse.

Log #000904-19 related to allegations of staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Associate Director of Care (ADOC), Behaviour Support Coordinator (BSC), RAI-Coordinator (RAI), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

The inspector also reviewed residents' health care records, the licensee's relevant policies and procedures, staffing schedules, observed the delivery of resident care and services, including staff to resident interactions and resident to resident interactions.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of the original inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **1 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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from alleged, suspected or witnessed abuse, pursuant to s.19 of the LTCHA.

Pursuant to the Long-Term Care Home Act (LTCHA) 2007, s. 20 (1), 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.

Inspector #601 reviewed the licensee's Abuse and Neglect – Zero Tolerance policy.

-The policy uses the definition of "abuse" and "neglect" from the Long-Term Care Homes Act (LTCHA). Staff should be aware that the LTCHA and this policy define abuse and neglect broadly and should make themselves familiar with the definitions.

Inspector #601 reviewed the licensee's specified policy related to the identified alleged resident to resident abuse.

Related to Log #027939-18:

A review of a Critical Incident Report (CIR) that was submitted to the Director on a specified date for allegations of resident to resident abuse that occurred on a specified date and time. The CIR indicated that resident #005 was upset following the incident and had a minor injury to a specified area. The CIR further indicated that resident #005 had settled and appeared to have no recollection of the incident.

A review of resident #004's care plan last reviewed on a specified date related to responsive behaviours identified that on a specified date, Registered Nurse/Behaviour Support Coordinator (RN/BSC) #108 implemented an identified

intervention to manage resident #004's identified responsive behaviours.

Inspector #601 reviewed resident #004's specified documentation for a specified month completed by the Director of Care (DOC) on a specified date. According to the DOC's documentation, resident #004's identified intervention was started on a specified date and utilized for an identified period of time. At that time, the resident had identified responsive behaviours. On a specified date, the identified intervention was increased to twenty four hours a day due allegations of resident #004 identified abuse towards a co-resident. According to the DOC's documentation, resident #004 continued have the specified responsive behaviour towards co-residents.

During an interview on a specified date, PSW #105 indicated to Inspector #601 that on the specified date, resident #004's SDM reported the incident to staff. PSW #105 indicated they immediately went to resident #004's room with RPN #106. According to PSW #105, resident #005 was upset and not able to verbalize how they felt. PSW #105 indicated that resident #005 was quiet about a half an hour after the incident. PSW #105 further indicated that resident #005 was upset following the incident and that it was not clear how to determine consent when residents have a cognitive impairment.

During an interview on a specified date, PSW #109 explained that they were coming on shift and getting report when resident #004's SDM reported the incident of resident to resident abuse. PSW 109 indicated that resident #005 had complained of discomfort and was upset. According to PSW #109, resident #005 settled after they were put to bed. PSW #109 further indicated that resident #005 was upset following the incident and that it was not clear how to determine consent when residents have a cognitive impairment.

During a telephone interview on a specified date, RPN #106 indicated to Inspector #601 that during shift change on the specified date, resident #004's Substitute Decision Maker (SDM) reported the incident of resident to resident abuse. RPN #106 indicated they immediately went to resident #004's room with PSW #105. According to RPN #106, resident #004 was upset when staff entered the room. According to RPN #106, resident #005 was upset. RPN #106 indicated that resident #005 was taken to their room by RPN #106, PSW #105 and PSW #109. RPN #106 indicated that they immediately informed the Nursing Supervisor, RN #107 and the RN had directed them to complete a head to toe assessment. RPN #106 further indicated they could not remember when RN #107 came to assess

the residents. RPN #106 indicated they had completed a head to toe assessment. Resident #005 was still upset while in the shower, but not as upset as originally. RPN #106 further indicated that resident #005 was upset following the incident and that it was not clear how to determine consent when residents have a cognitive impairment.

During the same telephone interview on a specified date, RPN #106 indicated that resident #004 had declined a head to toe assessment. RPN #106 indicated that RN #107 had directed them to document the incident and that management would be notifying the residents SDM's of the incident.

During an interview on a specified date, RN #107 indicated to Inspector #601 they could not recall all the details of the incident between resident #004 and resident #005, on the specified date. RN #107 indicated they remembered the RPN reporting the incident and believed they were at the nurse's station. RN #107 indicated that they remembered that resident to resident abuse had not occurred. RN #107 indicated that they had assessed resident #005, while they were in the shower chair and that resident #005 was smiling at this time. RN #107 further indicated that resident #005 was not upset and did not complain of discomfort, when assessed by RN #107 following their shower. RN #107 indicated that resident #005's SDM was informed of the incident and that an identified responsive behaviour had occurred. RN #107 further indicated that resident #005 was not sent to the hospital for assessment following the incident on the specified date.

Inspector #601 reviewed the Two-Week Schedule Report for when the incident occurred and PSW #116 was scheduled to provide the identified intervention for resident #004. Inspector #601 reviewed resident #004's Behaviour Observation Record completed by PSW #116 for the date and time of the specified incident and PSW #116 had documented that the identified responsive behaviour that occurred in resident #004's room was not witnessed, as they were at a PSW meeting at the time of the incident.

During a telephone interview on a specified date, RPN #106 indicated to Inspector #601 that resident #004 did not have the identified intervention in place when they entered resident #004's room on the specified date.

During a telephone interview on a specified date, the Director of Care (DOC) indicated that resident #004 had identified responsive behaviours towards co-

residents prior to the specified incident involving resident #004 and resident #005. According to the DOC, resident #004's plan of care at the time of the incident was to have an identified intervention in place during a specified period of time. The DOC said that the abuse policy did not direct to transfer resident #005 to the emergency room for assessment when the identified abuse was suspected. The DOC further indicated that the interaction between resident #004 and resident #005 was viewed on the camera and there was no indication that resident #005 was upset. The DOC further indicated that the licensee's zero tolerance of abuse policy was followed when the allegation of resident to resident abuse was reported to the Director and the police were notified, as per the regulations.

Related to resident #004 and #016:

Inspector #601 reviewed resident #004's progress notes for an identified period of time and identified that on a specified date and time, an alleged incident of resident to resident abuse involving resident #004 and resident #016 had occurred. The incident involving resident #004 and resident #016 on the specified date was not reported to the Director. RPN #122 documented that on the specified date and time, PSW #123 found resident #004 in resident #016's room displaying the identified responsive behaviour. RPN #122 attempted to remove resident #004 and the resident was resistive. According to the progress note on the date of the incident, RPN #122 and RN #112 had completed an assessment on resident #016 and there was no evidence of injury.

During a telephone interview on a specified date, RN #112 indicated to Inspector #601 that it was difficult to determine resident #016's understanding of the situation on the identified date. RN #112 further indicated that resident #004 was without the identified intervention at the time of the incident. According to RN #112, resident #004 had been placed on identified checks and the incident had occurred at shift change. RN #112 further indicated the staff providing the identified intervention went to see resident #004 at the start of their shift and couldn't find the resident at the time that the incident had occurred. RN #112 further indicated that resident #004's plan of care at the time of the incident was to have the specified intervention in place twenty-four hours a day.

The licensee failed to ensure that the identified incident involving resident #016 was reported to the Director and that resident #005 and resident #016 were protected from abuse by resident #004. The licensee's specified policy does not provide clear guidelines of how to assess and determine capacity, and consent

cannot be implied if capacity has not been established. In addition, the licensee failed to protect resident #005 and #016, when the care set out in the plan of care for resident #004 was not provided to the resident as specified in the plan related to the provision of the identified intervention when two separate incidents of resident to resident identified abuse took place. [s. 19. (1)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 001

WN #2: 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 :

1. The licensee has failed to ensure that there was a written plan of care for resident #004 that set out clear directions to staff and others who provided direct

care to the resident.

Related to Log #027939-18:

A review of a CIR submitted to the Director on an identified date and time for allegations of a resident to resident abuse incident towards resident #005 by resident #004 that occurred on a specified date and time.

A review of resident #004's progress notes, by Inspector #601 for a specified period of time, identified that resident #004 had an identified number of resident to resident altercations.

A review of resident #004's care plan interventions that were in place for a specified period of time identified that resident #004's written interventions related to responsive behaviours included identified interventions to manage the resident's specified responsive behaviours.

A review of resident #004's care plan interventions on a specified date related to responsive behaviours identified that updates had been made to resident #004's responsive behaviour plan of care on two identified dates and the first update was the identified intervention that was initiated for resident safety due to resident #004's specified responsive behaviours.

A review of the Behaviour Assessment Tool (BAT) for resident #004 that was initiated on a specified date. The BAT assessment identified that resident #004 had specific responsive behaviours and there were specific interventions identified.

During separate interviews on specified dates, with PSW #131, PSW #132, PSW #137, PSW #111, RN #112, RN #107, PSW #110 and RPN #106, reported to Inspector #601 that resident #004's had identified responsive behaviours.

During separate interviews on specified dates, with PSW #131, PSW #132, PSW #137, PSW #111, RN #112, RN #107, PSW #105, PSW #109 and PSW #110, reported to Inspector #601 resident #004's did have known triggers that may escalate the resident's responsive behaviours.

During separate interviews on specified dates, with PSW #131, PSW #132, PSW #137, PSW #111, RN #112, RN #107, PSW #105, PSW #109, PSW #110, RPN

#106 and review of resident #004's progress notes for a specified period of time by Inspector #601, identified that specified interventions had been utilized by staff to manage resident #004's responsive behaviours:

During an interview on a specified date, PSW #109 indicated to Inspector #601 that resident #004's current work sheet indicated that resident #004 had identified responsive behaviours.

During an interview on a specified date, the RN/RAI Coordinator #117 and the RN/BSC #108 indicated to Inspector #601, that at times when resident #004 required a specified intervention, to assess the resident's response to the intervention and they both indicated that they were not aware of any specific documentation completed when this specified intervention was used.

During a telephone interview on a specified date, the Director of Care (DOC) indicated the staff had been managing resident #004's responsive behaviours and the written plan of care included the interventions in place for resident #004. The DOC further indicated that names of other residents identified as a trigger would not be documented in resident #004's written care plan and that a communication board was used to inform staff of resident #004's responsive behaviours and interventions.

A review of resident #004's responsive behaviour plan of care interventions for a specified dates and the BAT that was initiated in a specified month did not reflect any evidence related to the frequency of resident #004's safety monitoring and when the identified intervention was to be in place to manage the resident's responsive behaviours.

The licensee did not ensure the written plan of care for resident #004 set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care for resident #004 was provided to the resident as specified in the plan related to an identified intervention.

Related to Log #027939-18:

A review of a CIR submitted to the Director on specified date and time of an alleged resident to resident abuse of resident #005 by resident #004 that occurred

on a specified date and time.

A review of resident #004's clinical health record identified that resident #004 had responsive behaviours.

A review of resident #005's clinical health record identified that resident #005 had poor decision making and was not able to express emotion or share information.

Inspector #601 reviewed resident #004's specified documentation for a specified month completed by the Director of Care (DOC) on a specified date. According to the DOC's documentation, resident #004's identified intervention was started on a specified date and utilized for an identified period of time. At that time, the resident had identified responsive behaviours. On a specified date, the identified intervention was increased to twenty four hours a day due allegations of resident #004 identified abuse towards a co-resident. According to the DOC's documentation, resident #004 continued to have the specified responsive behaviour towards co-residents.

Inspector #601 reviewed the Two-Week Schedule Report for when the incident occurred and PSW #116 was scheduled to provide the identified intervention for resident #004. Inspector #601 reviewed resident #004's Behaviour Observation Record completed by PSW #116 for the date and time of the specified incident and PSW #116 had documented that the identified responsive behaviour that occurred in resident #004's room was not witnessed, as they were at a PSW meeting at the time of the incident.

During a telephone interview on a specified date, RPN #106 indicated to Inspector #601 that resident #004 did not have the identified intervention in place when they entered resident #004's room when the incident occurred involving resident #005.

During a telephone interview on a specified date, the Director of Care (DOC) indicated to Inspector #601 that resident #004 had identified responsive behaviours towards co-residents prior to the identified responsive behaviour that occurred with resident #005. According to the DOC, resident #004's plan of care at the time of the incident was to have the identified intervention in place during a specified period of time.

Related to resident #004 and #016:

Inspector #601 reviewed resident #004's progress notes for an identified period of time and identified that on a specified date and time, an alleged incident of resident to resident abuse involving resident #004 and resident #016 had occurred. The incident involving resident #004 and resident #016 on the specified date was not reported to the Director. RPN #122 documented that on the specified date and time, PSW #123 found resident #004 in resident #016's room displaying the identified responsive behaviour. RPN #122 attempted to remove resident #004 and the resident was resistive. According to the progress note on the date of the incident, RPN #122 and RN #112 had completed an assessment on resident #016 and there was no evidence of injury.

A review of resident #016's clinical health record identified that resident #016 lacked insight to make appropriate decisions and was not able to express emotion and share information.

During a telephone interview on a specified date, RN #112 indicated to Inspector #601 that on a specified date, resident #004 was without the identified intervention during a specified period of time. According to RN #112, resident #004 had been placed on identified safety checks and the incident had occurred at shift change. RN #112 further indicated the staff providing the planned identified intervention went to see resident #004 at the start of their shift and couldn't find the resident at the time that the incident occurred. RN #112 further indicated that resident #004's plan of care at the time of the incident was to have the identified intervention in place twenty-four hours a day.

The licensee failed to protect resident #005 and #016, when the care set out in the plan of care for resident #004 was not provided to the resident as specified in the plan related to the provision of the identified intervention when two separate incidents of resident to resident abuse took place. [s. 6. (7)]

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 resident #004's written plan of care care set out clear direction to staff and that care is provided to the resident as specified in the plan related to the identified intervention, 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 when a 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.

Related to Log #027939-18:

A review of a CIR submitted to the Director on an identified date and time for

allegations of a resident to resident abuse incident towards resident #005 by resident #004 that occurred on a specified date and time.

A review of a copy of the licensee's CIR, by Inspector #601 identified the Associate Director of Care (ADOC) had initiated the CIR on the day of the incident at a specified time and saved the report without submitting to the Director. The information that was saved on the day of the specified incident, indicated that resident #004's Substitute Decision Maker (SDM) had reported the incident.

During a telephone interview on a specified date, the Director of Care (DOC), indicated to Inspector #601 that on the date of the incident, the ADOC had initiated the CIR and that they had received an email from the ADOC indicating the CIR had been submitted to the Director.

The licensee failed to ensure that the incident of alleged resident #004 to resident #005 abuse that occurred on a specified date and time was reported to the Director, as required. RN #107 was made aware of the incident of alleged abuse by RPN #106 on the specified date, at the time of the incident. The ADOC created the CIR on the specified date. The allegation of abuse was not reported to the Director under the LTCHA, until the following morning.

Related to resident #004 and #016:

Inspector #601 reviewed resident #004's progress notes for an identified period of time and identified that on a specified date and time, an alleged incident of resident to resident abuse involving resident #004 and resident #016 had occurred. The incident involving resident #004 and resident #016 on the specified date was not reported to the Director. RPN #122 documented that on the specified date and time, PSW #123 found resident #004 in resident #016's room displaying the identified responsive behaviour. RPN #122 attempted to remove resident #004 and the resident was resistive. According to the progress note on the date of the incident, RPN #122 and RN #112 had completed an assessment on resident #016 and there was no evidence of injury.

During a telephone interview on a specified date, RN #112 indicated to Inspector #601 that RPN #122 had made them aware of the incident involving resident #004 on the specified date. RN #112 further indicated that they had assessed resident #016 at the time of the incident and resident #016 was not upset. According to RN #112, they had emailed the mangers to notify them of the

incident. RN #112 further indicated the abuse policy directed them to contact the manager on call when abuse was suspected, and a decision would be made to determine if the Director should be notified.

During a telephone interview on a specified date, the DOC, indicated to Inspector #601, that there may have been other incidents of the identified responsive behaviour involving resident #004 and was not able to confirm at the time of the telephone interview.

The licensee failed to ensure that an incident of suspected or alleged resident #004 to resident #016 abuse that was documented in resident #004's progress notes on the specified date and time was reported to the Director, as required. RN #112 was made aware of the incident of alleged abuse by RPN #122 at the time of the incident. Record review of the Critical Incident System by Inspector #601 identified that the allegation of abuse was not reported to the Director under the LTCHA. [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 to ensure that when a person who has 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, to be implemented voluntarily.

Issued on this 26th day of September, 2019 (A1)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 Homes Division
Long-Term Care Inspections Branch

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by KARYN WOOD (601) - (A1)
Inspection No. / No de l'inspection :	2019_640601_0011 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	018462-18, 025279-18, 027939-18, 000904-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 26, 2019(A1)
Licensee / Titulaire de permis :	Centennial Place Millbrook Inc. 307 Aylmer Street, PETERBOROUGH, ON, K9L-7M4
LTC Home / Foyer de SLD :	Centennial Place Long-Term Care Home 2 Centennial Lane North, MILLBROOK, ON, M5J-2G2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Debbie Maddison

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 Centennial Place Millbrook Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

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 # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s.19 (1) of the LTCHA.

Specifically, the licensee shall ensure the following:

1. The licensee shall review and revise the identified policy #GA-A-21 to provide clear and more comprehensive guidance to staff to ensure that capacity of residents with cognitive impairment who demonstrate the identified responsive behaviour are being assessed; to support good decision-making in staff interventions and on-going monitoring, to support appropriate mandatory reporting under s. 24 (1) of the LTCHA, 2007, to ensure only consensual activity is occurring between residents, and to further ensure that residents are not vulnerable to abuse. Provide education to direct care staff on the revised policy #GA-A-21 and a documented record is to be kept.

2. The licensee shall develop and implement a process to ensure that the capacity of residents with cognitive impairment who demonstrate the identified responsive behaviour are being assessed; and to ensure that interventions put in place to manage the responsive behaviour, such as the identified intervention, are being consistently implemented and a documented record is kept.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from alleged, suspected or witnessed abuse, pursuant to s.19 of the LTCHA.

Pursuant to the Long-Term Care Home Act (LTCHA) 2007, s. 20 (1), 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.

Inspector #601 reviewed the licensee's Abuse and Neglect – Zero Tolerance policy.

-The policy uses the definition of "abuse" and "neglect" from the Long-Term Care Homes Act (LTCHA). Staff should be aware that the LTCHA and this policy define abuse and neglect broadly and should make themselves familiar with the definitions.

Inspector #601 reviewed the licensee's specified policy related to the identified alleged resident to resident abuse.

Related to Log #027939-18:

A review of a Critical Incident Report (CIR) that was submitted to the Director on a specified date for allegations of resident to resident abuse that occurred on a specified date and time. The CIR indicated that resident #005 was upset following the incident and had a minor injury to a specified area. The CIR further indicated that resident #005 had settled and appeared to have no recollection of the incident.

A review of resident #004's care plan last reviewed on a specified date related to responsive behaviours identified that on a specified date, Registered Nurse/Behaviour Support Coordinator (RN/BSC) #108 implemented an identified intervention to manage resident #004's identified responsive behaviours.

Inspector #601 reviewed resident #004's specified documentation for a specified month completed by the Director of Care (DOC) on a specified date. According to the DOC's documentation, resident #004's identified intervention was started on a specified date and utilized for an identified period of time. At that time, the resident had identified responsive behaviours. On a specified date, the identified intervention was increased to twenty four hours a day due allegations of resident #004 identified abuse towards a co-resident. According to the DOC's documentation, resident #004 continued have the specified responsive behaviour towards co-residents.

During an interview on a specified date, PSW #105 indicated to Inspector #601 that

on the specified date, resident #004's SDM reported the incident to staff. PSW #105 indicated they immediately went to resident #004's room with RPN #106. According to PSW #105, resident #005 was upset and not able to verbalize how they felt. PSW #105 indicated that resident #005 was quiet about a half an hour after the incident. PSW #105 further indicated that resident #005 was upset following the incident and that it was not clear how to determine consent when residents have a cognitive impairment.

During an interview on a specified date, PSW #109 explained that they were coming on shift and getting report when resident #004's SDM reported the incident of resident to resident abuse. PSW 109 indicated that resident #005 had complained of discomfort and was upset. According to PSW #109, resident #005 settled after they were put to bed. PSW #109 further indicated that resident #005 was upset following the incident and that it was not clear how to determine consent when residents have a cognitive impairment.

During a telephone interview on a specified date, RPN #106 indicated to Inspector #601 that during shift change on the specified date, resident #004's Substitute Decision Maker (SDM) reported the incident of resident to resident abuse. RPN #106 indicated they immediately went to resident #004's room with PSW #105. According to RPN #106, resident #004 was upset when staff entered the room. According to RPN #106, resident #005 was upset. RPN #106 indicated that resident #005 was taken to their room by RPN #106, PSW #105 and PSW #109. RPN #106 indicated that they immediately informed the Nursing Supervisor, RN #107 and the RN had directed them to complete a head to toe assessment. RPN #106 further indicated they could not remember when RN #107 came to assess the residents. RPN #106 indicated they had completed a head to toe assessment. Resident #005 was still upset while in the shower, but not as upset as originally. RPN #106 further indicated that resident #005 was upset following the incident and that it was not clear how to determine consent when residents have a cognitive impairment.

During the same telephone interview on a specified date, RPN #106 indicated that resident #004 had declined a head to toe assessment. RPN #106 indicated that RN #107 had directed them to document the incident and that management would be notifying the residents SDM's of the incident.

During an interview on a specified date, RN #107 indicated to Inspector #601 they

could not recall all the details of the incident between resident #004 and resident #005, on the specified date. RN #107 indicated they remembered the RPN reporting the incident and believed they were at the nurse's station. RN #107 indicated that they remembered that resident to resident abuse had not occurred. RN #107 indicated that they had assessed resident #005, while they were in the shower chair and that resident #005 was smiling at this time. RN #107 further indicated that resident #005 was not upset and did not complain of discomfort, when assessed by RN #107 following their shower. RN #107 indicated that resident #005's SDM was informed of the incident and that an identified responsive behaviour had occurred. RN #107 further indicated that resident #005 was not sent to the hospital for assessment following the incident on the specified date.

Inspector #601 reviewed the Two-Week Schedule Report for when the incident occurred and PSW #116 was scheduled to provide the identified intervention for resident #004. Inspector #601 reviewed resident #004's Behaviour Observation Record completed by PSW #116 for the date and time of the specified incident and PSW #116 had documented that the identified responsive behaviour that occurred in resident #004's room was not witnessed, as they were at a PSW meeting at the time of the incident.

During a telephone interview on a specified date, RPN #106 indicated to Inspector #601 that resident #004 did not have the identified intervention in place when they entered resident #004's room on the specified date.

During a telephone interview on a specified date, the Director of Care (DOC) indicated that resident #004 had identified responsive behaviours towards co-residents prior to the specified incident involving resident #004 and resident #005. According to the DOC, resident #004's plan of care at the time of the incident was to have an identified intervention in place during a specified period of time. The DOC said that the abuse policy did not direct to transfer resident #005 to the emergency room for assessment when the identified abuse was suspected. The DOC further indicated that the interaction between resident #004 and resident #005 was viewed on the camera and there was no indication that resident #005 was upset. The DOC further indicated that the licensee's zero tolerance of abuse policy was followed when the allegation of resident to resident abuse was reported to the Director and the police were notified, as per the regulations.

Related to resident #004 and #016:

Inspector #601 reviewed resident #004's progress notes for an identified period of time and identified that on a specified date and time, an alleged incident of resident to resident abuse involving resident #004 and resident #016 had occurred. The incident involving resident #004 and resident #016 on the specified date was not reported to the Director. RPN #122 documented that on the specified date and time, PSW #123 found resident #004 in resident #016's room displaying the identified responsive behaviour. RPN #122 attempted to remove resident #004 and the resident was resistive. According to the progress note on the date of the incident, RPN #122 and RN #112 had completed an assessment on resident #016 and there was no evidence of injury.

During a telephone interview on a specified date, RN #112 indicated to Inspector #601 that it was difficult to determine resident #016's understanding of the situation on the identified date. RN #112 further indicated that resident #004 was without the identified intervention at the time of the incident. According to RN #112, resident #004 had been placed on identified checks and the incident had occurred at shift change. RN #112 further indicated the staff providing the identified intervention went to see resident #004 at the start of their shift and couldn't find the resident at the time that the incident had occurred. RN #112 further indicated that resident #004's plan of care at the time of the incident was to have the specified intervention in place twenty-four hours a day.

The licensee failed to ensure that the identified incident involving resident #016 was reported to the Director and that resident #005 and resident #016 were protected from abuse by resident #004. The licensee's specified policy does not provide clear guidelines of how to assess and determine capacity, and consent cannot be implied if capacity has not been established. In addition, the licensee failed to protect resident #005 and #016, when the care set out in the plan of care for resident #004 was not provided to the resident as specified in the plan related to the provision of the identified intervention when two separate incidents of resident to resident identified abuse took place.

The severity of this issue was determined to be a level 3 as there was actual harm to resident #005. The scope of the issue was a level 1 as it related to one resident that required an identified intervention. The home had a level 3 history as they had

previous non-compliance with this section of the LTCHA that included:

-Compliance order (CO) pursuant to s.19 of the LTCHA was issued on September 19, 2016 with a compliance due date of September 30, 2016 (2016_270531_0025). (601)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 23, 2019(A1)

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 Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, 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:

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

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 Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS 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 de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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 de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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 26th day of September, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by KARYN WOOD (601) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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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

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