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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
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Bureau régional de services de Toronto
5700, rue Yonge 5e étage
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 5, 2020	2020_654618_0008	022412-19	Critical Incident System

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Streetsville Care Community
1742 Bristol Road West MISSISSAUGA ON L5M 1X9

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

CECILIA FULTON (618)

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 19, 20, 2020.

Intake Log # 022412-19, Critical Incident System Report (CIS) # 2648-000021-19, related to alleged resident abuse was inspected.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the assistant Director of Care (ADOC), Registered Staff (RN/RPN), Personal Support Works (PSW).

During the course of the inspection, the inspector conducted record review of relevant resident records and home policies and education records, observed residents and resident home areas and staff to resident interactions.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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 resident #001 was protected from abuse by

anyone

As per O. Reg. 79/10, s.2 (1), the definition of "physical abuse", subject to subsection (2) (1) of the Act, includes the use of physical force by anyone other than a resident that causes physical injury or pain.

This inspection was initiated in response to Critical Incident System Report (CIS) related to alleged abuse of resident #001 by a staff member.

Record review identified that on an identified date resident #001 alleged that PSW #102 had abused them.

PSW #102 was not available for interview during this inspection.

Interview with PSW #101 identified that they heard screaming and crying coming from resident #001's room and went to see what was happening. When they entered the room, resident #001 alleged that PSW #102 had abused them. PSW #101 stated that they told PSW #102 to leave the resident for a while, but PSW #102 wanted to complete the resident's care and ignored PSW #101's instructions.

PSW #101 stated that they immediately reported this to RPN #103 who was outside of the room, and RN #104 who was at the nursing station. PSW #101 reported that RPN #103 went to see the resident, and that the registered staff communicated to PSW #101 that this was the resident's normal behaviour.

RPN #103 stated that they had gone to see the resident in response to hearing the resident crying and that they directed PSW #102 to take their time when providing care to resident #001. RPN #103 believed the resident was crying because they did not want to get up. RPN #103 also stated that they had not conducted a skin assessment of resident #001 that day, however that they had taken a look at the resident when administering medications and saw nothing on resident #001's arms.

A skin assessment of resident #001 was conducted later that same day by RN #105. That report did identify bruising to identified areas on the resident. Comparison of this report to previous head to toe skin assessments identified that the documented bruising was new.

RN #105 documented that resident #001 alleged they had been abused by the PSW

#102.

Review of progress notes for the identified shift did not include anything about the abuse allegation or of any concerns raised by the resident.

Interview with PSW #106, identified that they worked the shift following this incident, and that resident #001 told them that they had been abused on the identified shift. PSW #106 identified that they observed bruising on the area identified by the resident. PSW #106 stated the resident had never made accusations of this nature in the past. PSW #106 reported the resident's concerns to RN #105.

RN #105 was not available for interview during this inspection, however they did assess the resident, and documented their findings, and reported to the Ministry of Health.

It is the conclusion of this inspection that the abuse of resident #001 did occur on November 24, 2019, as reported by Resident #001, PSW #101, PSW #106 and RN #105. [s. 19. (1)]

Additional Required Actions:

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

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

1. The Licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Review of the Licensee's written policy titled: Prevention of abuse and Neglect of a

Resident, Policy #VII-G_10.00, revision date April 2019, was reviewed during this inspection.

a. The policy states that all team members are required to immediately report any suspected or known incident of abuse or neglect.

Record review of the CIS report and the home's investigation notes and staff interviews identified that an alleged incident of abuse of resident #001 occurred on an identified date, when the resident was observed to be screaming, crying and alleged that they had been abused by the PSW #102.

PSW #101 responded to the screaming of resident #001, and was told by resident #001 that PSW #102 had abused them. PSW #101 told PSW #102 to leave the resident for a while but PSW#102 wanted to complete care and did not follow the instructions provided by PSW #101.

PSW #101 identified that RPN #103 and RN #104 were informed of the resident's allegations immediately. RPN #103 was reported to be outside of the resident's room and was observed by PSW #101 to go into the resident's room.

Written statements taken as part of the home's investigation into the allegation included statements by PSWs #101, and #102 that RPN #103 was made aware that the resident had concerns and that RPN #103 had gone to observe the resident.

Both RPN #103, and RN #104 were interviewed, and both stated that they had not been made aware of any allegations of resident abuse. RPN #103 identified that they gone to see the resident in response to hearing the resident crying.

The inspection did identify that an allegation of abuse was made by resident #001 on the identified date. The legislation requires that anyone can report and not necessarily only the one with the highest reporting responsibility. In this case there were several staff that heard or were aware of the incident. It is established that one or more of the staff members in attendance did not follow the requirements of the home's policy to immediately report.

b. The Prevention of Abuse and Neglect Policy, in point #5, under The Investigation section directs the ED or their designate to interview the resident, and/or persons who may have knowledge of the situation.

Review of the home's investigation documents did not include any interviews with RPN #103, or RN #104. Both staff members had been identified in the written statements of PSW #101 and #102 as having been made aware of the incident, and the policy directs that they should have been interviewed.

Interviews with the ADOC and ED confirmed that the home's investigation should have included interviews with these two staff members. [s. 20. (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 the written policies that promote zero tolerance of abuse and neglect of residents are complied with, to be implemented voluntarily.

Issued on this 5th day of March, 2020

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) :	CECILIA FULTON (618)
Inspection No. / No de l’inspection :	2020_654618_0008
Log No. / No de registre :	022412-19
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 5, 2020
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Streetsville Care Community 1742 Bristol Road West, MISSISSAUGA, ON, L5M-1X9
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Jennifer Lee

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

To Vigour Limited Partnership on behalf of Vigour General Partner Inc., 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. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The Licensee shall be compliant with Section 19 (1), and shall ensure that Resident #001, and all other residents are protected from abuse by anyone.

Grounds / Motifs :

1. 1. The Licensee has failed to ensure that resident #001 was protected from abuse by anyone

As per O. Reg. 79/10, s.2 (1), the definition of "physical abuse", subject to subsection (2) (1) of the Act, includes the use of physical force by anyone other than a resident that causes physical injury or pain.

This inspection was initiated in response to Critical Incident System Report (CIS) related to alleged abuse of resident #001 by a staff member.

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PSW #101 stated that they immediately reported this to RPN #103 who was

outside of the room, and RN #104 who was at the nursing station. PSW #101 reported that RPN #103 went to see the resident, and that the registered staff communicated to PSW #101 that this was the resident's normal behaviour.

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RN #105 documented that resident #001 alleged they had been abused by the PSW #102.

Review of progress notes for the identified shift did not include anything about the abuse allegation or of any concerns raised by the resident.

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RN #105 was not available for interview during this inspection, however they did assess the resident, and documented their findings, and reported to the Ministry of Health.

It is the conclusion of this inspection that the abuse of resident #001 did occur on November 24, 2019, as reported by Resident #001, PSW #101, PSW #106 and RN #105. [s. 19. (1)]

The Severity of this issue was determined to be a level 3 as there was actual harm to the resident. The Scope of the issue was a level 1 as it was isolated to one of three residents reviewed.
The home had a level 4 history of ongoing non-compliance with this subsection of the act that included:
Voluntary Plan of Correction (VPC) issued September 16, 2019, (2019_659189_0011). (618)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 16, 2020

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
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:

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
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 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 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 5th day of March, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cecilia Fulton

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