Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Amended Public Copy/Copie modifiée 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
Jun 19, 2020	2019_618211_0023 (A2)	012934-19, 015768-19, 017079-19, 017859-19, 018927-19, 021250-19	Critical Incident System

Licensee/Titulaire de permis

Corporation of the City of Cornwall
360 Pitt Street CORNWALL ON K6J 3P9

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

Glen-Stor-Dun Lodge
1900 Montreal Road CORNWALL ON K6H 7L1

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

Amended by JOELLE TAILLEFER (211) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Due to the current emergency orders is place amid the Coronavirus pandemic, the due date for compliance order #001 issued under O.Reg 79/10, s. 55 from inspection report 2019_618211_0023 to October 31, 2020.

Issued on this 19th day of June, 2020 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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

Amended by JOELLE TAILLEFER (211) - (A2)

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): October 10, 11, 15, 16, 17, 24, 25, 29, 30, 31, 2019 and November 1, 2019.

This inspection included 6 Critical Incident Reports (CIR)

-Log 012934-19, Log 017079-19 related to falls that caused injury whereby residents were taken to the hospital which resulted in significant change in health status.

-Log 015768-19 related to allegation of resident to resident abuse and a fall that caused injury whereby a resident was taken to the hospital which resulted in significant change in health status.

-Log 018927-19 related to allegation of staff to resident abuse.

-Log 017859-19 and Log #021250-19 (initiated by Inspector #211) both related to allegations of resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RNs), Resident Services Supervisor, Staff Development/Education/Infection Control, Resident Assessment Instrument Minimum Data Set (RAI-MDS) Coordinator, Registered Practical Nurses (RPNs), Behavioral Supports Ontario (BSO), Personal Support Workers (PSWs), Student Nurse, and residents.

In addition, the inspector reviewed residents' health care records, the High Intensity Needs sheets, the licensee's Resident Non-Abuse, Responsive Behaviors, Fall Prevention policies and procedures, licensee's Investigations, observed the resident care environments, resident to resident and staff 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.
- **11 WN(s)**
- **7 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 O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that procedures and interventions were implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviors and to minimize the risk of altercations and potentially harmful interactions between and among residents.

On an identified date, the licensee contacted the Infoline of the Ministry of Long-Term Care (MLTC) related to an alleged abuse from resident #010 toward resident #011. On an identified date, the MLTC received the amended Critical Incident Report (CIR) from the licensee that indicated resident #001 sustained two injuries. The CIR indicated that the home's video demonstrated that resident #011 walked toward resident #010 who was sitting at an identified area and they had a brief conversation. Resident #010 stood up beside resident #011. Resident #011 walked away, but then turned back and slapped resident #010's identified body area. Resident #010 responded by slapping back resident #011's identified body area, then grabbed resident #011's clothes and slapped again across another identified body area. Both residents grabbed each others clothes, then resident #010 pushed resident #011 backward. Resident #011 tripped and fell backward.

Review of resident #010's plan of care on an identified date, indicated that the resident had multiple responsive behaviors. The resident's plan of care had several interventions to decrease resident #010's responsive behaviors.

Resident #011's plan of care on an identified date, indicated that the resident had multiple responsive behaviors. The resident's plan of care had several interventions to manage resident #011's responsive behaviors. One of the interventions was to remove resident #011 from public area when the behavior was disruptive/unacceptable.

Review of resident #010's progress notes within eight months indicated that:
-On an identified date, resident #010 agitated co-residents and was attempting to hit them. Resident #010 was redirected to another area with effect.
-One month later, resident #010 refused to leave a co-resident's room and attempted to hit the resident. When a staff stepped in, the resident hit the staff. Resident #010 was medicated for agitation.
-Two days later, resident #010 was approached by resident #014. By the time the staff intervened, resident #014 received superficial injury to a specific area of the body.
-Twelve days later, resident #010 was applying physical force toward a co-resident's identified body area and the staff was able to free the co-resident from resident's grip.
-Seven days later, resident #010 became aggressive toward the staff when they tried to put on the resident's shoes.
-Two months later, resident #010 rummaged thru co-resident's room and the staff was unable to redirect as the resident was striking out.
-Ten days later, staff overheard an argument between residents #010 and #013. Resident #010 was hitting resident #013 with an identified item.
-Seven days later, the registered nurse was called at a specified time as there was a fight between residents #010 and #011. Resident #011 had a fall and was transferred to the hospital due to pain at a specific body area.
-Nine days later, the nurse practitioner wrote that it was reported that resident #010 had increased agitation and triggered by aggressive interactions with other residents. The resident's personal care was an issue during the morning and sometimes the resident's behaviors escalated during the evening.
-Two months later, resident #010 hit a staff on three identified body areas during care.

In an interview with RN #132 on an identified date, stated that resident #010 was difficult to monitor since the resident goes in every residents' room. The resident was ordered medication to decrease the behaviors, but the resident's behaviors were persisting. The resident was exhibiting communication deficit and several physical aggressive behaviors and was attempting to push others. The monitoring

of the resident was not written hourly but the resident's responsive behaviors were documented in the nursing notes.

In an interview with RN #125 on an identified date, stated that resident #010 was visually monitored every fifteen minutes, but the monitoring was not documented. A Dementia Observation System (DOS) was not initiated nor completed for resident #010, but would have been helpful to give a history of the resident's responsive behaviors. RN #125 indicated that the staff was keeping close supervision of the whereabouts of resident #010.

In an interview with the DOC on an identified date, stated that if the DOS would have been used, it could have determined if there was a pattern for resident #010's responsive behaviors. The DOC stated that the resident was seen previously by the BSO within a three months period. The DOC stated that the resident was not referred to specialized resources such as psychogeriatric team since they need the consent from the family.

The licensee has failed to ensure that procedures and interventions were implemented to minimize the risk of altercations and potentially harmful interactions between residents #010 and the other residents and to assist residents and staff who are at risk of harm or who are harmed as a result of resident #010's responsive behaviors. Consequently, resident #010 monitoring was not properly managed, therefore resident #011 sustained an injury related to resident #010's responsive behaviors. [s. 55. (a)]

2. On an identified date, Inspector #211 initiated an inspection related to resident #012 after being informed by PSW #112 that the resident was hit by resident #015. Review of the past Critical Incident Report (CIR) received by the licensee on a earlier date, indicated that the inquiry closed on an identified date was related to an alleged physical abuse from resident #016 toward resident #012. The CIR indicated that resident #016 became upset when resident #012 entered resident #016's specific area and punched resident #012 on an identified date.

Review of resident #012's health care records indicated that the resident was admitted in the home on an identified date and diagnosed with cognition impairment and other health conditions. The resident's plan of care on an identified date, indicated the resident had several responsive behaviors and multiple interventions were put in place.

In an interview with PSW #112 on an identified date, stated that resident #012 was still exhibiting an identified responsive behaviors and going into different areas on the unit. PSW #112 stated that co-residents were upset due to resident #012's responsive behaviors. PSW #112 indicated that resident #012 was watching and waiting for the staff to be occupied to exhibit the identified responsive behavior. Therefore, resident #012 was at risk of harm by other residents.

In an interview with the Administrator on an identified date, Inspector #211 relayed that the nursing personal staff were concerned for the safety of resident #012 and the other residents when resident #012 was exhibiting the identified responsive behaviors.

Review of the High Intensity Needs sheets was initiated on the day that the inspector relayed the concerned from the nursing personal staff and resident #012 was monitored closely with a staff on four specific dates for 24 hours. The High Intensity Needs sheets indicated that the close monitoring for resident #012 was changed to two identified shifts for the following six consecutive dates. However, the resident was not supervised closely by a staff member on seven identified dates.

Resident #012' progress notes on an identified date, indicated that resident #012 was found in an identified area with resident #015. The staff intervened and removed resident #012 from the identified area. A few minutes later, the staff noted that resident #012 had returned to the identified area with the presence of resident #015. As the staff was entering the identified area, resident #015 punched resident #012's specific body area and warned resident #012 not to return or resident #012 will be punched again. The notes indicated that there was no injuries or marks present to both residents.

Review of the High Intensity Needs sheets indicated that the close supervision was re-instated for resident #012 on the identified date when resident #012 was punched by resident #015 and the subsequent dates for 24 hours a day. However, the administrator stated that they were unable to put close supervision for resident #012 on two identified dates for a specified shift.

The licensee has failed to ensure that procedures and interventions were implemented to assist resident #012 with the identified responsive behaviors, to minimize the risk of altercations and potential harmful interactions between

residents #012 and #015. [s. 55. (a)]

3. On an identified date, the licensee reported to the Ministry of Long-Term Care (MLTC) by the Infoline that resident #009 hit resident #008 and resident #008 sustained two injuries.

On another identified date, the MLTC received a Critical Incident Report (CIR) from the licensee that resident #008 was found on the floor on an identified date and time, in a specific area. Resident #008 revealed losing balance and falling on the floor after being hit by resident #009. The CIR indicated that prior the incident, resident #008 had several complaints towards resident #009's behaviors.

Review of Resident #008’s health care records indicated that the resident was admitted on an identified date and was diagnosed with cognitive impairment and other health conditions. Resident #008 was transferred to another room several days after the incident.

The resident #008’s plan of care on an identified date, indicated the resident had several interventions in place.

Review of resident #009’s health care records indicated that the resident was admitted in the home on an identified date and was diagnosed with a cognitive impairment and other health conditions. Resident #009 current plan of care indicated that the resident had a chronic and progressing decline in cognitive functioning. Furthermore, resident #009 was demonstrating verbal and physical responsive behaviors but will not strike or verbally abused others. Several interventions were put in place.

Review of residents #008 and #009’s progress notes within six months, indicated the sequence of events for the following dates:
-On an identified date during the night shift, resident #009 was exhibiting a responsive behavior and resident #008 was upset at the disturbance.
-On month later during the night shift, resident #009 was awake and tearing apart resident #008's area.
-Nine days later during the evening shift, resident #009 was upset with co-resident #008. The resident was heard threatening to punch resident #008.
-Nine days later during the night shift, resident #009 was awake and standing next to resident #008. Resident #009 was throwing resident #008’s clothes and other items while resident #008 was sleeping. Resident #008 voiced being scared with

resident #009 present in the room. Resident #009 was monitored closely until the resident settled.
-During the evening shift of the following month, resident #009 was talking to self loudly and upsetting resident #008.
-On the next evening shift, resident #012 rang the call bell as resident #009 was staring at co-resident.
-One month later, RPN #116 wrote that resident #008 was upset because the resident #009 was moving resident #008's identified item around with the co-resident.
-Twelve days later during the evening shift, resident #009 was exhibiting responsive behaviors and scaring co-resident #008.
-Sixteen days later, resident #008 was found on the floor and stated losing balance when hit by resident #009.
-Two days later during the evening shift, resident #009 was restless and unable to express what was upsetting. The resident was grabbing co-residents and staff.
-Over two days later, the physician wrote that resident #008 was injured by roommate #009.
-Two days later, resident #009 was restless, moving furniture and yelling.
-Seven days later, resident #008 was transferred to another identified area.
-Nineteen days later, resident #009 was confused and grabbing other residents' utensils in the dining room.

In an interview with PSW #120 on an identified date, stated that resident #009 had exhibited verbal aggression toward the staff and the residents. PSW #120 indicated that residents #008 and #009 were always arguing and being verbally aggressive to each other. PSW #120 revealed that the nurses were informed repeatedly that both residents should be separated to stop them arguing with each other.

In an interview with PSW #123 on an identified date, stated not being surprised when they heard that resident #009 had pushed resident #008. PSW #123 indicated when resident #009 was becoming fidgety and demonstrating responsive behaviors towards resident #008, during the end of the evening shifts. Resident #009 was seen staring at resident #008. One time, they saw resident #009 removing resident #008's bed sheets. PSW #123 indicated that since resident #008 was transferred to another unit, they are worried for another resident's safety. Resident #009 started to exhibit the same responsive behaviors toward the identified resident as resident #008. PSW indicated that resident #009 was visually monitored every 15 minutes, but there was no documentation

indicating that the resident needed to be monitored every 15 minutes.

In an interview with RPN #121 on an identified date, stated when a resident exhibits responsive behavior, the team communicated with each other to keep the residents safe. A 15 minutes check sheet will be started and completed.

In an interview with the DOC on an identified date, stated being aware of the problems between residents #009 and #008 and that resident #009 was invading resident #008's space. Resident #008 was especially upset for a specified reason. The DOC indicated that resident #009 was visually monitored on the unit like the other residents. An identified Observation Sheet was not initiated and the resident was not referred to specialized resources. The DOC indicated waiting for the resident's Substitute Decision Maker (SDM)'s consent to refer resident to an identified specialized resource team and to transfer the resident to another area in the home. The DOC stated that steps to prevent altercations between resident #008 and #009 could have been put in place prior the incident on the identified date.

The licensee has failed to ensure that procedures and interventions were implemented to assist resident #008 who was harmed as a result of resident #009's behaviors, and to minimize the risk of altercations and potentially harmful interactions between both residents. [s. 55. (a)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the right of the residents to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On an identified date, Inspector #211 observed resident #007's plan of care and the "24 Hour Flow Sheet" placed inside a binder titled with the identified unit. This binder was placed inside a mobile storage rack in the opened communication area beside the wall in the middle of an identified unit. Likewise, Inspector #211 observed two more binders titled with another identified unit. All those binders contained all residents' plan of care.

Furthermore, an entry copied from resident #008's progress notes on an identified dated was taped on the top of the desk in the opened communication area of the identified unit. The note indicated the resident voicing a specific dislike with specific wishes and that the resident's care plan has been updated to reflect the resident preference.

On the same day, Inspector #211 observed that residents' plan of care with their Personal Health Information (PHI) were inserted inside a binder placed in a mobile storage rack in the opened concept of the communication area on another identified unit. Additionally, the residents' plan of care was put inside a binder located in the mounted wall's desk of the open concept nursing station situated in the middle of another unit.

In an interview with the Administrator on an identified date, stated that all these binders with residents' PHI must not be left unlocked in any area of the home. The Administrator also stated that a section of resident #008's progress notes shall not be taped on top of the communication area desk to protect confidential information. Therefore, the licensee has not respected and promoted residents' right to have their PHI kept confidential accordance with that Act. [s. 3. (1) 11. iv.]

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 right of the residents to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, to be implemented voluntarily.

WN #3: 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. (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 the care set out in the plan of care was provided to resident #012 as specified in the plan.

Review of the High Intensity Needs sheets indicated that a close supervision with a staff was in place for resident #012 on an identified date during a specified shift.

On that date, Inspector #211 observed resident #012 sitting in a chair in a specific area in the identified unit with 2 other residents present without the close monitoring from an identified staff supervision. PSW #133 was found standing in the hallway beside another area far away from resident #012. Inspector #211 observed that PSW #133 was too far from resident #012 to be able to intervene if there was an altercation between resident #012 and one of the other resident sitting in the identified area. When PSW #012 was approached and questioned by Inspector #211 related the close monitoring for resident #012, PSW responded “I have to be just beside resident #012?”.

In an interview with the Administrator on the same day, stated that the staff who was supervising resident #012 must be close enough to monitor resident #012’s responsive behaviors and prevent potential altercation between residents.

The licensee has failed to ensure that the close supervision by a staff for resident #012, set out in the plan of care was provided to resident #012 as specified in the plan. [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 the care set out in the plan of care was provided to resident #012 as specified in the plan, to be implemented voluntarily.

WN #4: 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 of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated.

On an identified date, the Ministry of Long-Term Care (MTLC) received a Critical Incident Report (CIR) related to alleged abuse from PSW #129 toward resident #013 from the previous day.

In an interview with the DOC on an identified date, stated that the investigation related to the alleged abuse from PSW #129 toward resident #013 was not immediately investigated on the day the incident occured. The DOC indicated that the email was sent by RN #132 on the day of the incident and read the next day. The email indicated that PSW #129's voice was raised and was verbally inappropriate toward resident #013. The DOC confirmed that RN #132 should have immediately contacted the manager on call by phone when the incident occurred. Therefore, investigation was not started until the next day.

The licensee has failed to ensure that the alleged abuse from PSW #129 to resident #013 was immediately investigated on the day of the incident. [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 to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #5: 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 a person who has reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or risk of harm to the resident, shall immediately report the suspicion and the information to the Director.

On an identified date, the Ministry of Long-Term Care (MTLC) received a Critical Incident Report (CIR) related to alleged abuse from PSW #129 toward resident #013 from the previous day.

In an interview with the DOC on an identified date, stated that the alleged abuse from PSW #129 toward resident #013 on an identified date was brought to their attention after reading RN #132's email on the following day. Therefore, the Director was only informed the day after the incident occured.

The licensee has failed to ensure that the Director was immediately informed on the day of the incident, when RN #132 witnessed abuse from PSW #129 toward resident #013. [s. 24. (1)]

2. Inspector #211 reviewed residents #013' s health care records written by RN #125 on an identified date, that resident #013's was found with two altered skin integrity to the identified body areas.

In an interview with RN #125 on an identified date, stated that the charting in resident #013's progress notes on the identified date indicated the resident was observed with an altered skin integrity to two identified body areas when informed by the staff that residents #010 and #013 were hitting each other on the previous day. RN #125 stated informing the DOC on that day.

In an interview with the Administrator on an identified date, stated that the MLTC should have been informed immediately when RN #125 suspected physical abuse when they observed resident #013 with two identified altered skin integrity on the specified body area. [s. 24. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or risk of harm to the resident, shall immediately report the suspicion and the information to the Director, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

Inspector #211 reviewed resident #013's health care records and discovered the following notes:
-On an identified date, staff overheard an argument between resident #013 and co-resident #010. Resident #010 was heard hitting resident #013 with an identified item. The residents were immediately separated, and the item removed. There were no injuries sustained to either residents.
-Nineteen days later, resident #013 heard yelling in the hallway. Resident #010 was found pushing resident #013 sitting in the wheelchair.
-The next month, resident #013 was found yelling and swinging at resident #010. The staff intervened before the residents were able to punch or hit each other.

-Two days later, RN #125 wrote that resident #013 was observed with two identified altered skin integrity to a specified body area. Staff reported that residents #013 and #010 had a fight the other day and they were found fighting with each other.

In an interview with PSW #124 on an identified date, stated there was an altercation between residents #010 and #013 on an identified date. When they heard yelling, they found both residents holding each other's clothing. PSW #124 stated that resident #010 went into resident #013' s identified area, grabbed and touched resident #013' s personal items before the altercation started. PSW #124 revealed that RPN #121 was informed that both residents were holding each other and resident #010 had an altered skin integrity on an identified body area. PSW #124 indicated that residents #010 was visually monitored. Residents #010 and #013 doesn't have a monitoring sheet to document at a set times when the residents were observed.

In an interview with PSW #131 on an identified date, stated that on an undetermined date, they heard screaming and found resident #013 was holding an identified body area and resident #010 was holding another identified body area. PSW #131 reported that a Registered Practical Nurse was informed related to resident's altered skin integrity on the identified body area but couldn't remember exactly who the nurse was.

In an interview with RN #125 on an identified date, stated charting in resident #013's progress notes on the day that the resident was observed with an altered skin integrity on two specified body areas. The staff informed RN #125 that residents #010 and #013 were hitting each other on the previous day. RN #125 stated informing the DOC on that day. RN #125 stated that the identified assessment tool was never implemented for resident #010 to provide a better history of the resident's responsive behaviors. Additionally, there was no determine time set documented when the resident was to be monitored.

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents #013 and #010, including identifying and implementing interventions. [s. 54. (b)]

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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among resident, including identifying and implementing interventions, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker (SDM), if any, and any other person specified by the resident was notified immediately upon the licensee becoming aware of an alleged, suspected or witness of abuse that causes distress to the resident that could potentially be detrimental to the resident's health or well-being.

On an identified date, the Ministry of Long-Term Care (MTLC) received a Critical Incident Report (CIR) related to alleged abuse from PSW #129 toward resident #013 on the previous day. The CIS indicated that RN #132 witnessed PSW #129's voice raised and was verbally inappropriate toward resident #013.

In an interview with the DOC on an identified date, stated that resident #013's SDM was notified the next day of the incident, related to the alleged abuse incident on the identified date by a PSW.

The licensee has failed to ensure that resident #013's SDM was notified on the day when the alleged abuse incident occurred. [s. 97. (1) (a)]

2. Inspector #211 reviewed residents #013' s health care records written by RN #125 on an identified date, that resident #013's was found with two altered skin integrity to the identified body areas.

In an interview with RN #125 on an identified date, stated that residents' family were not notified of the altercation between residents #010 and #013 on the identified date nor of the suspected abuse from resident #010 toward resident #013.

In an interview with the Administrator on an identified date, stated that resident #013's family was not notified of the suspected abuse when the resident #013 was discovered with two altered skin integrity to the specified body areas on the identified date. [s. 97. (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 to ensure that the resident's substitute decision-maker (SDM), if any, and any other person specified by the resident was notified immediately upon the licensee becoming aware of an alleged, suspected or witness of abuse that causes distress to the resident that could potentially be detrimental to the resident's health or well-being, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified on the identified date of the witnessed abuse from PSW #129 toward resident #013 that the licensee suspect may constitute a criminal offence.

On an identified date, the Ministry of Long-Term Care (MTLC) received a Critical Incident Report (CIR) related to alleged abuse from PSW #129 toward resident #013 on the previous day.

In an interview with DOC on an identified day, stated that the police force was not notified of the incident when PSW #129 abused resident #013. [s. 98.]

2. The licensee has failed to ensure that the appropriate police force was immediately notified on an identified date when RN #125 was notified of the altercation and suspected physical abuse from resident #010 toward resident #013 that may constitute a criminal offence.

Inspector #211 reviewed residents #013 and #010's health care records and discovered only in resident #013's progress notes the following information:
-On an identified date, resident #013 was yelling and swinging at resident #010. Resident #010 was grabbing resident #013's personal items. The staff intervened before the residents were able to punch or hit each other.
-Two days later, RN #125 wrote that resident #013 was observed with two altered skin integrity to the specified body areas. Staff reported that residents #013 and #010 had a fight the other day.

In an interview with RN #125 on an identified date, stated that the police force was not notified of the suspect physical abuse between residents #010 and #013 on the identified date. RN #125 stated that the DOC was informed that resident #013 was found with altered skin integrity to the specified body areas on an identified date.

In an interview with the Administrator on an identified date, stated that RN #125 didn't notify the police force on the identified date, when resident #013 was discovered with altered skin integrity to the specified body area. [s. 98.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the appropriate police force was immediately notified of the witnessed abuse from PSW #129 toward resident #013 that the licensee suspect may constitute a criminal offence, to be implemented voluntarily.

WN #9: 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 to protect resident #013 from alleged abuse by PSW #129.

On an identified date, the Ministry of Long-Term Care (MTLC) received a Critical Incident Report (CIR) related to alleged abuse from PSW #129 toward resident #013 on the previous day. The CIR indicated while PSW #129 was serving food in an identified area, resident #013 started yelling and was exhibiting verbal responsive behavior toward PSW #129. PSW #129's voice was raised and was verbally inappropriate towards resident #013.

Review of resident #013’s progress notes written by the specialized resource team on an identified date, indicated that the resident was on a special diet and was exhibiting responsive behaviors because the resident was forgetting that the meal was already eaten. The resident’s behaviors were escalating and upsetting the other residents during meal times.

In an interview with PSW #129 on an identified date, confirmed being verbally inappropriate toward resident #013. PSW #129 stated that it was not the first time resident #013 was disruptive during meal times and the other residents were becoming anxious. Resident #013 was repetitively asking for an identified beverage and at the time there was no intervention to deescalate resident #013’s behaviors.

In an interview with the DOC on an identified date, stated PSW #129 was told the following day of the incident, that there is a zero tolerance of abuse toward residents and disciplinary measures were taken.

The licensee has failed to ensure to protect resident #013 from abuse by PSW #129 on an identified date, when resident’s responsive behaviors were escalating in an identified area. [s. 19. (1)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Review of resident #013's progress notes on an identified date, RN #125 wrote that resident #013 was observed with altered skin integrity to a specified body area.

Interview with the DOC on an identified date, stated that resident #013 did not received an appropriate skin assessment when the resident was discovered with the altered skin integrity to the specified body area.

The licensee failed to ensure when resident #013 was discovered on an identified date with altered skin integrity to the specified body area to use a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment by a registered nursing staff. [s. 50. (2) (b) (i)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure at least annually, the matters referred to in subsection (1) are developed and implemented and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

On an identified date, Inspector #211 requested a copy of the licensee's Responsive Behaviors policy. The inspector obtained from the DOC a copy of the Responsive Behavior Program with written corrections. The copy indicated that the program and the policy were in development.

In an interview with the Administrator on an identified date, stated the policy #MM-1105-11 titled "Prevention and Management of Disturbing Behavior" was dated July 1997. The Administrator expressed concerns related to the outdated responsive behavior policy and relayed that the policy should have been revised since the Long-Term Care Homes legislation came into force in 2010. [s. 53. (3) (b)]

Issued on this 19th day of June, 2020 (A2)

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JOELLE TAILLEFER (211) - (A2)
Inspection No. / No de l'inspection :	2019_618211_0023 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	012934-19, 015768-19, 017079-19, 017859-19, 018927-19, 021250-19 (A2)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 19, 2020(A2)
Licensee / Titulaire de permis :	Corporation of the City of Cornwall 360 Pitt Street, CORNWALL, ON, K6J-3P9
LTC Home / Foyer de SLD :	Glen-Stor-Dun Lodge 1900 Montreal Road, CORNWALL, ON, K6H-7L1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Steven Golden

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Corporation of the City of Cornwall, 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 :

O.Reg 79/10, s. 55. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Order / Ordre :

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

The licensee shall be compliant with s. 55 (a) of Ontario Regulation 79/10.

Specifically, the licensee shall ensure procedures and interventions are implemented to assist residents and staff who are at risk of harm or who are harmed as a result of residents #009, #010, #012's responsive behaviors, to minimize the risk of altercations and potentially harmful interactions between and among residents by completing the following:

1. Ensure interventions for residents' displaying responsive behaviors are assessed for effectiveness by registered nursing staff or/and the Behavioral Support Ontario (BSO) team.

2. Ensure registered nursing staff understand when and how to seek assistance from the internal BSO team and/or the external psycho-geriatric outreach team.

3. Ensure residents' plan of care indicates how often the resident needs to be monitored and their interventions are provided as specified in their plan of care.

Grounds / Motifs :

1. The licensee has failed to ensure that procedures and interventions were implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviors and to minimize the risk of altercations and potentially harmful interactions between and among residents.

On an identified date, the licensee contacted the Infoline of the Ministry of Long-Term Care (MLTC) related to an alleged abuse from resident #010 toward resident #011. On an identified date, the MLTC received the amended Critical Incident Report (CIR) from the licensee that indicated resident #001 sustained two injuries. The CIR indicated that the home's video demonstrated that resident #011 walked toward resident #010 who was sitting at an identified area and they had a brief conversation. Resident #010 stood up beside resident #011. Resident #011 walked away, but then turned back and slapped resident #010's identified body area. Resident #010 responded by slapping back resident #011's identified body area, then grabbed resident #011's clothes and slapped again across another identified body area. Both residents grabbed each others clothes, then resident #010 pushed resident #011

backward. Resident #011 tripped and fell backward.

Review of resident #010's plan of care on an identified date, indicated that the resident had multiple responsive behaviors. The resident's plan of care had several interventions to decrease resident #010's responsive behaviors.

Resident #011's plan of care on an identified date, indicated that the resident had multiple responsive behaviors. The resident's plan of care had several interventions to manage resident #011's responsive behaviors. One of the interventions was to remove resident #011 from public area when the behavior was disruptive/unacceptable.

Review of resident #010's progress notes within eight months indicated that:
-On an identified date, resident #010 agitated co-residents and was attempting to hit them. Resident #010 was redirected to another area with effect.
-One month later, resident #010 refused to leave a co-resident's room and attempted to hit the resident. When a staff stepped in, the resident hit the staff. Resident #010 was medicated for agitation.
-Two days later, resident #010 was approached by resident #014. By the time the staff intervened, resident #014 received superficial injury to a specific area of the body.
-Twelve days later, resident #010 was applying physical force toward a co-resident's identified body area and the staff was able to free the co-resident from resident's grip.
-Seven days later, resident #010 became aggressive toward the staff when they tried to put on the resident's shoes.
-Two months later, resident #010 rummaged thru co-resident's room and the staff was unable to redirect as the resident was striking out.
-Ten days later, staff overheard an argument between residents #010 and #013. Resident #010 was hitting resident #013 with an identified item.
-Seven days later, the registered nurse was called at a specified time as there was a fight between residents #010 and #011. Resident #011 had a fall and was transferred to the hospital due to pain at a specific body area.
-Nine days later, the nurse practitioner wrote that it was reported that resident #010 had increased agitation and triggered by aggressive interactions with other residents. The resident's personal care was an issue during the morning and sometimes the resident's behaviors escalated during the evening.

-Two months later, resident #010 hit a staff on three identified body areas during care.

In an interview with RN #132 on an identified date, stated that resident #010 was difficult to monitor since the resident goes in every residents' room. The resident was ordered medication to decrease the behaviors, but the resident's behaviors were persisting. The resident was exhibiting communication deficit and several physical aggressive behaviors and was attempting to push others. The monitoring of the resident was not written hourly but the resident's responsive behaviors were documented in the nursing notes.

In an interview with RN #125 on an identified date, stated that resident #010 was visually monitored every fifteen minutes, but the monitoring was not documented. A Dementia Observation System (DOS) was not initiated nor completed for resident #010, but would have been helpful to give a history of the resident's responsive behaviors. RN #125 indicated that the staff was keeping close supervision of the whereabouts of resident #010.

In an interview with the DOC on an identified date, stated that if the DOS would have been used, it could have determined if there was a pattern for resident #010's responsive behaviors. The DOC stated that the resident was seen previously by the BSO within a three months period. The DOC stated that the resident was not referred to specialized resources such as psychogeriatric team since they need the consent from the family.

The licensee has failed to ensure that procedures and interventions were implemented to minimize the risk of altercations and potentially harmful interactions between residents #010 and the other residents and to assist residents and staff who are at risk of harm or who are harmed as a result of resident #010's responsive behaviors. Consequently, resident #010 monitoring was not properly managed, therefore resident #011 sustained an injury related to resident #010's responsive behaviors. [s. 55. (a)] (211)

2. On an identified date, Inspector #211 initiated an inspection related to resident #012 after being informed by PSW #112 that the resident was hit by resident #015. Review of the past Critical Incident Report (CIR) received by the licensee on a earlier date, indicated that the inquiry closed on an identified date was related to an alleged physical abuse from resident #016 toward resident #012. The CIR indicated that

resident #016 became upset when resident #012 entered resident #016's specific area and punched resident #012 on an identified date.

Review of resident #012's health care records indicated that the resident was admitted in the home on an identified date and diagnosed with cognition impairment and other health conditions. The resident's plan of care on an identified date, indicated the resident had several responsive behaviors and multiple interventions were put in place.

In an interview with PSW #112 on an identified date, stated that resident #012 was still exhibiting an identified responsive behaviors and going into different areas on the unit. PSW #112 stated that co-residents were upset due to resident #012's responsive behaviors. PSW #112 indicated that resident #012 was watching and waiting for the staff to be occupied to exhibit the identified responsive behavior. Therefore, resident #012 was at risk of harm by other residents.

In an interview with the Administrator on an identified date, Inspector #211 relayed that the nursing personal staff were concerned for the safety of resident #012 and the other residents when resident #012 was exhibiting the identified responsive behaviors.

Review of the High Intensity Needs sheets was initiated on the day that the inspector relayed the concerned from the nursing personal staff and resident #012 was monitored closely with a staff on four specific dates for 24 hours. The High Intensity Needs sheets indicated that the close monitoring for resident #012 was changed to two identified shifts for the following six consecutive dates. However, the resident was not supervised closely by a staff member on seven identified dates.

Resident #012' progress notes on an identified date, indicated that resident #012 was found in an identified area with resident #015. The staff intervened and removed resident #012 from the identified area. A few minutes later, the staff noted that resident #012 had returned to the identified area with the presence of resident #015. As the staff was entering the identified area, resident #015 punched resident #012's specific body area and warned resident #012 not to return or resident #012 will be punched again. The notes indicated that there was no injuries or marks present to both residents.

Review of the High Intensity Needs sheets indicated that the close supervision was re-instated for resident #012 on the identified date when resident #012 was punched by resident #015 and the subsequent dates for 24 hours a day. However, the administrator stated that they were unable to put close supervision for resident #012 on two identified dates for a specified shift.

The licensee has failed to ensure that procedures and interventions were implemented to assist resident #012 with the identified responsive behaviors, to minimize the risk of altercations and potential harmful interactions between residents #012 and #015. [s. 55. (a)] (211)

(A1)
3. On an identified date, the licensee reported to the Ministry of Long-Term Care (MLTC) by the Infoline that resident #009 hit resident #008 and resident #008 sustained two injuries.

On another identified date, the MLTC received a Critical Incident Report (CIR) from the licensee that resident #008 was found on the floor on an identified date and time, in a specific area. Resident #008 revealed losing balance and falling on the floor after being hit by resident #009. The CIR indicated that prior the incident, resident #008 had several complaints towards resident #009's behaviors.

Review of Resident #008's health care records indicated that the resident was admitted on an identified date and was diagnosed with cognitive impairment and other health conditions. Resident #008 was transferred to another room several days after the incident.

The resident #008's plan of care on an identified date, indicated the resident had several interventions in place.

Review of resident #009's health care records indicated that the resident was admitted in the home on an identified date and was diagnosed with a cognitive impairment and other health conditions. Resident #009 current plan of care indicated that the resident had a chronic and progressing decline in cognitive functioning. Furthermore, resident #009 was demonstrating verbal and physical responsive behaviors but will not strike or verbally abused others. Several interventions were put in place.

Review of residents #008 and #009's progress notes within six months, indicated the sequence of events for the following dates:
-On an identified date during the night shift, resident #009 was exhibiting a responsive behavior and resident #008 was upset at the disturbance.
-On month later during the night shift, resident #009 was awake and tearing apart resident #008's area.
-Nine days later during the evening shift, resident #009 was upset with co-resident #008. The resident was heard threatening to punch resident #008.
-Nine days later during the night shift, resident #009 was awake and standing next to resident #008. Resident #009 was throwing resident #008's clothes and other items while resident #008 was sleeping. Resident #008 voiced being scared with resident #009 present in the room. Resident #009 was monitored closely until the resident settled.
-During the evening shift of the following month, resident #009 was talking to self loudly and upsetting resident #008.
-On the next evening shift, resident #012 rang the call bell as resident #009 was staring at co-resident.
-One month later, RPN #116 wrote that resident #008 was upset because the resident #009 was moving resident #008's identified item around with the co-resident.
-Twelve days later during the evening shift, resident #009 was exhibiting responsive behaviors and scaring co-resident #008.
-Sixteen days later, resident #008 was found on the floor and stated losing balance when hit by resident #009.
-Two days later during the evening shift, resident #009 was restless and unable to express what was upsetting. The resident was grabbing co-residents and staff.
-Over two days later, the physician wrote that resident #008 was injured by roommate #009.
-Two days later, resident #009 was restless, moving furniture and yelling.
-Seven days later, resident #008 was transferred to another identified area.
-Nineteen days later, resident #009 was confused and grabbing other residents' utensils in the dining room.

In an interview with PSW #120 on an identified date, stated that resident #009 had exhibited verbal aggression toward the staff and the residents. PSW #120 indicated that residents #008 and #009 were always arguing and being verbally aggressive to each other. PSW #120 revealed that the nurses were informed repeatedly that both

residents should be separated to stop them arguing with each other.

In an interview with PSW #123 on an identified date, stated not being surprised when they heard that resident #009 had pushed resident #008. PSW #123 indicated when resident #009 was becoming fidgety and demonstrating responsive behaviors towards resident #008, during the end of the evening shifts. Resident #009 was seen staring at resident #008. One time, they saw resident #009 removing resident #008's bed sheets. PSW #123 indicated that since resident #008 was transferred to another unit, they are worried for another resident's safety. Resident #009 started to exhibit the same responsive behaviors toward the identified resident as resident #008. PSW indicated that resident #009 was visually monitored every 15 minutes, but there was no documentation indicating that the resident needed to be monitored every 15 minutes.

In an interview with RPN #121 on an identified date, stated when a resident exhibits responsive behavior, the team communicated with each other to keep the residents safe. A 15 minutes check sheet will be started and completed.

In an interview with the DOC on an identified date, stated being aware of the problems between residents #009 and #008 and that resident #009 was invading resident #008's space. Resident #008 was especially upset for a specified reason. The DOC indicated that resident #009 was visually monitored on the unit like the other residents. An identified Observation Sheet was not initiated and the resident was not referred to specialized resources. The DOC indicated waiting for the resident's Substitute Decision Maker (SDM)'s consent to refer resident to an identified specialized resource team and to transfer the resident to another area in the home. The DOC stated that steps to prevent altercations between resident #008 and #009 could have been put in place prior the incident on the identified date.

The licensee has failed to ensure that procedures and interventions were implemented to assist resident #008 who was harmed as a result of resident #009's behaviors, and to minimize the risk of altercations and potentially harmful interactions between both residents. [s. 55. (a)] (211)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2020(A2)

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:

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

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

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

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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 19th day of June, 2020 (A2)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by JOELLE TAILLEFER (211) - (A2)

Ontario

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