Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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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## 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 |
|---|---|---|---|
| Dec 3, 2020 | 2020_640601_0022 | 011375-20, 011762-20, 012248-20, 014164-20, 014893-20, 016688-20, 017608-20, 020947-20 | Critical Incident System |

**Licensee/Titulaire de permis**

The Corporation of the County of Northumberland
983 Burnham Street Cobourg ON K9A 5J6

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

Golden Plough Lodge
983 Burnham Street Cobourg ON K9A 5J6

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

KARYN WOOD (601), CHANTAL LAFRENIERE (194)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): November 6, 10, 12, 13, 16, 17, 18, 19, and 20, 2020.**

**The following intakes were completed in this Critical Incident System (CIS) Report Inspection:**

**Five logs related to allegations of resident to resident abuse.**

**Two logs related to allegations of staff to resident neglect and abuse.**

**A log related to a fall that resulted in a change in condition.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), RAI Coordinator/RPN/Days Admissions and Documentation (RAI/RPN/DAD), Personal Support Workers (PSW), Housekeeper, and residents.**

**The inspector also reviewed resident health care records, internal investigation documentation, applicable policies, observed the delivery of resident care and services, including staff to resident interactions and resident to resident interactions.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Falls Prevention**
**Infection Prevention and Control**
**Pain**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**
**Safe and Secure Home**

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

**6 WN(s)**
**5 VPC(s)**
**1 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 protect resident #007 from physical abuse by resident #006.

Physical abuse is defined under O. Reg. 79/10 as including the use of physical force by a resident that causes physical injury to another resident.

Resident #006 and resident #007 were known to have responsive behaviours that have resulted in altercations with each other, and other residents'. RN #106, RPN #111, RPN #116, and RPN #120 indicated that resident #007's known responsive behaviours could be triggered by resident #006's responsive behaviour. RPN #114 observed a physical altercation between resident #006 and resident #007 and the altercation resulted in actual harm, as resident #007 sustained a injury.

Interventions to manage resident #006's and resident #007's responsive behaviors did not prevent resident #006 from physically abusing resident #007.

Sources: CIS, a resident's care plan, MDS RAP assessment, progress notes and interviews with RN #106, RPN #111, RPN #116, and RPN #120. [s. 19. (1)]

2. The licensee has failed to protect resident #006 from physical abuse by resident #007.

RN #106, RPN #111, RPN #116, and RPN #120 indicated that resident #007's known responsive behaviours could be triggered by resident #006's responsive behaviour. PSW #105 witnessed resident #007 become visibly angry due to resident #006's known responsive behaviour. Resident #007 threw an object at resident #006 and the resident sustained an injury. The resident to resident altercation resulted in actual harm, as resident #006 sustained an injury following the incident.

Interventions to manage resident #007's and resident #006's responsive behaviors did not prevent resident #007 from physically abusing resident #006.

Sources: CIS, a resident's care plan, MDS RAP assessment, progress notes and interviews with RN #106, RPN #111, RPN #116, and RPN #120. [s. 19. (1)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home was a safe environment related to the failure to maintain infection prevention and control measures specified in Directive #3 regarding the proper use of the surgical procedure mask and maintaining two meters distance from others while not a wearing a mask.

Physical distancing was not being maintained as residents' and staff were observed to be within two meters of others with no surgical procedure mask or with the mask not covering their mouth and/or nose.

The Chief Medical Officer of Health (CMOH) implemented Directive #3 which has been issued to long-term care homes and sets out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak of COVID-19 in long-term care homes. As per the version of Directive #3 effective October 16, 2020, all staff of long-term care homes must always wear a surgical procedure mask for the duration of their shift. When staff are not in contact with residents or in resident areas during their breaks, staff may remove their surgical procedure mask but must remain two meters away from other staff to prevent staff to staff transmission of COVID-19. Long-term care homes must have a plan for and use, to the extent possible, staff and resident cohorting as part of their approach to preparedness as well as to prevent the spread of COVID-19 once identified in the home. Resident cohorting may include alternative accommodation in the home to maintain physical distancing of 2 metres at all times.

The Director of Care (DOC) acknowledged they had observed staff to be within two meters of others with no surgical procedure mask or with the mask not covering their mouth and/or nose.

The lack of adherence to Directive #3 related to the use of surgical/procedure mask and physical distancing presented an actual risk of exposing the residents to COVID-19.

Sources: Directive #3 (version dated October 14, 2020), observations throughout the home, and interview with the DOC. [s. 5.]

***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 ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.***

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

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #001's plan of care included clear directions to staff related to when the resident's continence care should be provided.

PSW #103 reported to RPN #129 that resident #001 had not received continence care on their shift. PSW #105 immediately provided the resident's care and discovered the resident had been incontinent.

The resident's care plan related to continence care directed for the resident to receive total assistance from two staff for continence care, as required when incontinent. PSW #102, RPN #104, and RPN #106 indicated the resident could inform staff when they required continence care and they were not aware the resident had not received continence care on their shift. The plan of care did not provide clear direction to staff on when they needed to ask the resident if they required continence care. The resident was

at risk for altered skin integrity and urinary tract infection due to the lack of clear direction for staff providing care to the resident related to continence care.

ADOC #107 indicated the resident's written care plan did not provide clear direction regarding when the resident should receive continence care and it was determined the resident had not received continence care on a specified shift.

Sources: A resident's care plan, MDS RAP assessment, point of care documentation, progress notes, internal investigation notes, and interviews with PSW #102, RPN #104, RPN #106 and ADOC #107. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care for resident #002 related to continence care was provided to them as specified in the plan.

PSW #103 reported to RPN #129 that resident had not received continence care on their shift. PSW #105 discovered the resident had been incontinent.

The resident was incontinent and had a history of refusing continence care due to known responsive behaviours. The resident's care plan related to continence care and skin integrity directed for the resident to receive extensive assistance from one to two staff for toileting and to receive continence care after each episode of incontinence. The resident's care plan had interventions in place to manage the resident's responsive behaviours for care. PSW #102 indicated they were working when the resident had not received continence care and they did not wake the resident to provide care due to their responsive behaviours. PSW #102 further indicated they had checked on the resident throughout the day and they thought the plan of care was to leave the resident until they woke on their own. PSW #102, RPN #104, and RPN #106 indicated the resident had responsive behaviours, and would refuse continence care. The resident was at risk for altered skin integrity when continence care was not provided on the specified shift.

ADOC #107 indicated resident #002’s written care plan was clear regarding how to manage the resident’s responsive behaviours related to when the resident should receive continence care and it was determined the resident’s plan of care was not followed when the resident’s care was not provided on the specified shift.

Sources: A resident's care plan, MDS RAP assessment, point of care documentation, progress notes, internal investigation notes, and interviews with PSW #102, RPN #104, RPN #106 and ADOC #107. [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 ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident and ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.***

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**WN #4: 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 abuse policy was complied with related to reporting allegations of staff to resident neglect related to pain management.

Review of the licensee’s Prevention, Reporting and Elimination of Resident Abuse policy directed that all staff are required to comply with the guidelines for the prevention of resident abuse and the reporting of suspected resident abuse. Golden Plough Lodge expects that staff immediately report every alleged, suspected or witnessed incident of abuse. Staff must report the matter without delay to their immediate supervisor and the Director of Care, or designate who must then immediately forward notification to the Administrator. Every reported incident of abuse of a resident is reported to the Ministry of Health and Long Term Care immediately.

PSW #109 notified RPN #110 that a resident was crying and was requesting pain medication due to severe discomfort. PSW #109 indicated they were concerned the resident's pain was not being managed and they had approached RPN #110 three times

to provide the resident’s pain medication. PSW #109 indicated they informed RPN #130 who spoke with RPN #110 about the resident’s pain. ADOC #101 indicated they received a note from RPN #130 three days after regarding the allegations that RPN #110 had not administered the resident's pain medication in a timely manner.

The Critical Incident System (CIS) Report was submitted to the Director six days after the allegations were brought forward by PSW #109. ADOC #101 indicated that RPN #130 should have immediately notified them of the allegations of staff to resident neglect, and the Director was not immediately notified.

Sources: CIS, Prevention, Reporting and Elimination of Resident Abuse policy, a resident's progress notes, medication administration record, the licensee’s internal investigation, and interviews with PSW #109, RPN #110, and ADOC #101. [s. 20. (1)]

2. The licensee has failed to ensure that the abuse policy was complied with related to reporting allegations of resident to resident physical abuse.

RPN #114 observed a physical altercation between resident #006 and resident #007 that resulted in resident #007's sustaining an injury. RN #113 indicated that RPN #114 had assessed resident #007’s injury and immediately reported the resident to resident physical altercation to RN #113. RN #113 indicated the abuse policy directs them to notify a manager and receive direction to call the action line. RN #113 indicated they should have immediately notified a manager and the Director was not immediately notified.

The Critical Incident System (CIS) Report was submitted to the Director on the following day. ADOC #101 indicated that RN #113 should have immediately notified them of the altercation and the Director was not immediately notified.

Sources: CIS, Prevention, Reporting and Elimination of Resident Abuse policy, a resident's progress notes, the licensee’s internal investigation, and interviews with RN #113 and ADOC #101. [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 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, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a resident was assessed using a clinically appropriate assessment when they were exhibiting pain that was not relieved by the initial intervention.

The licensee's "Pain Assessment and Management" policy required registered nursing staff to assess residents' pain using a "Pain Monitoring Flow Sheet" and "Comprehensive Pain Assessment" to determine efficacy of pain management strategies. Registered staff will initiate a "Pain Monitoring Flow Sheet" when a resident has been assessed for pain management upon admission, when a new regular pain medication is ordered, there is a dosage decrease or increase in regular pain medication, pain medication is discontinued or as required pain medication is used for three consecutive days. The policy also directed that intervention was required to reduce the resident's pain level to four or less when a resident exhibited a pain level of four out of ten for more than 48 hours.

PSW #109 indicated they were concerned that the resident's pain was not being managed and they notified RPN #110. The resident had a history of pain and had been prescribed routine pain medication. The PSWs documented in Point of Care (POC) that

the resident had experienced moderate to severe pain on ten shifts. Registered staff documented in the resident's electronic Medication Administration Record (e-MAR) that the resident had a numerical pain score of four or above almost daily for seventeen days. The resident's pain score ranged from two to ten and the resident received breakthrough pain medication daily, twice daily on nine days, and three times on two days. The resident's plan of care directed to assess, record, and report signs and symptoms of distress or unrelieved pain to the physician. The resident's pain medication had been increased three times over a seventeen day period.

RAI/RPN/DAD #125 indicated they completed a pain assessment for all residents within 14 days of admission, quarterly and when a significant change was being completed for a resident. RAI/RPN/DAD #125 indicated they reviewed the residents' documentation completed by the PSWs in POC, the residents' progress notes, and e-MAR for routine pain medication and how often the breakthrough pain medication was being utilized. RAI/RPN/DAD #125 indicated they had completed a pain assessment for the resident and identified the resident was experiencing pain.

PSW #109, RPN #110, RPN #127, RAI/RPN/DAD #125, and ADOC #101 indicated the resident was experiencing pain. RPN #110, RPN #127, RAI/RPN/DAD #125 indicated the resident was able to report if they were experiencing pain and seldom requested pain medication. RPN #127 indicated the PSWs would report to registered staff and document in Point of Care (POC) that the resident was showing signs of non-verbal pain during care. RPN #110, RPN #127, RAI/RPN/DAD #125 indicated their role in identifying and treating residents with pain was to complete a numerical score from zero to ten when giving routine or as required pain medication. They also indicated that if a resident had a cognitive impairment, they would base the numerical score on the residents' non-verbal signs of pain. A pain score of zero was no pain and a score of ten was worst possible pain. Registered staff also indicated the pain score and the effectiveness of the pain medication administered to a resident was documented in the resident's e-MAR. RPN #110 and RPN #127 indicated they did not routinely make a referral to the physician or the NP when a residents' pain rating scale was greater than four for 48 hours. They further indicated they did not complete a “Pain Monitoring Flow Sheet” or a “Comprehensive Pain Assessment” for the resident when they were experiencing a pain score of four or greater for more than 48 hours or when the resident had an increase in their pain medication.

The “Pain Monitoring Flow Sheet” and the “Comprehensive Pain Assessment” was not completed for the resident . There was actual risk that the resident's pain was not being

managed when registered staff did not complete a clinically appropriate pain assessment to determine if the resident’s pain was being managed.

Sources: Pain Assessment and Management policy, a resident's plan of care, progress notes, e-MAR, Pain Assessment, MDS RAP Assessment, and interviews with PSW #109, RPN #110, RPN #127, RAI/RPN/DAD #125, and ADOC #101. [s. 52. (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 ensure that when a resident’s pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,**
**(a) infectious diseases; O. Reg. 79/10, s. 229 (3).**
**(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).**
**(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).**
**(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).**
**(e) outbreak management. O. Reg. 79/10, s. 229 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the designated staff member who co-ordinated the infection prevention and control program had the education and experience in infection prevention and control practices including infectious disease; cleaning and disinfection; data collection and trend analysis reporting protocols and; outbreak management.

The Assistant Director of Care (ADOC) indicated they were the designated lead for infection control in the home. The ADOC also indicated that they do not have specialized education or experience in infection prevention, outbreak management and control practices related to infectious diseases, cleaning and disinfecting, data collection and trend analysis. There is a risk that the required outbreak management and infection control practices may not be implemented when the designated infection prevention lead does not have the required infection prevention and control education.

Sources: Interview with the ADOC. [s. 229. (3)]

***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 shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including, (a) infectious diseases; (b) cleaning and disinfection; (c) data collection and trend analysis; (d) reporting protocols; and (e) outbreak management, to be implemented voluntarily.***

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**Issued on this 4th day of December, 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** | **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 |

**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) :** | KARYN WOOD (601), CHANTAL LAFRENIERE (194) |
| **Inspection No. / No de l'inspection :** | 2020_640601_0022 |
| **Log No. / No de registre :** | 011375-20, 011762-20, 012248-20, 014164-20, 014893-20, 016688-20, 017608-20, 020947-20 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Dec 3, 2020 |
| **Licensee / Titulaire de permis :** | The Corporation of the County of Northumberland<br>983 Burnham Street, Cobourg, ON, K9A-5J6 |
| **LTC Home / Foyer de SLD :** | Golden Plough Lodge<br>983 Burnham Street, Cobourg, ON, K9A-5J6 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | William Detlor |

To The Corporation of the County of Northumberland, you are hereby required to comply with the following order(s) by the date(s) set out below:

**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 must be compliant with LTCHA, 2007, c.8, s. 19:

Specifically, the licensee must:

1) Review the grounds of the order with the staff caring for resident #006 and resident #007.

2) Implement a monitoring process for resident #006 and resident #007 exhibiting physically threatening behaviours to ensure that staff intervene before resident abuse occurs.

3) Educate staff on implementing immediate interventions and preventative measures that can be used to reduce the risk of resident to resident abuse.

**Grounds / Motifs :**

1. The licensee has failed to protect resident #007 from physical abuse by resident #006.

Physical abuse is defined under O. Reg. 79/10 as including the use of physical force by a resident that causes physical injury to another resident.

Resident #006 and resident #007 were known to have responsive behaviours that have resulted in altercations with each other, and other residents'. RN #106, RPN #111, RPN #116, and RPN #120 indicated that resident #007's known responsive behaviours could be triggered by resident #006's responsive behaviour. RPN #114 observed a physical altercation between resident #006 and resident #007 and the altercation resulted in actual harm, as resident #007

sustained a injury.

Interventions to manage resident #006’s and resident #007’s responsive behaviors did not prevent resident #006 from physically abusing resident #007.

Sources: CIS, a resident’s care plan, MDS RAP assessment, progress notes and interviews with RN #106, RPN #111, RPN #116, and RPN #120. [s. 19. (1)] (601)

2. The licensee has failed to protect resident #006 from physical abuse by resident #007.

RN #106, RPN #111, RPN #116, and RPN #120 indicated that resident #007's known responsive behaviours could be triggered by resident #006's responsive behaviour. PSW #105 witnessed resident #007 become visibly angry due to resident #006's known responsive behaviour. Resident #007 threw an object at resident #006 and the resident sustained an injury. The resident to resident altercation resulted in actual harm, as resident #006 sustained an injury following the incident.

Interventions to manage resident #007’s and resident #006's responsive behaviors did not prevent resident #007 from physically abusing resident #006.

Sources: CIS, a resident's care plan, MDS RAP assessment, progress notes and interviews with RN #106, RPN #111, RPN #116, and RPN #120. [s. 19. (1)]

An order was made by taking the following factors into account:

Severity: There was actual risk that resident #006 and resident #007’s responsive behaviour interventions in place have not been effective as two altercation have occurred between the two residents that resulted in an injury to both residents.

Scope: The scope of this non-compliance was a pattern because two out of the three residents reviewed during this inspection had ongoing altercations.

Compliance history: A Voluntary Plan of Correction (VPC) was issued for the

same sections of the legislation in the past 36 months. (601)

**This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le :** Jan 01, 2021

## 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 3rd day of December, 2020**

**Signature of Inspector / Signature de l’inspecteur :**

**Name of Inspector / Nom de l’inspecteur :** Karyn Wood

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