Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jan 11, 2018;	2017_578672_0013 (A1)	031180-16, 031612-16, 000115-17, 002297-17, 005424-17, 005691-17, 008828-17, 011851-17, 015171-17, 017322-17, 017502-17	Critical Incident System

Licensee/Titulaire de permis

REGIONAL MUNICIPALITY OF DURHAM
605 Rossland Road East WHITBY ON L1N 6A3

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

HILLSDALE ESTATES
590 Oshawa Blvd. North OSHAWA ON L1G 5T9

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

JENNIFER BATTEN (672) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Licensee contacted inspector #672, requesting an extension for CO#901 and CO#902, from January 15, 2018 to February 15, 2018. Request was granted.

Issued on this 11 day of January 2018 (A1)

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

Original report signed by the inspector.

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

JENNIFER BATTEN (672) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): July 18, 19, 20, 21, 24, 25, 26, 27, 2017, and August 1, 2017. On August 3 and 21, 2017, offsite interviews were conducted.

The following Logs were inspected during this inspection:

Logs #002297-17, #008828-17, and #011851-17, related to falls management

Logs #005691-17, #031180-16, #015171-17, and #017502-17, related to allegations of resident to resident sexual abuse

Log #005424-17 related to allegations of staff to resident abuse

Log #031612-16 related to missing/unaccounted for controlled substances

Log #017322-17 related to allegations of resident to resident emotional abuse

Log #000115-17 related to allegations of resident to resident physical abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Administrator, Director of Care (DOC), Resident Care Coordinators (RCCs), RAI Coordinator, Occupational Therapists (OT), Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Social Worker (SW), family members,

Substitute Decision Makers (SDM), and residents.

Also during the inspection, the inspectors toured the home, observed resident care, resident to resident interactions, staff to resident interactions, reviewed clinical health records, and reviewed corporate policies and procedures.

The following Inspection Protocols were used during this inspection:

Admission and Discharge

Critical Incident Response

Falls Prevention

Hospitalization and Change in Condition

Medication

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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

10 WN(s)
1 VPC(s)
2 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	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #014's written plan of care set out the planned care for the resident as it relates to identified responsive behaviours.

Related to Log #015171-17, regarding resident #014;

The Resident Care Coordinator (RCC) #103, submitted a Critical Incident Report to the Director, regarding an alleged incident of resident to resident sexual abuse, between resident #014 and resident #015.

A review of resident #014's current plan of care was conducted by Inspector #570. The written plan of care identified that resident #014 exhibited identified responsive behaviours. The plan did not identify that the resident had specific identified

responsive behaviours, or specific interventions in place, to assist in managing the identified responsive behaviours.

During separate interviews with RN #114 and PSW #132, both indicated that resident #014 continued to have an intervention in place, due to the alleged incident with resident #015. RN #114 further indicated the specified responsive behaviours and intervention were not included in the written plan of care for resident #014.

Resident #014 was observed by Inspector #570 during the day shift and beginning of the evening shift, where it was noted that resident #014 had an intervention in place.

During an interview, RCC #103 indicated that the written plan of care should have been updated to reflect the changes and interventions put in place to manage resident #014's responsive behaviours.

Resident #014's written plan of care did not identify the planned care for the resident, or the planned interventions implemented to address the responsive behaviours. [s. 6. (1) (a)]

2. Related to Log #005691-17, regarding resident #007 and resident #008;

A Critical Incident Report was submitted to the Director, related to an alleged incident of resident to resident sexual abuse, between resident #007 and resident #008.

Inspector #672 reviewed the current written plan of care and the clinical documentation for resident #008, and noted that the plan of care did not reflect the incident or interventions, nor were there any clear directions listed to provide direction to staff regarding resident #008.

Inspector #672 reviewed the written plan of care for resident #007, which was put in place following the identified incident. The revised plan of care indicated that resident #007 was to receive one nursing intervention at all times, along with another nursing intervention.

Inspector #672 interviewed RCC #103, who indicated that resident #007 did not receive the nursing intervention 'at all times', as stated in the written plan of care,

rather the intervention was in place during specified hours daily. RCC #103 further indicated that outside of the hours when the nursing intervention was implemented, there was another intervention in place for resident #007. There were no clear directions listed in the written plan for care for staff to follow regarding the second intervention.

Inspector #672 observed resident #007, and noted there was an intervention in place. Inspector #672 reviewed the current written plan of care for resident #007, and noted that the intervention was not mentioned, nor were there clear directions provided for the staff.

The licensee failed to ensure that the plan of care set out clear directions to staff, related specifically to resident #007, regarding the times in which a nursing intervention was occurring, or the expected actions of the staff, related to the second intervention for resident #007.

Related to resident #008, the licensee failed to ensure that the written plan of care provided clear direction to staff regarding three specified interventions. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the care set out in the plan of care is based on an assessment of resident #018 and the needs and preferences of that resident.

Related to Log #00542-17, regarding resident #018;

A Critical Incident Report was submitted to the Director, regarding an incident which caused an injury to resident #018, for which the resident was taken to hospital and resulted in a significant change in health status.

Review of the progress notes for resident #018 indicated:

- RN #139 documented the PSW reported that resident #018 was complaining of pain. When RN #139 examined the resident, they stated they wanted to go to hospital. The resident was not sent to hospital at that time, and received an analgesic, with no effect.

- Clinical documentation indicated that resident #018 complained of severe pain in a specified body part, and again requested to go to hospital for assessment.

Analgesic was given, with no effect. Resident #018's SDM was notified, and agreed to meet resident in hospital.

- Upon return from hospital, RN #131 documented the resident was noted to have increased pain, with old bruising to the area, and resident #018 required a new analgesic order to manage the pain. A report was received from the hospital, which indicated a medical condition. The physician was notified, and a new order was given for increased analgesia.

During an interview, RN #131 indicated to Inspector #570 that as per the progress notes, resident #018 expressed that during care, while being assisted by staff, severe pain was felt in a body part; and resident #018 wanted to go to hospital. The RN indicated that when the resident asked to go to the hospital, an assessment should have been completed, the physician should have been called, and a report should have been given regarding the resident's complaint of increased pain, and wish to go to the hospital.

Care was not provided to resident #018 based on an assessment of the resident and the resident's needs and preferences, specifically when resident #018 was not sent to hospital when the resident reported pain, and requested to be sent to hospital for assessment. Also, the physician was not notified when resident #018 reported pain, and requested to be sent to hospital. Resident #018 was transferred to the hospital, approximately sixteen hours after the resident reported pain and requested to be sent. The resident was diagnosed to have a medical condition, and required increased analgesia, along with the use of a medical device. [s. 6. (2)]

4. The licensee has failed to ensure that the care set out in the plan of care for resident #007 and resident #008 was provided to both residents, as specified in the plan.

Related to Log #005691-17 and Log #017502-17, regarding residents #007 and #008:

A Critical Incident Report was submitted to the Director, regarding an alleged incident of resident to resident sexual abuse, between resident #007 and resident #008. A second Critical Incident Report was submitted to the Director, related to another alleged incident of resident to resident sexual abuse, between resident #007 and resident #008. The CIR further indicated that following this incident,

resident #007 was removed from the home for a specified period of time, then returned and continued to remain in the same resident home area of the long term care home.

Inspector #672 interviewed the Director of Care (DOC), who indicated that the nursing team had put several interventions in place, in an attempt to prevent further incidents involving resident #007 from occurring.

Inspector #672 observed resident #008 throughout several days during the inspection, and noted resident #008 did not have an intervention in place which had been requested by resident #008's family.

Inspector #672 reviewed the written plan of care for resident #007. Interventions listed in the written plan of care stated resident #007 was to have interventions in place.

Inspector #672 observed resident #007, and noted resident #007 did not have one of the specified interventions in place.

Inspector #672 interviewed RPN #117, who indicated that resident #007 had a nursing intervention during specified times on a daily basis, along with another intervention. RPN #117 further indicated that resident #007 had not had a required intervention in place earlier, when observed by Inspector #672.

Inspector #672 then interviewed RCC #103, who verified that resident #007 had a nursing intervention during specified times, not 'at all times' as stated within the written plan of care, and resident #007 did not have a required intervention in place when earlier observed by Inspector #672.

Inspector #672 interviewed PSW #146 and PSW #147 at separate times. PSW #146 and PSW #147 indicated that two staff members were supposed to provide personal care to resident #007, but that intervention had not been complied with, as only one staff member provided care to resident #007 at certain times.

The licensee has failed to ensure that the care set out in the plan of care for resident #007 was provided to the resident as specified in the plan, by not ensuring that resident #007 received the interventions as listed in the plan of care, and by having an incorrect number of staff members assist resident #007 with personal care.

The licensee has failed to ensure that the care set out in the plan of care for resident #008 was provided to the resident as specified in the plan, by not ensuring that requested nursing interventions were in place for resident #008. [s. 6. (7)]

5. Related to Log #000115-17, regarding resident #006:

The licensee has failed to ensure that the written plan of care for resident #006 was provided to the resident as specified in the plan.

A Critical Incident Report was submitted to the Director, regarding an alleged incident of resident to resident physical abuse, between resident #005 and resident #006. It was noted that resident #005 had sustained two injuries, and resident #006 was noted to have sustained one injury.

Inspector #672 reviewed the written plan of care for resident #006, which indicated that three interventions were supposed to be in place for resident #006.

Inspector #672 interviewed RN #114, RPN #112, and PSW #115 at different intervals, who indicated that resident #006 did not have two of the interventions listed in the plan of care in place at all, and the third intervention for resident #006 was supposed to be implemented at all times.

Inspector #672 observed resident #006 on multiple dates during the inspection, and noted that the three required interventions were not in place on any of those dates.

The licensee has failed to ensure that the plan of care for resident #006 was provided as specified in the written plan of care, by ensuring that resident #006 utilized the required nursing interventions listed within the written plan of care. [s. 6. (7)]

6. The licensee has failed to ensure that resident #023 was reassessed and the plan of care was reviewed and revised when the resident's care needs changed, in relation to the use of a specific intervention.

Related to Log #011851-17, regarding resident #023:

A Critical Incident Report (CIR) was submitted to the Director, for an incident which

caused an injury to resident #023, for which the resident was taken to hospital and resulted in a significant change in the resident's health status. The resident was transferred to hospital, and diagnosed with a medical condition to the body part.

Review of the progress notes for resident #023 indicated a number of documented incidents involving resident #023, while using a specified device.

During separate interviews with PT #136 and RN #148, both indicated that they had witnessed incidents involving resident #023 while using a specified device, and had to provide certain interventions and assistance when the incidents were observed.

During separate interviews with PSWs #137 and #138, both indicated that resident #023 required a certain level of assistance when using the device. Both PSWs indicated resident #023's written plan of care indicated the resident was independent in using the device, and any safety concerns related to the use of the device were reported to Registered staff and the Occupational Therapist.

Upon review of the written plan of care for resident #023 in effect at the time of the incident with Resident Care Coordinator (RCC) #104, RCC #104 confirmed that the written plan of care did not include the safety concerns identified, or the interventions put in place for the resident, specific to the use of the device.

Record reviews and staff interviews indicated resident #023's written plan of care was not revised, nor was it updated specific to safety concerns related to any risk of injury to self and others. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 901

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #008, #016, #019, #020, #021, and #025 were protected from abuse by resident #007.

For the purposes of the definition of "abuse" in subsection 2(1) of the Long Term Care Homes Act, 2007, "sexual abuse" means,

(a) Subject to subsection (3), any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or

(b) Any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member

Related to Log #005691-17 and Log #017502-17, regarding resident #007 and resident #008:

A Critical Incident Report was submitted to the Director, related to an incident of alleged resident to resident sexual abuse, between resident #007 and resident #008.

Review of the progress notes for resident #007 indicated that the resident was moved to the current resident home area following a specified number of previous incidents of alleged resident to resident sexual abuse, which occurred on another resident home area in the home. Inspector #672 interviewed the DOC, who indicated that resident #007 was moved to the current resident home area with the thought that resident #007 would do better on that home area. The DOC further

indicated that the nursing management team had put several interventions in place, in an attempt to prevent further incidents involving resident #007 from occurring.

Inspector #672 interviewed RN #119, PSW #120, and RPN #121 at separate intervals, all of whom stated resident #007 would exhibit specific responsive behaviours.

Inspector #672 reviewed the written plan of care for resident #007, which was in place prior to the incident. The written plan of care indicated that resident #007 exhibited several responsive behaviours. Interventions were indicated in the written plan of care.

Inspector #672 reviewed the revised written plan of care following the incident. The revised written plan of care indicated that resident #007 was to receive specific interventions, one of which was to be in place at all times.

Inspector #672 interviewed RCC #103, who indicated that resident #007 did not receive an intervention 'at all times', as stated in the written plan of care, the intervention was scheduled during specified times daily.

Inspector #672 interviewed the DOC, who indicated that resident #007 would exhibit responsive behaviours outside of the times of the planned nursing interventions.

A Critical Incident Report was submitted to the Director, related to a second alleged incident of resident to resident sexual abuse, involving resident #007 and resident #008. Following this incident, resident #007 was removed from the home for a specified period of time, then returned and continued to remain in the same resident home area of the long term care home.

Inspector #672 reviewed the current written plan of care for resident #008, which was in place at the time of the second incident, and noted that there were no interventions or directions listed to direct staff to provide specified interventions, which were to be implemented.

Inspector #672 observed resident #008 throughout several days during the inspection, and noted resident #008 did not have a specified intervention in place at any time during the inspection.

Inspector #672 interviewed PSW #123, who indicated that resident #007 would routinely not have an intervention in place, which was listed within the written plan of care.

Inspector #672 interviewed RN #142, who indicated that resident #007 was known to not have a required intervention in place, outside of the hours of another specified intervention.

Inspector #672 interviewed the DOC and Assistant Administrator, where the DOC indicated that due to the second incident, the management team had instituted a specified intervention for resident #007 at all times, until resident #007 was reassessed. The DOC further indicated that resident #007 had the cognitive ability to plan the responsive behaviours exhibited around interventions which were currently in place.

The licensee had knowledge of resident #007's responsive behaviours, but failed to ensure that resident #008 was protected from these responsive behaviours.

2. Related to Log #017322-17, regarding resident #007, resident #016, resident #019, resident #020, resident #021, and resident #025:

Review of the progress notes for resident #007 revealed a specific number of incidents, where resident #007 targeted residents #016, #019, #020, #021, and #025. Inspector #672 interviewed the DOC, who indicated awareness of the incidents where resident #007 targeted the above noted residents, and exhibited responsive behaviours towards them.

A Critical Incident Report (CIR) was submitted to the Director, related to ongoing incidents exhibited by resident #007 towards five residents within the home.

According to the Long Term Care Homes Act, 2007, the definition of emotional abuse means:

(a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or

(b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.

The definition of verbal abuse means:

(a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident, or

(b) any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences.

Inspector #672 reviewed the written plan of care for resident #007. There were no strategies noted regarding residents #016, #019, #020, #021, or #025 being targeted by resident #007, nor were there strategies listed for staff to follow or implement regarding how to react to, or cease these behaviours, if they were exhibited towards these, or any other resident within the home.

Inspector #672 interviewed resident #016. Resident #016 indicated feeling fearful of resident #007, especially regarding verbal confrontations, feeling fearful of not knowing what resident #007 may be capable of, and stated he/she found resident #007's behaviours harassing. Resident #016 further indicated that when incidents occurred which caused feelings of fear or being threatened by resident #007, they were reported to the staff, and that resident #007 was avoided whenever possible.

Inspector #672 interviewed resident #021. Resident #021 indicated having feelings of being intimidated by resident #007, stating resident #007 name called, yelled, and screamed at resident #021. Resident #021 further indicated that he/she felt bullied by resident #007, and fearful related to 'not knowing what [resident #007] was capable of'. Resident #021 stated the Social Worker, DOC, and RCC #103 were aware of the feelings of harassment and intimidation related to resident #007.

Inspector #672 attempted to interview resident #020, but resident #020 declined.

Inspector #672 attempted to interview resident #019, but was unable to, due to resident #019's current health condition, and cognitive status.

Inspector #672 interviewed PSW #116, PSW #118, and RN #119 at different intervals, who indicated that there were no interventions or strategies in place for resident #007, in an attempt to decrease the incidents of responsive behaviours, other than redirection, which had not been effective.

Inspector #672 interviewed RCC #103, who indicated awareness that resident #007 was exhibiting behaviours towards other residents within the home, and indicated that resident #007 was known to target specific residents.

Inspector #672 reviewed the written plan of care for resident #007. There were no strategies, interventions, or directions noted regarding residents #016, #019, #020, #021, or #025 being targeted by resident #007, nor were there strategies, interventions, or directions for staff to follow, regarding how to cease these behaviours, if they were exhibited towards these, or any other resident within the home, other than "tell resident that these behaviours are not appropriate and not tolerated. Report to Registered Staff".

Review of the progress notes for resident #007, revealed that resident #007 had been involved in a specific number of documented incidents of resident to resident emotional, verbal, sexual abuse, and/or physical aggression, directed towards residents #016, #019, #020, #021, and #025.

Inspector #672 reviewed the written plans of care for resident #016, #019, #020, #021, and #025. There were no focuses, interventions, strategies or directions listed which informed staff that the residents were targeted by resident #007, or needed to be protected from resident #007.

The licensee had knowledge of incidents of sexual, emotional and/or verbal abuse exhibited by resident #007, but failed to protect residents #008, #016, #019, #020, #021, and #025 from being abused by resident #007. [s. 19. (1)]

Additional Required Actions:

CO # - 902 was served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 902

WN #3: The Licensee has failed to comply with LTCHA, 2007, 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 management team fully respected and promoted resident #007's right to participate fully in making any decision concerning discharge from the long-term care home.

The Director received a letter from the licensee, stating that the management team held a meeting on a specified date, along with the Central East LHIN/CCAC, to inform the Substitute Decision Maker (SDM) of resident #007 that the management team was planning to discharge resident #007 from the home within a set period of time. The reasons for discharge, as outlined in the letter, were that resident #007 had exceeded the twenty-one vacation days allotted to each resident per calendar year; that the resident had been involved in a specified number of Critical Incidents since admission to the home; and that the nursing team was no longer able to meet the needs of resident #007. Resident #007's SDM did not attend that meeting, therefore the meeting was rescheduled.

Inspector #672 interviewed the DOC, who indicated that the meeting held on a specified date, had not occurred as outlined in the letter to the Director, as the SDM of resident #007 did not attend that meeting. The management team continued the meeting with the Central East LHIN/CCAC, to discuss the needs of resident #007, and the team's plan to discharge the resident, within a specified time period. The Inspector asked the DOC if resident #007 had been invited to attend the meeting, and the DOC indicated that the resident had not been invited.

The DOC indicated she was unaware if resident #007 had received a copy of the letter which had been provided to the Director, and to the SDM of resident #007. The DOC further indicated that no one from the management team had followed up with resident #007.

Inspector #672 asked the DOC if resident #007 had previously been informed of what the vacation day entitlement was for each resident, or the fact that the vacation days were getting close to exceeding the maximum allotment for the calendar year, prior to the letter being created. The DOC indicated that resident #007 had not been informed.

The licensee has failed to ensure that the management team fully respected and promoted resident #007's right to participate fully in making any decision concerning possible discharge from the long-term care home. [s. 3. (1) 11. iii.]

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 A) ensure that all residents are involved in the decision making process regarding the provision of care and delivery of services, when cognitively capable to do so, and,
B) that resident SDMs are only involved in the decision making process if requested by the resident, or the resident has been deemed incapable to do so., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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 resident abuse that the licensee knows of, or that is reported, is immediately investigated.

Related to Log #017322-17, regarding resident #007:

Inspector #672 reviewed the progress notes for resident #007, and noted a specific number of documented incidents of resident #007 exhibiting identified responsive behaviours towards other residents in the home.

Inspector #672 interviewed PSW #116, PSW #118, and RN #119 at separate intervals, who all indicated that resident #007 had exhibited specific responsive behaviours towards other residents in the resident home area. They further indicated that when resident #007 exhibited these behaviours, staff attempted to redirect the resident, with poor effect, and there were no other interventions in place for staff to follow. These incidents were reported to the Registered Staff on duty. RN #119 indicated that when she was informed of incidents involving resident #007, the DOC and RCC #103 were both informed.

Inspector #672 interviewed resident #016. Resident #016 indicated feeling fearful of resident #007, and stated he/she found resident #007's behaviours harassing. Resident #016 further indicated that when incidents occurred which caused feelings of fear or being threatened by resident #007, they were reported to the staff, and that resident #007 was avoided whenever possible.

Inspector #672 interviewed resident #021. Resident #021 indicated having feelings of being intimidated by resident #007, stating resident #007 name called, yelled, and screamed at resident #021. Resident #021 further indicated that he/she felt bullied by resident #007, and fearful related to 'not knowing what [resident #007] was capable of'. Resident #021 stated the Social Worker, DOC, and RCC #103 were aware of the feelings of harassment and intimidation related to resident #007.

Inspector #672 attempted to interview resident #020, but resident #020 declined.

Inspector #672 attempted to interview resident #019, but was unable to, due to resident #019's current health condition and cognitive status.

Inspector #672 interviewed the DOC, regarding the incidents. The DOC indicated that she was aware of "most" of the incidents involving resident #007, and the incidents had not been internally investigated. Following review of the definition(s)

of resident to resident abuse, the DOC indicated that resident #007's behaviours towards other residents in the home met the definition(s), and acknowledged that the incidents should have been immediately investigated, responded to, and acted upon, following becoming aware of each of the incidents.

2. Related to Log #017502-17, regarding resident #007:

A Critical Incident Report was submitted to the Director, related to an alleged incident of resident to resident sexual abuse, involving resident #007 and resident #008. The CIR indicated that following this incident, resident #007 was removed from the home for a specified period of time, then returned and continued to remain in the same resident home area of the long term care home.

Inspector #672 interviewed resident #016, who indicated that he/she had observed the incident between resident #007 and resident #008, and reported the incident to PSW #123 within five to ten minutes following the incident occurring. Resident #016 further indicated that no other staff member, other than RN #142, had discussed the incident with him/her, since the date of the incident.

Inspector #672 interviewed PSW #123, who indicated being notified by resident #016 of the incident between resident #007 and resident #008, and that he/she had immediately informed RN #142 of what resident #016 had reported. PSW #123 further indicated that no other staff member, other than RN #142, had spoken to him/her regarding this matter, nor had a formal written statement of facts been requested, as of the time of the interview with Inspector #672.

Inspector #672 interviewed RN #142, who indicated PSW #123 reported the alleged incident to him/her immediately following being notified by resident #016. RN #142 indicated that he/she contacted the manager on call, to report the incident. RN #142 further indicated that no one from management had spoken to her regarding this matter, after reporting the issue, and a formal written statement of facts had not been requested, as of the time of the interview with Inspector #672.

Inspector #672 interviewed RCC #103, who indicated that RN #142 had contacted him/her on the date of the incident. Inspector #672 asked RCC #103 if an internal investigation had been initiated, and RCC #103 indicated being unsure, as that was the role of the DOC.

Inspector #672 interviewed the DOC and Assistant Administrator. The DOC indicated being notified of the incident on the date of the incident, and the team had discussed the incident in a meeting the following day. When Inspector #672 asked the DOC for the notes to the internal investigation, the DOC indicated that she had not yet had a chance to begin the internal investigation, nor secure statements from any of the staff or residents involved in the incident. The DOC indicated knowledge of the requirement to conduct an immediate investigation regarding every alleged, suspected or witnessed incident of resident abuse by anyone, which the licensee knows of.

The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated, regarding alleged incidents, related to resident #007. [s. 23. (1) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the admission care plan must include, at a minimum, the following with respect to the resident, any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks.

Under O. Reg. 79/10, s. 24 (1) - Every licensee of a long-term care home shall ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home.

Related to Log #015171-17 regarding resident #014:

Resident #014 was admitted to the long-term care home on a specified date, with multiple medical diagnosis listed.

The clinical health record, for resident #014, were reviewed by Inspector #570, for a specified time period, which revealed that Physiotherapist #106 indicated in his initial assessment that resident #014 was at high risk for falls related to medical diagnosis', which required staff supervision and assistance for safety.

On a specified date and time, resident #014 had an unwitnessed fall, with an injury present.

The admission care plan document completed within 24 hours of admission, failed to provide documentation regarding the identified falling risk of the resident, and did not include any interventions in place to mitigate the risk for falls, although the resident was identified at high risk for falls and sustained a fall approximately three weeks prior. [s. 24. (2) 1.]

2. Related to Log #002297-17 related to resident #017

A Critical Incident Report was received by the Director, for a fall which resulted in an injury to resident #017, which led to being taken to hospital and resulted in a significant change in condition. The CIR indicated that on a specified date and time, resident #017 rang for assistance using the call bell. When PSW staff arrived, resident #017 stated that he/she fell out of bed while sleeping. The resident was sent to hospital for assessment, and returned on the same day, but continued to complain of pain to a specific body part. A medical test was done on a following date, and indicated a medical condition to the body part.

The clinical health record for resident #017 was reviewed by Inspector #570. The admission progress note: Initial Safety Concerns and FRAT (Falls Risk Assessment) sections were not completed.

The admission care plan for resident #017 failed to identify the falls risk of the resident, and did not include any interventions to mitigate the risk of falling until after a fall, with a confirmed medical condition. [s. 24. (2) 1.]

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that an incident of resident abuse has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, regarding allegations of resident to resident abuse, related to resident #007.

Related to Log #017322-17, regarding resident #007:

Inspector #672 reviewed the progress notes for resident #007, and noted a specific number of documented incidents of resident #007 exhibiting identified responsive behaviours towards other residents on the same resident home area of the long term care home.

Inspector #672 interviewed at separate intervals, PSW #116, PSW #118, and RN #119, who indicated that resident #007 exhibited identified responsive behaviours towards other residents from the same resident home area. PSW #116 and PSW #118 indicated that when resident #007 exhibited these behaviours, staff attempted to redirect the resident, with poor effect, that there were no other interventions in place for staff to follow, and that the incidents were reported to the Registered Staff on duty. RN #119 indicated that when incidents of resident #007 exhibiting identified responsive behaviours were reported, the DOC and RCC #103 were both informed.

Inspector #672 interviewed resident #016. Resident #016 indicated feeling fearful of resident #007, and stated he/she found resident #007's behaviours harassing. Resident #016 further indicated that when incidents occurred which caused feelings of fear or being threatened by resident #007, they were reported to the staff, and that resident #007 was avoided whenever possible.

Inspector #672 interviewed resident #021. Resident #021 indicated having feelings of being intimidated by resident #007, stating resident #007 name called, yelled, and screamed at resident #021. Resident #021 further indicated that he/she felt bullied by resident #007, and fearful related to 'not knowing what [resident #007] was capable of'. Resident #021 stated the Social Worker, DOC, and RCC #103 were aware of the feelings of harassment and intimidation related to resident #007.

Inspector #672 attempted to interview resident #020, but resident #020 declined.

Inspector #672 attempted to interview resident #019, but was unable to, due to resident #019's current health condition, and current cognitive status.

Inspector #672 interviewed the DOC regarding the alleged incidents. The DOC indicated being aware of "most" of the incidents involving resident #007 exhibiting identified responsive behaviours. The DOC further indicated that the incidents had not been reported to the Director. Following review of the definition of resident to

resident abuse, the DOC stated that resident #007's behaviours towards other residents from the same resident home area met the definition. The DOC acknowledged that the incidents of resident to resident abuse should have been immediately reported to the Director, upon becoming aware of each of the incidents.

The licensee has failed to ensure that the person who had reasonable grounds to suspect that any form of resident abuse had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, regarding resident to resident abuse, related to resident #007. [s. 24. (1)]

WN #7: 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 were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment, and on information provided to the licensee or staff through observation, which could potentially trigger such altercations, related to resident #007, regarding alleged incidents of resident to resident abuse.

Related to Log #017322-17:

A Critical Incident Report was submitted to the Director related to ongoing alleged incidents of resident to resident abuse, related to resident #007.

Inspector #672 interviewed PSW #116, PSW #118, and RN #119 at separate intervals, who all indicated that resident #007 exhibited identified responsive behaviours towards other residents from the same resident home area of the home.

Inspector #672 interviewed RCC #103, who indicated that strategies were being put in place to attempt to assist resident #007 with the behaviours exhibited. The strategies were not listed within the written plan of care for resident #007.

Inspector #672 reviewed the written plan of care for resident #007, along with the clinical health records. There were no noted steps taken to minimize the risk of altercations and potentially harmful interactions between resident #007, and the specific residents targeted by resident #007, nor were there documented interventions listed for staff to implement, should the responsive behaviours be exhibited by resident #007.

Review of the progress notes for resident #007 revealed that resident #007 had been involved in a specified number of documented incidents of identified responsive behaviours, directed towards residents #016, #019, #020, #021, and #025.

Triggers were identified for resident #007's responsive behaviours, yet there was no documented evidence of the nursing team taking any steps to minimize the risk of altercations and potentially harmful interactions between resident #007 and the residents targeted by resident #007.

Related to Log #005691-17 and Log #017502-17:

A Critical Incident Report was submitted to the Director, related to an incident of alleged resident to resident sexual abuse, involving resident #007 and resident #008. Another Critical Incident Report was submitted to the Director, related to a second incident of alleged resident to resident sexual abuse, between residents #007 and #008. The CIR indicated that following this incident, resident #007 was

removed from the home for a specified period of time, then returned and continued to remain in the same resident home area of the long term care home.

Inspector #672 interviewed the DOC, who indicated resident #007 specifically targeted a group of residents, and exhibited identified responsive behaviours. The DOC further indicated that resident #007 actively targeted the group of residents outside of the hours when a nursing intervention was in place, or when staff were busy on the unit assisting other residents, in an attempt to not be observed. These triggers were not documented within the written plan of care for resident #007.

Inspector #672 interviewed RN #142, who indicated that resident #007 was known to not follow one of the specified interventions within the written plan of care, and further indicated that resident #007 had specified triggers to act out, which caused the exhibited responsive behaviours. These triggers were not listed within the written plan of care for resident #007.

Inspector #672 interviewed RCC #103, who indicated there were identified triggers, and set interventions to address the triggers for resident #007. These triggers and interventions were not listed within the written plan of care.

Inspector #672 reviewed the current written plan of care and clinical health records for resident #008, which was in place at the time of the second incident, and noted that there were no focuses documented related to the first incident, with one intervention documented. The one intervention documented for resident #008 had been ineffective, and the nursing team had not taken any further steps to review and revise the interventions for resident #008, to minimize the risk of altercations and potentially harmful interactions between resident #007 and resident #008.

A review of the clinical health records for resident #007 indicated that interventions which were in place included a nursing intervention during specific times daily; along with four other interventions. According to PSW #116, RPN #117, RN #119, and RN #142, the interventions for resident #007 were ineffective.

Staff verbally identified triggers for resident #007's identified responsive behaviours. Although staff were able to verbally identify triggers to the responsive behaviours identified for resident #007, the written plans of care were not updated to reflect the triggers identified. The progress notes indicated there were a specific number of incidents of identified responsive behaviours which had occurred since resident #007 had moved into the home, yet there was no documented evidence

of the nursing team taking any steps to minimize the risk of altercations and potentially harmful interactions between residents, by identifying factors which could potentially trigger such altercations.

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment, and on information provided to the licensee or staff through observation, which could potentially trigger such altercations, related to resident #007, regarding alleged incidents of resident to resident abuse. [s. 54. (a)]

2. The licensee has failed to ensure that strategies were developed and implemented, and that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents, by identifying factors which could potentially trigger such altercations, regarding resident #006, who was exhibiting identified responsive behaviours.

Related to Log #000115-17:

A Critical Incident Report was submitted to the Director, regarding an incident of resident to resident physical abuse. The CIR indicated that resident #005 and resident #006 were noted to be in an altercation, and resident #005 had sustained two injuries, while resident #006 was noted to have one injury.

Review of resident #006's progress notes and incident reports for the ninety days prior and the ninety days following the incident revealed that resident #006 had been involved in a specified number of incidents of identified responsive behaviours in the ninety days prior to the incident, a specific number of which had involved resident #005; and continued to have identified responsive behaviours in the ninety days following the incident.

Inspector #672 interviewed RPN #112 and PSW #115 at separate intervals during the inspection, who both indicated that resident #006 had several triggers to the responsive behaviours exhibited.

The written plan of care for resident #006, in place at the time of the incident, and the written plan of care following the incident were reviewed. It was noted that the written plan of care for resident #006 had not been revised following the incident

until the next scheduled quarterly review, and there had been no changes to the interventions or strategies listed to reflect the ongoing identified responsive behaviours exhibited by resident #006, nor were any steps taken to minimize the risk of potentially harmful interactions between residents. There were strategies listed within the written plan of care for staff to implement for resident #006.

Inspector #672 interviewed RN #114, RPN #112, and PSW #115 at different intervals, who indicated that resident #006 did not have two of the documented interventions within the written plan of care in place; and another documented intervention within the written plan of care was supposed to be followed at all times.

Inspector #672 observed resident #006 on multiple dates during the inspection, and noted that none of the interventions listed within the written plan of care were being implemented.

Inspector #672 interviewed RAI Coordinator #133, who indicated it was the responsibility of the Registered Staff to update the written plans of care on a daily basis, as needed; that it was an expectation that strategies be developed and implemented for residents exhibiting responsive behaviours, and these strategies were to be included in the written plan of care; interventions or strategies were to be removed from the written plan of care if they were found to have been ineffective; and the triggers identified which could potentially lead to resident to resident altercations should also be included in the written plan of care, and these strategies and potential triggers were to be communicated to the front line staff.

Although staff were able to verbally identify triggers to the responsive behaviours identified for resident #006, the written plans of care were not updated to reflect the triggers identified, and the written plans of care continued to list strategies which had been found to be ineffective, or were no longer in place. The progress notes indicated there were a specific number of incidents of identified responsive behaviours and potentially harmful interactions following the incident, yet there was no documented evidence of the nursing team taking any steps to minimize the risk of altercations and potentially harmful interactions between residents. [s. 54. (a)]

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training
Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have received retraining annually related to the following:

The Residents' Bill of Rights
The licensee's policy to promote zero tolerance of abuse and neglect of residents
The licensee's policy regarding the duty to make mandatory reports under section 24
The whistle-blowing protections

Related to Log #005691-17;

A Critical Incident Report was submitted to the Director on a specified date, for an incident of alleged resident to resident abuse.

Inspector #672 interviewed PSW #115 and RPN #111 at separate intervals during the inspection, related to Log #005691-17. Both staff members indicated they had not completed the mandatory training regarding the Residents' Bill of Rights, the licensee's policy to promote zero tolerance of abuse and neglect of residents, the licensee's policy regarding the duty to make mandatory reports under section 24, or the whistle-blowing protections, within the last twelve months.

Inspector #672 interviewed the DOC, who indicated she was not aware that there were currently staff members working within the home who had not completed the

mandatory education, but did acknowledge that she was aware of the legislative requirements that all staff were supposed to be trained annually in the following areas: The Residents' Bill of Rights, the licensee's policy to promote zero tolerance of abuse and neglect of residents, the licensee's policy regarding the duty to make mandatory reports under section 24, and the whistle-blowing protections.

Inspector #672 interviewed Assistant Administrator #122, who indicated that the nursing team had staff members working with residents who had not completed the mandatory training. After review of the education documentation, it was revealed that the nursing team had at least 17 staff members actively working within the home, who had not completed the mandatory education within the last twelve months, but did have over 97 percent of the staff trained on the mandatory topics. The Assistant Administrator did acknowledge to Inspector #672 that she was aware of the legislative requirements.

The licensee has failed to ensure that all staff have received retraining annually relating to the following:

The Residents' Bill of Rights
The licensee's policy to promote zero tolerance of abuse and neglect of residents
The licensee's policy regarding the duty to make mandatory reports under section 24
The whistle-blowing protections [s. 76. (4)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the report to the Director included what care was given or action taken, as a result of a critical incident related to residents #007 and #008, and by whom.

Related to Log #005691-17:

A Critical Incident Report was submitted to the Director, related to an incident of alleged resident to resident sexual abuse, between resident #007 and resident #008.

Resident #007 had a history of exhibited identified responsive behaviours. Due to this, the nursing management team had put several interventions into place.

Inspector #672 reviewed the CIR submitted to the Director, and noted that the CIR had not been amended since it was submitted.

Inspector #672 reviewed the progress notes for resident #008, and noted that on a specified date, there was an entry which stated that the SDM for resident #008 decided they did not wish to have one of the interventions listed within the CIR in place, and requested another intervention be implemented, effective immediately. Inspector #672 observed resident #008 during the inspection, and noted that the intervention was not in place. Inspector #672 interviewed RPN #117, who verified that the intervention was not in place.

The CIR submitted to the Director was not amended to include six interventions which were documented within resident #007 and resident #008's written plans of care. The CIR also did not list specified strategies for resident #007, to manage the exhibited responsive behaviours. [s. 104. (1) 3.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident:
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.

Related to Log #002297-17

A Critical Incident Report was submitted to the Director, for a fall resulting in an injury which the resident was taken to hospital, and resulted in a significant change in condition. The CIR indicated that on a specified date and time, resident #017 rang for assistance using the call bell. When PSW staff arrived, the resident stated that he/she fell out of bed while sleeping. The resident was sent to hospital for assessment, and returned on the same day, but continued to complain of pain to the body part. A medical test was done two days later, and indicated a medical condition.

The name of the PSW staff who responded to the resident, and reported the incident to RPN #133, was not included in the report. [s. 107. (4) 2.]

2. Related to Log #005424-17:

A Critical Incident Report was submitted to the Director, for an incident which

caused an injury to a resident, for which the resident was taken to hospital, and resulted in a significant change in the resident's health status.

The CIR indicated resident #018 complained of pain in the body part during personal care. The resident was assessed by the RN, and scheduled pain medication was administered by the RPN. Consultation with resident #018's daughter was completed by the RN, to discuss the resident's pain and assessment of the body part. The RN assessed if proper turning and positioning techniques were used by the PSW's performing routine personal care. Resident #018 continued to have pain the following day, and was transferred to hospital for a medical test. A report was received from the hospital, which indicated resident #018 had a confirmed medical condition.

The names of the two PSW staff who provided the personal care to the resident, the name of RN who assessed the resident and the name of the RPN who administered the pain medication to the resident were not included in the report. [s. 107. (4) 2.]

Issued on this 11 day of January 2018 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : JENNIFER BATTEN (672) - (A1)

Inspection No. / No de l'inspection : 2017_578672_0013 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 031180-16, 031612-16, 000115-17, 002297-17, 005424-17, 005691-17, 008828-17, 011851-17, 015171-17, 017322-17, 017502-17 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Jan 11, 2018;(A1)

Licensee / Titulaire de permis : REGIONAL MUNICIPALITY OF DURHAM
605 Rossland Road East, WHITBY, ON, L1N-6A3

LTC Home / Foyer de SLD : HILLSDALE ESTATES
590 Oshawa Blvd. North, OSHAWA, ON, L1G-5T9

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Gina Peragine

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To REGIONAL MUNICIPALITY OF DURHAM, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 901

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee is ordered to:

1) Review and update all written plans of care for residents exhibiting responsive behaviours, specifically responsive behaviours of a sexual nature, and responsive behaviours with demonstrated physical aggression, to ensure the plan of care clearly identifies (a) the behaviours exhibited, (b) the triggers to the behaviours, (c) resident specific interventions related to the responsive behaviours, (d) the goals the care is intended to achieve, (e) directions to front line staff if the interventions are not effective

2) Develop and implement a communication and reporting protocol between RNs, RPNs, and PSWs, so that information regarding residents exhibiting new and/or potentially harmful responsive behaviours, experiencing poor effect with interventions currently listed within the plan of care, or a significant change in condition, is clear, accurate and acted upon immediately, including updating the written plan of care

Grounds / Motifs :

1. The licensee has failed to ensure that resident #014's written plan of care set out

the planned care for the resident as it relates to identified responsive behaviours.

Related to Log #015171-17, regarding resident #014;

A Critical Incident Report was submitted to the Director, regarding an alleged incident of resident to resident sexual abuse, involving resident #014 and resident #015.

A review of resident #014's current plan of care was conducted. The written plan of care identified that resident #014 exhibited identified responsive behaviours. The plan did not identify that the resident had exhibited identified responsive behaviours on the date of the alleged incident, and did not identify that resident #014 currently had a nursing intervention in place.

During separate interviews, RN #114 and PSW #132 indicated that resident #014 continued to have a nursing intervention in place, due to the incident with resident #015, and indicated the identified responsive behaviours and the identified intervention were not included in the written plan of care for resident #014.

Resident #014 was observed by Inspector #570, where it was noted that resident #014 continued to have the nursing intervention in place.

During an interview, RCC #103 indicated that the written plan of care should have been updated to reflect the changes and interventions put in place to manage resident #014's identified responsive behaviours.

Resident #014's written plan of care did not identify the planned care for the resident, related to identified responsive behaviours, or the planned interventions implemented to address the identified responsive behaviours, including a specific nursing intervention.

2. The licensee failed to ensure that there was a written plan of care for each resident, which set out clear directions to staff and others who provided direct care to the resident.

Related to Log #005691-17, regarding resident #007 and resident #008;

A Critical Incident Report was submitted to the Director, related to an alleged incident of resident to resident sexual abuse, between resident #007 and resident #008.

Inspector #672 reviewed the current written plan of care and the clinical documentation for resident #008, and noted that the plan of care did not reflect the incident which occurred, nor were there any clear directions listed to provide direction to staff regarding interventions put in place following the incident for resident #008.

Inspector #672 reviewed the written plan of care for resident #007, which was put in place following the incident. The revised plan of care indicated that resident #007 was to receive a nursing intervention at all times, along with another intervention.

Inspector #672 interviewed RCC #103, who indicated that resident #007 did not have the nursing intervention in place 'at all times', as stated in the written plan of care, rather the intervention was in place during specific times daily. RCC #103 further indicated that outside of the hours with the nursing intervention, there were other interventions in place.

Inspector #672 observed resident #007, and noted there was an intervention in place. Inspector #672 reviewed the current written plan of care for resident #007, and noted that the observed intervention was not mentioned within the written plan of care, nor were there clear directions provided for the staff regarding the intervention.

The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident, related specifically to resident #007, regarding interventions within the written plan of care.

Related to resident #008, the licensee failed to ensure that the written plan of care provided clear direction to staff regarding interventions which were to be put in place.

3. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of resident #018, and the needs and preferences of that resident.

Related to Log #00542-17, regarding resident #018;

A Critical Incident Report was submitted to the Director, related to an incident involving resident #018, which caused an injury to the resident, for which the resident was taken to hospital and resulted in a significant change in health status.

The CIR indicated resident #018 complained of pain. The resident was assessed by the RN, who documented that resident #018 complained of pain, and requested to be transferred to hospital for assessment. Resident #018 was administered an analgesic, and was not transferred to hospital. Resident #018 continued to have pain the following day, and was then transferred to hospital for assessment.

Review of the progress notes for resident #018 indicated that resident #018 began to complain of pain during care, and requested to be transferred to hospital for assessment. Scheduled analgesia was given to the resident by the RPN, and staff continued to monitor, but the resident was not transferred to hospital.

On a later date and time, the resident complained of severe pain, and requested to go to hospital; analgesic was given, with no effect. Resident #018's SDM was notified, and agreed to meet resident in hospital.

The resident returned from hospital, still complaining of pain, with greenish bruising observed to the area where resident #018 experienced the pain. Routine analgesic was given with no effect. The physician was notified, and a new order to increase the analgesic was received.

Review of the health record revealed a report was received from hospital, indicating a medical diagnosis to the area. The physician was notified, and gave a new order for a medical intervention.

Care was not provided to resident #018 based on an assessment of the resident and the resident's needs and preferences, specifically when the Physician was not notified of resident #018's condition, and resident #018 was not sent to hospital when the resident reported pain, and requested to be sent. Resident #018 was transferred to the hospital approximately sixteen hours after the resident reported pain, and requested to be sent to hospital. The resident was diagnosed to have a medical condition, and required increased analgesia, along with the use of a medical intervention.

4. The licensee has failed to ensure that the care set out in the plan of care for resident #007 and resident #008 was provided to the residents as specified in the plan.

Related to Log #005691-17 and Log #017502-17, regarding residents #007 and

#008, related to resident to resident sexual abuse:

A Critical Incident Report was submitted to the Director, for an alleged incident of resident to resident sexual abuse, between resident #007 and resident #008. A second Critical Incident Report was submitted to the Director, related to another alleged incident of resident to resident sexual abuse, between resident #007 and resident #008. The second CIR indicated that following this incident, resident #007 was removed from the home for a specified period of time, then returned and continued to remain in the same resident home area of the long term care home.

Inspector #672 interviewed the Director of Care (DOC), who indicated that the nursing team had put several interventions in place, in an attempt to prevent further incidents involving resident #007 from occurring.

Inspector #672 observed resident #008 throughout several days during the inspection, and noted resident #008 did not have interventions which were listed within the clinical health record, in place at any time during the inspection.

Inspector #672 reviewed the written plan of care for resident #007, which was updated on a specified date.

Inspector #672 observed resident #007 during the inspection, and observed the interventions listed within the written plan of care were not being followed.

Inspector #672 interviewed RPN #117, who indicated that resident #007 had a nursing intervention in place during specific hours on a daily basis, along with other interventions. RPN #117 acknowledged that resident #007 was not following the interventions documented within the written plan of care.

Inspector #672 then interviewed RCC #103, who verified that resident #007 had a nursing intervention in place during specified hours of the day, not 'at all times', as stated within resident #007's written plan of care.

Inspector #672 interviewed PSW #146 and PSW #147 at separate times. Both PSWs indicated that resident #007 was supposed to have two staff members assist with personal care, due to responsive behaviours, but only one staff member actually provided the personal care.

The licensee has failed to ensure that the care set out in the plans of care for residents #007 and #008 was provided to the residents as specified in the plan.

5. The licensee has failed to ensure that the written plan of care for resident #006 was provided to the resident as specified in the plan.

Related to Log #000115-17, regarding resident #006:

A Critical Incident Report was submitted to the Director, regarding an incident of resident to resident physical abuse, between resident #005 and resident #006. Resident #005 sustained two injuries, and resident #006 sustained one injury.

Inspector #672 reviewed the written plan of care for resident #006, which indicated that interventions were to be in place.

Inspector #672 interviewed RN #114, RPN #112, and PSW #115 at different intervals, who indicated that resident #006 did not have the interventions in place, as listed within the written plan of care, and was supposed to have another intervention in place.

Inspector #672 observed resident #006, and noted that the interventions were not in place.

Inspector #672 interviewed RAI Coordinator #133, who indicated that it was an expectation that the written plans of care were reviewed and revised on a daily basis, as needed, when new interventions were being initiated for a resident, or when interventions had not been effective, and were no longer being implemented.

The licensee has failed to ensure that the plan of care for resident #006 was provided as specified in the written plan of care.

6. The licensee has failed to ensure that resident #023 was reassessed and the plan of care was reviewed and revised when the resident's care needs changed.

Related to Log #011851-17, regarding resident #023:

A Critical Incident Report was submitted to the Director, for an incident involving resident #023, which caused an injury which the resident was taken to hospital and

resulted in a significant change in health status. The CIR indicated that resident #023 had sustained a fall, while using a mobility aid. The resident was transferred to hospital, and diagnosed with a medical condition.

During an interview, resident #023 indicated to Inspector #570 that there were no issues using the mobility aid, and was told by the Occupational Therapist (OT) #145 prior to the fall to continue using the mobility aid.

Review of the progress notes for resident #023 indicated a number of documented falls, while the resident was using the mobility aid.

During separate interviews with PT #136 and RN #148, both indicated that they had witnessed resident #023 having difficulty with the mobility aid, and had to assist the resident on several occasions.

Upon review of the written plan of care for resident #023 in effect at the time of the incident with the Resident Care Coordinator (RCC) #104, the RCC confirmed that the written plan of care did not include the safety concerns identified, or the interventions put in place for the resident, specific to the use of the mobility aid.

Review of the written plan of care following the incident indicated the plan was not updated for the resident's locomotion using the mobility aid, or that the resident was currently using a different mobility aid, with a different dependence level on staff for locomotion on the unit, related to a medical condition.

An order is issued due to the severity, scope and history of the non-compliance found in relation to plan of care. Non-compliance with plan of care was identified involving multiple residents. Due to this non-compliance, there was a potential risk of harm to residents when their care and safety needs were not met. In addition, resident #006 was actually harmed when his/her plan of care was not revised; resident #023 sustained several injuries at different times, when the plan of care was ineffective; and resident #008 was actually harmed when the plan of care was not followed as directed. In addition, a review of the compliance history of the licensee indicated the following ongoing non-compliance related to plan of care: July 9, 2015, Inspection #2015_291552_0019, VPC issued under s.6.(1)(c), s.6.(1)(a), s.6.(9)(1) and s.6.(10)(b); September 30, 2015, Inspection #2015_360111_0020, VPC issued under s.6.(2) and s.6.(5); April 18, 2016, Inspection #2016_389601_0008, VPC issued under s.6.(7); July 20, 2016, Inspection #2016_178624_0019, VPC issued

under s.6.(7); January 9, 2017, Inspection #2017_598570_0001, VPC issued under s.6.(10)(b).
(570)

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

Feb 15, 2018(A1)

Order # /
Ordre no : 902

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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 is ordered to:

Ensure that procedures and interventions are implemented to assist residents who are at risk of harm or who are harmed as a result of another resident's responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents including but not limited to the following:

1) Ensure the Behaviour Support Ontario (BSO) team is immediately notified of all residents, including resident #007, demonstrating altercations and

potentially harmful interactions between and among other residents, specifically related to residents #008, #016, #019, #020, #021, and #025.

2) Ensure the BSO team and the interdisciplinary team identify factors which could potentially trigger a resident altercation or incident for residents identified as having responsive behaviours, specifically responsive behaviours of a sexual nature, and resident #007 individually. Identify and implement interventions to manage these responsive behaviours through appropriate assessments (i.e. BAT/PIECES/DOS).

3) Develop and implement a process to ensure the plan of care for residents exhibiting responsive behaviours of a sexual nature, or are demonstrating altercations and potentially harmful interactions between and among other residents, are reviewed and revised, and to incorporate assessments completed by BSO.

4) Develop and implement a process to ensure all staff providing care to those residents
know which of the residents are at risk for altercations and potentially harmful interactions,
and understand how and when to implement the planned interventions to manage
responsive behaviours of a sexual nature.

5) Retrain all Registered nursing staff on the licensee's Responsive Behaviour Prevention and Management policy; the licensee's Abuse and Neglect - Prevention, Reporting & Investigation policy; and the overall BSO program, with the goal of ensuring the staff are aware of their roles and responsibilities, related to managing residents demonstrating responsive behaviours of a sexual nature. In addition, retraining the Registered Nursing staff on when to refer to additional services (i.e. psychogeriatric services, BSO, and when to implement one to one monitoring)

6) Develop and implement a monitoring tool to ensure the planned, revised interventions and strategies are effective in managing the responsive behaviours of resident #007, with special attention to minimizing risks associated with potentially harmful interactions between resident #007 and cognitively impaired female residents, along with residents #008, #016, #019,

#020, #021 and #025.

7) Develop and put in place a process whereby the Director of Care and/or delegates
are reviewing all documentation and communication from the front line staff at least daily
to determine if any high risk responsive behaviours have occurred in the home; and this
shall continue until compliance is achieved.

Grounds / Motifs :

1. The licensee has failed to ensure that residents #008, #016, #019, #020, #021, and #025 were protected from abuse by resident #007.

For the purposes of the definition of "abuse" in subsection 2(1) of the Long Term Care Homes Act, 2007, "sexual abuse" means,

(a) Subject to subsection (3), any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or

(b) Any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member

Related to Log #005691-17 and Log #017502-17, regarding resident #007 and resident #008:

A Critical Incident Report was submitted to the Director, related to an incident of alleged resident to resident sexual abuse, between resident #007 and resident #008.

Inspector #672 interviewed the DOC, who indicated that resident #007 had been moved to the current resident home area following a number of previous incidents on another resident home area in the home. The DOC further indicated having hope that resident #007 would do better on the current resident home area, as resident #007 would purposely target a specific type of resident, and there were only a

specified number of that type of residents on the current home area.

Inspector #672 interviewed RN #119, PSW #120, and RPN #121 at separate intervals, all of whom stated resident #007 would purposely target a specific type of resident, for the purposes of exhibiting identified responsive behaviours, and there were multiple residents of that type who resided in the same resident home area, along with resident #007.

Inspector #672 reviewed the written plan of care for resident #007, which was in place prior to the incident. The written plan of care indicated that resident #007 had identified responsive behaviours. Interventions for these responsive behaviours were indicated in the written plan of care.

Inspector #672 reviewed the revised written plan of care following the incident. The revised written plan of care indicated that resident #007 was to receive a nursing intervention at all times, along with other interventions as needed.

Inspector #672 interviewed RCC #103, who indicated that resident #007 did not receive the nursing intervention 'at all times', as stated in the written plan of care, the intervention was scheduled during specific hours daily.

Inspector #672 interviewed the DOC, who indicated that resident #007 would specifically target a specific type of resident, and exhibit identified responsive behaviours. According to the DOC, resident #007 would actively target the specified type of residents outside of the times of the nursing intervention, or when resident #007 believed the staff were busy on the unit assisting other residents, in an attempt to not be observed by staff.

A Critical Incident Report was submitted to the Director, related to a second incident of alleged resident to resident sexual abuse, between resident #007 and resident #008. Following this incident, resident #007 was removed from the home for a specified period of time, then returned and continued to remain in the same resident home area of the long term care home.

Inspector #672 reviewed the current written plan of care for resident #008, which was in place at the time of the second incident, and noted that there were no focuses, interventions or directions listed to direct staff related to the incident.

Inspector #672 observed resident #008 throughout several days during the inspection, and noted resident #008 did not have a required intervention which was listed within the health record, observed to be in place, at any time during the inspection.

Inspector #672 interviewed PSW #123, RN #142, and RCC #103 at separate intervals, who all indicated resident #007 frequently did not follow the interventions in place as per the written plans of care, and/or the other documented interventions were not effective. RCC #103 further indicated identified triggers for resident #007's responsive behaviours, and the management team had instituted a nursing intervention for resident #007 to be in place at all times.

The licensee had knowledge of resident #007's identified responsive behaviours, but failed to ensure that resident #008 was protected from being exposed to these responsive behaviours.

2. Related to Log #017322-17, regarding resident #007, resident #016, resident #019, resident #020, resident #021, and resident #025:

Review of the progress notes for resident #007 revealed a number of incidents of identified responsive behaviours, where resident #007 targeted residents #016, #019, #020, #021, and #025. Inspector #672 interviewed the DOC, who indicated awareness of the incidents where resident #007 targeted the above noted residents, and exhibited identified responsive behaviours towards them. The DOC acknowledged being familiar with the definition of resident to resident abuse, and verified that the responsive behaviours exhibited by resident #007 fit the definitions.

A Critical Incident Report (CIR) was submitted to the Director, related to ongoing incidents of resident to resident abuse, exhibited by resident #007 towards five residents within the home. The CIR indicated examples of resident #007's identified responsive behaviours.

According to the Long Term Care Homes Act, 2007, the definition of emotional abuse means:

(a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of

acknowledgement or infantilization that are performed by anyone other than a resident, or

(b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.

The definition of verbal abuse means:

(a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident, or

(b) any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences.

Inspector #672 reviewed the written plan of care for resident #007. There were no strategies noted regarding residents #016, #019, #020, #021, or #025 being targeted by resident #007, nor were there strategies listed for staff to follow or implement regarding how to react to, or cease these behaviours, if they were exhibited towards these, or any other resident within the home.

Inspector #672 interviewed resident #016. Resident #016 indicated feeling fearful of resident #007, feeling fearful of not knowing what resident #007 may be capable of, and stated he/she found resident #007's behaviours harassing. Resident #016 further indicated that when incidents occurred which caused feelings of fear or being threatened by resident #007, they were reported to the staff, and that resident #007 was avoided whenever possible.

Inspector #672 interviewed resident #021. Resident #021 indicated having feelings of being intimidated by resident #007, stating resident #007 name called, yelled, and screamed at resident #021. Resident #021 further indicated that he/she felt bullied by resident #007, and fearful related to 'not knowing what [resident #007] was capable of'. Resident #021 stated the Social Worker, DOC, and RCC #103 were aware of the feelings of harassment and intimidation related to resident #007.

Inspector #672 attempted to interview resident #020, but resident #020 declined.

Inspector #672 attempted to interview resident #019, but was unable to, due to resident #019's current health condition, and cognitive status.

Inspector #672 interviewed PSW #116, PSW #118, and RN #119 at different intervals, who indicated that there were no interventions or strategies in place for resident #007, in an attempt to decrease the incidents of identified responsive behaviours, other than redirection, which had not been effective.

Inspector #672 interviewed RCC #103, who indicated awareness that resident #007 had been exhibiting identified responsive behaviours towards other residents within the home, and indicated that resident #007 was known to target specific residents.

Inspector #672 reviewed the written plan of care for resident #007. There were no strategies, interventions, or directions noted regarding residents #016, #019, #020, #021, or #025 being targeted by resident #007, nor were there strategies, interventions, or directions for staff to follow, regarding how to cease these behaviours, if they were exhibited towards these, or any other resident within the home.

Review of the progress notes for resident #007 during a four month time period, revealed that resident #007 had been involved in a specified number of documented incidents of resident to resident abuse, directed towards residents #016, #019, #020, #021, and #025.

Inspector #672 reviewed the written plans of care for resident #016, #019, #020, #021, and #025. There were no focuses, interventions, strategies or directions listed which informed staff that the residents were targeted by resident #007, or needed to be protected from incidents of identified responsive behaviours, as exhibited by resident #007.

The licensee had knowledge of incidents of identified responsive behaviours exhibited by resident #007, but failed to protect residents #008, #016, #019, #020, #021, and #025 from being abused by resident #007.

An order is issued due to the severity, scope and history of the non-compliance

found in relation to protecting each resident within the home from abuse and neglect. Non-compliance was identified involving multiple residents being abused by resident #007. Due to this non-compliance, there was a potential risk of harm to residents #016, #019, #020, #021, and #025 when they were not protected from abuse by resident #007. In addition, resident #008 was actually harmed through abuse by resident #007 on two separate occasions. Furthermore, a review of the compliance history of the licensee indicated a repeated non-compliance to a similar Order, related to ensuring residents were protected from abuse by anyone, and/or were not neglected by the licensee or staff, which was issued: July 9, 2015, Inspection #2015_291552_0019, with a Compliance Order was served on August 28, 2015 under s.19(1). This Order was complied on January 29, 2016. (672)

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

Feb 15, 2018(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 11 day of January 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JENNIFER BATTEN - (A1)

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Service Area Office / Bureau régional de services : Ottawa