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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Oct 23, 2015;	2015_360111_0010 (A1)	O-001418-14, O-000686-14, O-000924-14, O-000980-14, O-000981-14, O-001231-14, O-001879-15	Follow up

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

LAKEVIEW MANOR
133 Main Street P.O. Box 514 Beaverton ON L0K 1A0

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

LYNDA BROWN (111) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Good morning Ms. Babic,

Please review the revised Inspection Report and Order #002 for Lakeview Manor, which include an extension to the compliance date for LTCHA, 2007,s.19(1) to November 30, 2015.

Thanks
Lynda Brown, RN, BScN
LTCH Inspector, Nursing

Issued on this 23 day of October 2015 (A1)

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

Original report signed by the inspector.

Ontario

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The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 27 to May 1, 2015

The following inspections were completed concurrently during this inspection: (one follow up (log#001418-14), one complaint (log# 000924-14), one other (log# 000686-14) and four critical incidents (log # 001879-15, 001231-14, 000980-14, 000981-14).

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, the Director of Care (DOC), Registered Nurses(RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents, Resident Care Coordinators (RCC), RAI Coordinator, Manager of Nursing Practice, and Scheduling Clerk.

During the course of the inspection, the inspector also observed residents, reviewed health care records of current and deceased residents, reviewed staffing schedules, home's investigations, staff training records, complaint logs, staff files, and reviewed the following home's polices: smoking, prevention of abuse and neglect, and continence management.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Responsive Behaviours

Sufficient Staffing

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

5 WN(s)
0 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the residents related to safety risks.

Related to log #001418:

Interview of RCC #1 indicated the home currently has identified residents that are at risk for injury related to unsafe practices (smoking). The RCC indicated that the RN's on each unit are responsible for completing the assessments related to those safety risks, and updating the residents' care plan.

Interview of Staff #102 indicated if there are concerns related to the unsafe practices (smoking), then the resident would be reassessed again (using the Assessment Tool) and the care plan updated.

Review of the home's "Smoking Policy" (ADM-01-03-37) indicated definitions of smoking risk (low, moderate and high) which relates to resident's ability to safely manage smoking supplies. Under procedure, the resident is receive a copy of the home's smoking policy upon admission and comply with the policy. The Registered Staff are to identify residents who smoke, ensure cigarettes and lighter/matches are

stored in a designated locked area for smokers, and assess each resident for care and safety needs using the "Smoking Assessment Tool". They are to document smoking restrictions on the resident's care plan, and if risk /non-compliance is identified, call a problem solving care conference.

Interview of Staff #100 indicated Resident #2 is identified at risk related to unsafe smoking practices, had an assessment tool completed, and stated "has had some concerns" related to these unsafe practices.

Interview of Staff #101 indicated Resident #2 is identified at risk related to unsafe smoking practices and stated "has been concerns" related to these unsafe practices.

Review of the (current)"Smoking Assessment Tool" for Resident #2 indicated the resident was known to engage in unsafe smoking practices.

Review of the care plan (current) for Resident #2 indicated under safety(smoking)had no indication of the level of risk, whether the resident was able to manage own supplies, where the supplies were to be stored/locked, or concerns related to these unsafe practices, and strategies to manage those concerns.

Interview of Staff #102 indicated Resident #3 is identified at risk for injury related to unsafe practices (smoking), had an assessment completed, and had no concerns related to these unsafe practices.

Review of the progress notes for Resident #3 indicated on a specified date and time, the resident was found engaging in unsafe practices (smoking) and resulted in a near miss injury.

Review of an email correspondence indicated concern re: completion of assessments for Resident #3.

Review of the "Smoking Assessment Tool" for Resident #3 (completed 4 years ago) indicated the resident was known to engage in unsafe practices (smoking) resulting in potential injury to the resident.

Review of the care plan (current) for Resident #3 indicated under safety(smoking)that staff report that resident does have indication of potential for injury to self. There was no indication of the level of risk, whether the resident was able to manage own supplies, where the supplies were to be stored, concerns related to these unsafe

practices, and no clear direction on how to manage the resident's risk.

The severity is the licensee was issued a compliance order during inspection #2014_293554_0032 on September 1, 2014 for LTCHA, s.6 related to safety (smoking) and were to be complied by January 16, 2015. The scope is that 2 out 4 residents were identified as a safety risk related to smoking. [s. 6. (1) (c)]

2. Related to log #001879:

The licensee has failed to ensure the plan of care for Resident #11 was based on the resident's assessed needs related to continence care.

A critical incident report was received by the Director on a specified date for a staff to resident verbal/emotional abuse incident that occurred three days prior. The CIR indicated that Resident #11 had reported (the day after the incident)to a staff member that another staff member refused to provide toileting assistance and used inappropriate language.

Review of the home's investigation indicated the staff member received disciplinary action for "verbal and emotional abuse" towards Resident #11.

Interview of Resident #11 indicated staff are called for assistance (when required) for toileting assistance.

Interview of Staff #101 indicated Resident #11 generally requires one staff to assist with toileting and only occasionally requires two staff assistance with toileting. Staff #101 indicated the resident is occasionally incontinent, wears an incontinence product, and will call for staff assistance with toileting. The staff member indicated the resident has to be checked/changed routinely.

Review of the (current) plan of care for Resident #11 related to continence indicated the resident was incontinent of bladder, on "customary toileting routine and frequency" (prompted voiding),resident will ask to use washroom when needed, requires limited assistance of 2 staff, and wears continence product.

Therefore, the plan of care was not based on the resident's assessed needs as the plan of care does not indicate toileting needs during the night, the staff and resident indicated the resident was only "occasionally incontinent", only required 2 staff assistance with toileting on days when strength is reduced and resident still has to be

checked on for toileting needs as "does not always ring for assistance". [s. 6. (2)]

3. The licensee has failed to ensure the resident, the SDM, if any, and the designate of the resident/SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.

Related to log #000981:

Review of the progress notes of Resident #7 & #8 and interview of staff indicated that on a specified date, Resident #7 and Resident #8 began demonstrating responsive behaviours towards one another. These responsive behaviours continued and escalated over a two month period to sexually inappropriate responsive behaviours. Resident #8 also began demonstrating physical and verbal aggression towards staff when staff attempted to intervene.

A care conference was held with the SDM's of Resident #8 (two days after the responsive behaviours began). There was no further documented evidence that the SDM was notified of the escalated responsive behaviours of sexually inappropriate to participate fully in the development and implementation of Resident #8 plan of care.

Review of the progress notes of Resident #7 indicated a 6 week post-admission care conference was held with the family of Resident #7 on a specified date. There was no documented evidence the family was notified at that time of the sexually inappropriate responsive behaviours and no documented evidence the SDM of Resident #7 was ever made aware of the ongoing sexually inappropriate responsive behaviours that occurred over a two month period. [s. 6. (5)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 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 failed to comply with LTCHA, 2007, s.19(1) by ensuring Resident #7 was protected from sexual and physical abuse by Resident #8.

Under O.Reg. 79/10, s.2 (1) for the purpose of the definition of abuse in subsection 2(1) of the Act, "sexual abuse" is defined as 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.

Under O.Reg.79/10, s.2(1) for the purpose of the definition of abuse in subsection 2(1) of the Act, "physical abuse" is defined as the use of of physical force by a resident that causes physical injury to another resident.

2. Related to log #000981:

A critical incident report was received on a specified date for a resident to resident physical abuse incident that occurred three days prior. The CIR indicated that Resident #8 was found being physically abusive towards Resident #7. Staff immediately intervened and removed Resident #7 from the room. Resident #7 was assessed and complained of pain to a specified area. Resident #8 was placed on 1:1 monitoring and a referral to psychogeriatric resources. Resident #7 was relocated the following day.

Interview of RCC #1, Staff #103 & Staff #104, observation/interview of the resident, and review of the health record for Resident #8 indicated: the resident was cognitively impaired, independently wanders throughout the unit/other resident rooms, rummages/hoards other residents personal items, can become easily agitated and/or verbally/physically aggressive towards staff and other residents, is resistive to care, is difficult to redirect/distract and unpredictable. Staff indicated Resident #8 had a "romantic companionship" with Resident #7.

Interview of RCC #1, Staff #103 & Staff #104, observation/interview of the resident, and review of the health record of Resident #7 indicated the resident was cognitively impaired, independently wanders throughout the unit/other resident rooms, can become agitated and verbally aggressive towards staff during personal care and towards other residents but is generally easily redirected/distracted. Staff reported the resident was "courting" and having a "romantic companionship" with Resident #8 until Resident #7 became physically aggressive towards Resident #8.

3. Review of the progress notes (for Resident #7 & #8)for a three month period indicated the following:
-Resident #7 was admitted to the unit approximately nine days before displaying "affectionate" responsive behaviours towards Resident #14.
-Two days later, Resident #7 was observed approaching “other male residents” and had to be redirected. The resident was also demonstrating responsive behaviours of exit-seeking, wandering, and repetitive requests.
-Four days later, Resident #7 was found in another resident’s bed and was redirected “with difficulty”.
-The following day, staff noted "increased affectionate contact" between Resident #7 and Resident #8 continuing.
-Both residents were checked on throughout the night and staff noted "they were fine", “sleeping and cuddling” one another.
-Over the following weeks, the residents' inappropriate sexual responsive behaviours continued and escalated, and Resident #8 became more physically aggressive (towards the female resident) and staff attempted to intervene. The physician was notified and new medication orders were received and provided to Resident#8 after one physically abusive incident towards another female resident and staff when staff were attempting to intervene. The resident was placed on "every 30 minute checks for a 7 day observation period" and a referral to psycho-geriatric resources was completed "to ensure that the relationship is consensual".
-The following evening, Resident #8 was found in Resident #13 room with Resident #7. Resident #13 reported Resident #8 "grabbed a hold of me" but no injuries noted to Resident #13. Resident #7 & Resident #13 were easily redirected from the room but Resident #8 "refused to leave and had to be redirected again later".
-Two days later the physician assessed Resident#8, and was aware of sexually inappropriate responsive behaviours escalating. The physician increased the psychotropic medication and started the resident on an antidepressant. The physician also assessed Resident #7 and indicated “discussed behaviour with staff”. The physician increased the psychotropic medication and indicated staff to "monitor”.

-Two nights later, Resident #8 had slept in Resident #7 bed "all night".
-Two days later, Resident #8 was placed on every 15 minute monitoring and to be reassessed in two days. Psychogeriatric resources was contacted for possible placement of Resident #8 "due to increased incidents of responsive behaviours".
-Two days later, staff witnessed Resident #8 display physical aggression with an object towards Resident #7 in a specified area. Resident #7 was witnessed attempting to strike back at Resident#8 when Resident #8 threatened Resident #7. Later in the evening, Resident #7 was attempting to go to sleep alone and Resident #8 "became agitated with redirection".
-Eight days later, the physician assessed Resident #8 and noted (increased lethargy) with increased psychotropic and dose was reduced. Antidepressant was increased. The physician noted "not as sexually aggressive".
-Five days later in the evening, Resident#8 was found in Resident #7 bed and when staff attempted to redirect, Resident #8 became verbally and physically aggressive towards staff.
-Two days later, in the evening, Resident #8 was found in another resident's bed (with Resident #7). Staff attempted to redirect both residents so the other resident could sleep. Resident #8 became angry and shut the door "on staff". The other resident was redirected to another bed to sleep until an hour later when both residents "were successfully redirected".
-Two days later, a 6 week post-admission care conference was held with family of Resident #7.
-Three days later, Resident #8 spent the night sleeping with Resident #7 in the "respite room". Both residents "were checked on regularly to ensure they do not enter other resident's rooms".
-Two days later, Resident #7 & Resident #8 were heard yelling from Resident #8 room. Staff found Resident #8 being physically aggressive towards Resident #7 (when staff intervened). Resident #7 was crying and staff removed Resident #7 from the room. Resident #7 reported that Resident #8 had been repeatedly physically abusive towards the resident resulting in pain to a specified area. The police, physician, POA's of both residents, and the Director were notified. Door sensor alarm was placed on Resident #8 door to alert staff when the resident left the room.
-The following day, Resident #8 was placed on 1:1 monitoring. Resident #7 was relocated to another area.

4. Review of current care plan for Resident #8 related to responsive behaviours indicated the resident "has found romantic companionship with a female co-resident, has demonstrated responsive behaviour toward staff who the resident feels are attempting to remove the control of this relationship". The resident has demonstrated

agitated/aggressive behaviour when co-residents or staff attempt to take one of the residents 'treasures' from the resident. Wanders and hoards and is suspicious of other that are "trying to steal" own belongings. Verbally abusive towards spouse and will physically try to remove the spouse from a chair by pulling on arms. Interventions included:
-allow other resident's to share either the residents' or co-resident's beds if they choose (do not remove one from the room to go to their own room) and provide the resident and companion nourishment together.
-ensure the resident is not present when personal care is provided to companion.
-allow the resident's to "express their romantic companionship" and "respect the resident's choice to be left in privacy with companion".
-attempt to remove other resident's away if redirection is not possible.
-allow the resident to keep the hoarded items (and remove/return to owner) when the resident leaves the item behind or goes to sleep.
-re-approach later

Review of the care plan (in place at time of incidents) for Resident #7 indicated the resident has moderate cognitive impairment with short and long term memory loss. Illicit family input for best approaches to resident. There was no indication of sexually inappropriate behaviour towards other male residents or ongoing "romantic relationship" with Resident #8 and strategies to manage these behaviours.

5. Therefore, the licensee failed to protect Resident #7 from sexual and physical abuse by Resident #8 by:
-failing to ensure the resident, the SDM, if any, and the designate of the resident/SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care for Resident # 7 & #8 as identified under LTCHA, 2007, s.6(5) under WN #1.
-failing to ensure that behavioural triggers for the residents are identified, where possible, strategies were developed and implemented to respond to these behaviours, where possible, as indicated under O.Reg. 79/10, s.53(4)(a)(b) under WN#4.
-failing to ensure the home's policy of "Abuse & Neglect-Prevention, Reporting & Investigating" contained procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected, contained procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate, and identified measures and strategies to prevent abuse and neglect as identified under O.Reg. 79/10, s.96(a)(b)(c) under WN #5. [s. 19. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

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

Related to log #001231:

Review of the home's policy "Abuse & Neglect-Prevention, Reporting & Investigating" (ADM-01-03-05) indicated:
- employees who witness or suspect alleged abuse or neglect will document details as soon as possible, including dates/times/witnesses on "Allegation Report Form" (appendix #7).
-the DOC/Senior Manager on Call/Designate "to determine appropriate action to be taken from findings of investigation" and "complete Findings of Investigation Form to complete the investigation file at the conclusion of the investigation" (appendix 9).

A Critical Incident Report was received on a specified date for a allegation of improper care by staff to Resident#9. The CIR indicated 3 days prior, the family of the resident reported an allegation of improper care and emotional abuse by a staff member. The resident no longer resides in the home. The outcome of the investigation indicated "no evidence of the resident's health, safety, or well-being jeopardized".

Interview of the Acting Administrator and DOC indicated the staff member involved in the allegation of abuse was suspended pending an investigation but no disciplinary action occurred as the conclusion of the investigation indicated no harm to resident and investigation was "inconclusive". The Administrator and DOC confirmed there was no "Allegation Report Form or Findings of Investigation Form" used for this incident. [s. 20. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies had been developed and implemented to respond to the residents demonstrating responsive behaviours, where possible.

Related to log #000981:

Review of the care plan (current and in place at time of incidents) for Resident #8 related to responsive behaviours indicated the resident has cognitively impaired, incoherent speech at times, independently wanders throughout the secure unit daily (including into other residents' rooms) to lay on beds or to rummage/hoard other residents personal items (treasures), can become easily agitated and/or verbally/physically aggressive towards staff and other residents, is resistive to care, and is difficult to redirect/distract and unpredictable. The resident "has found romantic companionship with a female co-resident, has demonstrated responsive behaviour toward staff who the resident feels are attempting to remove the control of this relationship". The resident has demonstrated agitated/aggressive/suspicious behaviour when co-residents or staff attempts to take one of the residents perceived 'treasures' from the resident. “Verbally abusive towards spouse and will physically try to remove the spouse from a chair by pulling on arms”.
Interventions included:
-allow other resident's to share either the residents' or co-resident's beds if they choose;do not remove one from the room to go to their own room; provide the resident and companion nourishment together.
-ensure the resident is not present when personal care is provided to “companion”.
-allow the “resident's to express their romantic companionship and respect the resident's choice to be left in privacy with companion”.
-attempt to remove other resident's away if redirection is not possible.
-allow the resident to keep the 'treasures' and remove (and return to owner) when the resident leaves it behind or goes to sleep.
-re-approach later.

Review of the care plan (in place at time of incidents) for Resident #7 indicated the resident has moderate cognitive impairment, and to illicit family input for best approaches to resident. There was no indication of sexually inappropriate behaviours towards other male residents or ongoing "romantic relationship" with Resident #8, no indication of family input, no indication of determining consent (due to cognitive impairment) and strategies to manage these behaviours,and any other strategies to use when the residents were no longer consensual. [s. 53. (4) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure the home's policy of "Abuse & Neglect-Prevention, Reporting & Investigating" contained procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected, contained procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate, and identified measures and strategies to prevent abuse and neglect.

Related to log #000981:

Review of the home's policy "Abuse & Neglect-Prevention, Reporting & Investigating" (revised April 2014) defined sexual abuse on page 3 of 23. The "Reporting and Investigating" chart on page 8 of 23 does not include sexual abuse of a resident (by anyone). On page 9 of 23 indicates under resident to resident abuse, if the resident who committed "verbal or emotional abuse" does not understand the consequences of his/her actions, staff will complete an incident report and staff will document the follow-up interventions used in order to minimize re-occurrence of this type of event. This does not include sexual abuse or how the home is to determine if the behaviour is consensual and what actions are to be taken to protect the residents from reoccurrence of sexual abuse. [s. 96. (c)]

Issued on this 23 day of October 2015 (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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : LYNDA BROWN (111) - (A1)

Inspection No. / No de l'inspection : 2015_360111_0010 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : O-001418-14, O-000686-14, O-000924-14, O-000980-14, O-000981-14, O-001231-14, O-001879-15 (A1)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Oct 23, 2015;(A1)

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

LTC Home / Foyer de SLD : LAKEVIEW MANOR
133 Main Street, P.O. Box 514, Beaverton, ON, L0K-1A0

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Susanne Babic

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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 : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_293554_0032, CO #001;

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 shall develop, submit and implement a corrective action plan to include the following:
1) Complete "Smoking Assessment Tools" as per the home's policy for all resident's currently in the home at risk for safety related to smoking use.
2) Review and revise and the plan of care for Resident #2 and Resident #3, (and any other residents identified as a moderate to high smoking risk), to ensure the plan of care provides clear direction to staff and others related to smoking risk, where smoking items are to be stored, and interventions to be used to manage the risk (based on the smoking assessments).
3) Retrain the Registered Nursing staff on the home's "Smoking" policy and develop a process to ensure the policy is complied with.

The plan shall include who shall undertake each item and the date of completion.

This plan is to be submitted via email to Lynda Brown at: Lynda.Brown2@ontario.ca by June 15, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the residents related to safety risks.

Related to log #001418:

Interview of RCC #1 indicated the home currently has identified residents that are at risk for injury related to unsafe practices (smoking). The RCC indicated that the RN's on each unit are responsible for completing the assessments related to those safety risks, and updating the residents' care plan.

Interview of Staff #102 indicated if there are concerns related to the unsafe practices (smoking), then the resident would be reassessed again (using the Assessment Tool) and the care plan updated.

Review of the home's "Smoking Policy" (ADM-01-03-37) indicated definitions of smoking risk (low, moderate and high) which relates to resident's ability to safely manage smoking supplies. Under procedure, the resident is receive a copy of the home's smoking policy upon admission and comply with the policy. The Registered

Staff are to identify residents who smoke, ensure cigarettes and lighter/matches are stored in a designated locked area for smokers, and assess each resident for care and safety needs using the "Smoking Assessment Tool". They are to document smoking restrictions on the resident's care plan, and if risk /non-compliance is identified, call a problem solving care conference.

Interview of Staff #100 indicated Resident #2 is identified at risk related to unsafe smoking practices, had an assessment tool completed, and stated "has had some concerns" related to these unsafe practices.

Interview of Staff #101 indicated Resident #2 is identified at risk related to unsafe smoking practices and stated "has been concerns" related to these unsafe practices.

Review of the (current)"Smoking Assessment Tool" for Resident #2 indicated the resident was known to engage in unsafe smoking practices.

Review of the care plan (current) for Resident #2 indicated under safety(smoking)had no indication of the level of risk, whether the resident was able to manage own supplies, where the supplies were to be stored/locked, or concerns related to these unsafe practices, and strategies to manage those concerns.

Interview of Staff #102 indicated Resident #3 is identified at risk for injury related to unsafe practices (smoking), had an assessment completed, and had no concerns related to these unsafe practices.

Review of the progress notes for Resident #3 indicated on a specified date and time, the resident was found engaging in unsafe practices (smoking) and resulted in a near miss injury.

Review of an email correspondence indicated concern re: completion of assessments for Resident #3.

Review of the "Smoking Assessment Tool" for Resident #3 (completed 4 years ago) indicated the resident was known to engage in unsafe practices (smoking) resulting in potential injury to the resident.

Review of the care plan (current) for Resident #3 indicated under safety(smoking)that staff report that resident does have indication of potential for injury to self. There was

no indication of the level of risk, whether the resident was able to manage own supplies, where the supplies were to be stored, concerns related to these unsafe practices, and no clear direction on how to manage the resident's risk.

The severity is the licensee was issued a compliance order during inspection #2014_293554_0032 on September 1, 2014 for LTCHA, s.6 related to safety (smoking) and were to be complied by January 16, 2015. The scope is that 2 out 4 residents were identified as a safety risk related to smoking. [s. 6. (1) (c)] (111)

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

Jul 31, 2015

Order # /
Ordre no : 002

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

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 :

(A1)
The licensee shall prepare, implement and submit a corrective action plan to include the following:
-Review and revise the plan of care for Resident #7 & Resident #8 (and any other residents at risk related to sexually inappropriate responsive behaviours) to ensure the triggers are identified, where possible, and strategies are developed and implemented to reduce the risks to residents at risk for abuse.
-Ensure the resident, the SDM, if any, and the designate of the resident SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.
-Review and revise the home s policy on "Abuse & Neglect-Prevention, Reporting & Investigating" to ensure the policy contains: procedures and interventions to deal with person(s) who have sexually abused or allegedly sexually abused residents (as appropriate), and when involving resident to resident, determining consensual non-consensual, cognitive and cognitively impaired residents, and identifies measures and strategies to prevent sexual abuse, by another resident.
-Re-train all staff on the home s "revised" policy of "Abuse & Neglect-Prevention, Reporting & Investigating".
-Develop and implement a monitoring process for ongoing monitoring to ensure compliance with the home s Abuse & Neglect-Prevention, Reporting & Investigating policy.

The plan shall include who will be responsible for each action and the completion date.

The plan is to be submitted to Lynda Brown, LTCH Inspector (Nursing) at: lynda.brown2@ontario.ca by June 15, 2015.

Grounds / Motifs :

1. The licensee failed to comply with LTCHA, 2007, s.19(1) by ensuring Resident #7 was protected from sexual and physical abuse by Resident #8.

Under O.Reg. 79/10, s.2 (1) for the purpose of the definition of abuse in subsection 2(1) of the Act, "sexual abuse" is defined as 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.

Under O.Reg.79/10, s.2(1) for the purpose of the definition of abuse in subsection 2(1) of the Act, "physical abuse" is defined as the use of of physical force by a resident that causes physical injury to another resident.

2. Related to log #000981:

A critical incident report was received on a specified date for a resident to resident physical abuse incident that occurred three days prior. The CIR indicated that Resident #8 was found being physically abusive towards Resident #7. Staff immediately intervened and removed Resident #7 from the room. Resident #7 was assessed and complained of pain to a specified area. Resident #8 was placed on 1:1 monitoring and a referral to psychogeriatric resources. Resident #7 was relocated the following day.

Interview of RCC #1, Staff #103 & Staff #104, observation/interview of the resident, and review of the health record for Resident #8 indicated: the resident was cognitively impaired, independently wanders throughout the unit/other resident rooms, rummages/hoards other residents personal items, can become easily agitated and/or verbally/physically aggressive towards staff and other residents, is resistive to care, is difficult to redirect/distract and unpredictable. Staff indicated Resident #8 had a "romantic companionship" with Resident #7.

Interview of RCC #1, Staff #103 & Staff #104, observation/interview of the resident, and review of the health record of Resident #7 indicated the resident was cognitively impaired, independently wanders throughout the unit/other resident rooms, can become agitated and verbally aggressive towards staff during personal care and towards other residents but is generally easily redirected/distracted. Staff reported the resident was "courting" and having a "romantic companionship" with Resident #8 until Resident #7 became physically aggressive towards Resident #8.

3. Review of the progress notes (for Resident #7 & #8)for a three month period indicated the following:
-Resident #7 was admitted to the unit approximately nine days before displaying "affectionate" responsive behaviours towards Resident #14.
-Two days later, Resident #7 was observed approaching “other male residents” and had to be redirected. The resident was also demonstrating responsive behaviours of

exit-seeking, wandering, and repetitive requests.
-Four days later, Resident #7 was found in another resident's bed and was redirected "with difficulty".
-The following day, staff noted "increased affectionate contact" between Resident #7 and Resident #8 continuing.
-Both residents were checked on throughout the night and staff noted "they were fine", "sleeping and cuddling" one another.
-Over the following weeks, the residents' inappropriate sexual responsive behaviours continued and escalated, and Resident #8 became more physically aggressive (towards the female resident) and staff attempted to intervene. The physician was notified and new medication orders were received and provided to Resident#8 after one physically abusive incident towards another female resident and staff when staff were attempting to intervene. The resident was placed on "every 30 minute checks for a 7 day observation period" and a referral to psycho-geriatric resources was completed "to ensure that the relationship is consensual".
-The following evening, Resident #8 was found in Resident #13 room with Resident #7. Resident #13 reported Resident #8 "grabbed a hold of me" but no injuries noted to Resident #13. Resident #7 & Resident #13 were easily redirected from the room but Resident #8 "refused to leave and had to be redirected again later".
-Two days later the physician assessed Resident#8, and was aware of sexually inappropriate responsive behaviours escalating. The physician increased the psychotropic medication and started the resident on an antidepressant. The physician also assessed Resident #7 and indicated "discussed behaviour with staff". The physician increased the psychotropic medication and indicated staff to "monitor".

-Two nights later, Resident #8 had slept in Resident #7 bed "all night".
-Two days later, Resident #8 was placed on every 15 minute monitoring and to be reassessed in two days. Psychogeriatric resources was contacted for possible placement of Resident #8 "due to increased incidents of responsive behaviours".
-Two days later, staff witnessed Resident #8 display physical aggression with an object towards Resident #7 in a specified area. Resident #7 was witnessed attempting to strike back at Resident#8 when Resident #8 threatened Resident #7. Later in the evening, Resident #7 was attempting to go to sleep alone and Resident #8 "became agitated with redirection".
-Eight days later, the physician assessed Resident #8 and noted (increased lethargy) with increased psychotropic and dose was reduced. Antidepressant was increased. The physician noted "not as sexually aggressive".
-Five days later in the evening, Resident#8 was found in Resident #7 bed and when

staff attempted to redirect, Resident #8 became verbally and physically aggressive towards staff.
-Two days later, in the evening, Resident #8 was found in another resident's bed (with Resident #7). Staff attempted to redirect both residents so the other resident could sleep. Resident #8 became angry and shut the door "on staff". The other resident was redirected to another bed to sleep until an hour later when both residents "were successfully redirected".
-Two days later, a 6 week post-admission care conference was held with family of Resident #7.
-Three days later, Resident #8 spent the night sleeping with Resident #7 in the "respite room". Both residents "were checked on regularly to ensure they do not enter other resident's rooms".
-Two days later, Resident #7 & Resident #8 were heard yelling from Resident #8 room. Staff found Resident #8 being physically aggressive towards Resident #7 (when staff intervened). Resident #7 was crying and staff removed Resident #7 from the room. Resident #7 reported that Resident #8 had been repeatedly physically abusive towards the resident resulting in pain to a specified area. The police, physician, POA's of both residents, and the Director were notified. Door sensor alarm was placed on Resident #8 door to alert staff when the resident left the room.
-The following day, Resident #8 was placed on 1:1 monitoring. Resident #7 was relocated to another area.

4. Review of current care plan for Resident #8 related to responsive behaviours indicated the resident "has found romantic companionship with a female co-resident, has demonstrated responsive behaviour toward staff who the resident feels are attempting to remove the control of this relationship". The resident has demonstrated agitated/aggressive behaviour when co-residents or staff attempt to take one of the residents 'treasures' from the resident. Wanders and hoards and is suspicious of other that are "trying to steal" own belongings. Verbally abusive towards spouse and will physically try to remove the spouse from a chair by pulling on arms. Interventions included:
-allow other resident's to share either the residents' or co-resident's beds if they choose (do not remove one from the room to go to their own room) and provide the resident and companion nourishment together.
-ensure the resident is not present when personal care is provided to companion.
-allow the resident's to "express their romantic companionship" and "respect the resident's choice to be left in privacy with companion".
-attempt to remove other resident's away if redirection is not possible.

-allow the resident to keep the hoarded items (and remove/return to owner) when the resident leaves the item behind or goes to sleep.
-re-approach later

Review of the care plan (in place at time of incidents) for Resident #7 indicated the resident has moderate cognitive impairment with short and long term memory loss. Illicit family input for best approaches to resident. There was no indication of sexually inappropriate behaviour towards other male residents or ongoing "romantic relationship" with Resident #8 and strategies to manage these behaviours.

5. Therefore, the licensee failed to protect Resident #7 from sexual and physical abuse by Resident #8 by:
-failing to ensure the resident, the SDM, if any, and the designate of the resident/SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care for Resident # 7 & #8 as identified under LTCHA, 2007, s.6(5) under WN #1.
-failing to ensure that behavioural triggers for the residents are identified, where possible, strategies were developed and implemented to respond to these behaviours, where possible, as indicated under O.Reg. 79/10, s.53(4)(a)(b) under WN#4.
-failing to ensure the home's policy of "Abuse & Neglect-Prevention, Reporting & Investigating" contained procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected, contained procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate, and identified measures and strategies to prevent abuse and neglect as identified under O.Reg. 79/10, s.96(a)(b)(c) under WN #5. [s. 19. (1)] (111)

2.
(111)

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

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

Nov 30, 2015(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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 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
Performance Improvement and Compliance 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

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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

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 23 day of October 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

Service Area Office /
Bureau régional de services : Ottawa