Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

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


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

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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
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Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
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## Amended Public Copy/Copie modifiée du rapport public

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log #/ No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jun 18, 2020 | 2020_760758_0005 (A2) | 016234-19, 021857-19, 023742-19, 024475-19 | Critical Incident System |

### Licensee/Titulaire de permis

LaPointe-Fisher Nursing Home, Limited
1934 Dufferin Avenue WALLACEBURG ON N8A 4M2

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

LaPointe-Fisher Nursing Home
271 Metcalfe Street GUELPH ON N1E 4Y8

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

Amended by DANIELA LUPU (758) - (A2)

## Amended Inspection Summary/Résumé de l'inspection modifié

**The CDD extension due to pandemic emergency order and amendments to O. Reg. 79/10.**

**Issued on this 18th day of June, 2020 (A2)**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

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


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

Amended by DANIELA LUPU (758) - (A2)

## Amended Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): February 19-21, 24-28, and March 2, 2020.**

**The following intakes were completed in this Critical Incident System inspection:**

**Log #023742-19/ Follow up to CO #001 related to prevention of abuse and neglect,**

**Log #016234-19/ Follow up to CO#001 related to sufficient staffing and**

**Log #021857-19 and Log #024475-19 related to alleged resident to resident abuse.**

**PLEASE NOTE: Written Notifications and Compliance Orders related to LTCHA, 2007, c.8, s.6(1)(c), and O.Reg.79/10, s.53(4)(c), identified in a concurrent inspection #2020_760758_0006 (Log #000576-20) were issued in this report.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing (DON), the Director of Quality Improvement, the Business Manager, the Resident Care Coordinator (RCC), the Activation Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), the Behavioural Support Ontario (BSO) RPN, Personal Support Workers (PSW), a Nursing Aide (NA) and a Dietary Aide (DA).**

**The inspector(s) reviewed clinical records, plans of care for relevant residents, pertinent policies and procedures, the home's relevant investigative records, relevant employee files and staff schedules, observed resident and staff interactions and interviewed residents and staff.**

**The following Inspection Protocols were used during this inspection:**

**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**
**Sufficient Staffing**

**During the course of the original inspection, Non-Compliances were issued.**
- **5 WN(s)**
- **1 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**
**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| LTCHA, 2007 S.O. 2007, c.8 s. 19. (1) | CO #001 | 2019_793743_0018 | 758 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>WAO – Ordres : travaux et activités |
| Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)<br><br>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. | Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.)<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the written plan of care set out clear directions regarding responsive behaviours interventions to staff and others who provide direct care to the residents.

A) A complaint was received by the Ministry of Long-Term Care (MLTC) regarding an identified responsive behaviour of resident #005 towards resident #001 and other residents.

Director of Nursing (DON) #102 and Registered Nurse (RN) #103 stated that the interventions related to responsive behaviours were documented in resident plans of care, which included individual care plans, responsive behaviours tool kits and kardex.

Resident #005's plan of care did not contain specific and consistent directions for staff to manage resident #005's identified responsive behaviours towards resident #001 and other residents.

Personal Support Workers (PSW) #104 and #108 stated that staff referred to the care plans, tool kits and kardex for responsive behaviours interventions. However, they stated they did not have clear directions on implementing the interventions.

Resident #001’s plan of care did not include specific and clear interventions for staff to manage resident #001's identified responsive behaviours towards resident #005 and other residents.

Behavioural Support Ontario (BSO) Registered Practical Nurse (RPN) #107 stated that the interventions in the plan of care did not provide clear directions to staff regarding the residents' identified behaviours.

DON #102 stated that residents #001’s and #005’s care plans did not include clear interventions to direct staff to manage their identified responsive behaviours and acknowledged that there were gaps related to care plans reviews. (758).

B) A complaint was submitted to the MLTC related to alleged identified responsive behaviours between residents #003 and #006.

Resident #003 had an identified cognitive status and a history of the identified responsive behaviours towards resident #006.

Resident #006 had an identified cognitive functioning and a history of identified responsive behaviours.

Multiple progress notes documented both residents ongoing identified responsive behaviours.

On a specified date, residents #003 and #006 were observed displaying the identified responsive behaviour.

DON #102, also the BSO program lead, said that the residents identified responsive behaviours were ongoing.

BSO RPN #107 said that staff were to consult the residents' plans of care and tool kits to find interventions related to residents #003's and #006's identified responsive behaviours.

Resident #003's plan of care did not include specific interventions related to their identified behaviours towards resident #006.

Resident #003's responsive behaviours tool kit informed staff of a specified intervention.

Resident #006's plan of care documented multiple interventions to address their identified responsive behaviours.

PSW #121, #123 and #124 stated that they received conflicting information from the home regarding how to manage the residents' identified responsive behaviours.
PSW #123 and #124 also reported that residents #003's and #006's plans of care did not provide clear directions.

BSO RPN #107 acknowledged that the plan of care was confusing.(743)

The licensee failed to ensure the written plan of care provided clear direction to staff regarding the interventions to be implemented when residents #001 and #005 and residents #003 and #006 were displaying identified responsive behaviours. [s. 6. (1) (c)]

***Additional Required Actions:***

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

**(A1)**
**The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001**

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**WN #2: 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 failed to ensure that actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to the interventions were documented.

A) A critical incident was submitted to the MLTC about the alleged abuse of residents #002 and #003 by resident #001.

On a specified date, Dietary Aide (DA) #114 observed resident #001 displaying the identified responsive behaviour towards resident #002. Soon afterwards, DA #114 observed resident #001 displaying the identified responsive behaviour towards resident #003.

Documentation in Point Click Care (PCC) indicated that resident #001 had history of the identified responsive behaviours towards other residents.

Multiple interventions were added to the resident's plan of care to manage the resident's identified responsive behaviours. Resident #001 continued to further exhibit the identified responsive behaviours towards other residents in three separate incidents on identified dates.

i) Review of the resident #001's plan of care found that no new interventions were implemented until after the incident involving residents #002 and #003, when resident #001 was placed on safety checks.

Safety checks records after the incident showed multiple occasions where the safety checks were not documented.

According to DON #102, safety checks were to be completed in their entirety and acknowledged that there were gaps on their completion for resident #001.

DON #102 stated that safety checks were implemented for residents exhibiting the identified responsive behaviours in order to prevent and monitor if the behaviours occurred. For resident #001, safety checks were to be implemented to monitor the identified behaviours.

Resident #001's safety checks on specified dates did not direct staff to record if the resident was exhibiting the identified behaviours.

DON #102 said there should have been a code added to safety checks legend for the identified behaviours; and acknowledged that the safety checks did not capture the resident #001's identified behaviours. (743)

ii) Resident #001's clinical records on a specified date, indicated that the resident was started on an identified medication to assist in the management of a specified behaviour. A monitoring form was initiated to record the effectiveness of their identified medication.

The form was reviewed and showed incomplete documentation on three identified days.

BSO RPN #107 stated that the form should have been completed in its entirety

and acknowledged that there were gaps in the documentation to monitor the effectiveness of the identified medication for resident #001.(758)

B) A critical incident was submitted to the MLTC related to an alleged incident of abuse by resident #001 towards resident #004. The report documented that resident #001 was placed on safety checks as an immediate follow up action.

Resident #001's plan of care showed no evidence indicating that the safety checks were initiated.

DON #102 stated that safety checks for resident #001 were not initiated in the plan of care after the incident.

C) A complaint was received by the MLTC regarding specified responsive behaviours of resident #005 towards resident #001 and other residents.

Resident #005's clinical records documented an ongoing history of the behaviour.

i) Resident #005's progress notes documented that they had the identified responsive behaviours towards resident #001 and other residents and interventions were initiated to include monitoring through safety checks. Progress notes on a specified date, documented that safety checks were to continue until further notice.

DON #102 stated that the direct care staff were to document resident #005's whereabouts on the safety checks forms and the registered staff were to document in the progress notes if the specified responsive behaviour was displayed.

Review of resident #005's safety checks showed incomplete documentation on multiple dates and times over the two months.

ii) Progress notes documented that resident #005 had displayed an identified responsive behaviour on seven different occasions in a two-month period.

RN #103 and PSW #108 said that the responsive behaviours were to be documented on the flow sheets under the behaviours section.

Resident #005's flow sheets showed missing documentation under the

behaviours section on three identified dates.

DON #102 stated that the expectation was that safety checks and flow sheets were to be completed in their entirety and acknowledged that there were several gaps in the documentation for residents #005.

iii) Resident #005's clinical records on a specified date indicated that the resident was started on a new medication to manage their identified behaviours. A monitoring form was initiated to record the effectiveness of the new medication.

The form showed incomplete documentation for several hours on multiple days.

BSO RPN #107 stated that staff were expected to fully complete the monitoring form and acknowledged that the effectiveness of interventions and the identified responsive behaviours were not properly monitored for resident #005.

iv) The home initiated additional interventions to manage resident #005's identified responsive behaviours through one-to-one monitoring. One-to-one monitoring was discontinued after a week as it was documented that the resident did not demonstrate the identified responsive behaviours.

Resident #005's care plan documented that multiple interventions to manage resident's identified responsive behaviours were not added prior to the one-to-one monitoring discontinuation, and no new interventions were implemented afterwards.

Progress notes documented that on two specified dates resident #005 continued to exhibit the identified responsive behaviours towards resident #001 and they were very difficult to redirect.

On two identified dates, LTCH inspector observed resident #005 attempting to go into resident #001's room and pushing resident #001's assistive device. Two PSW staff were needed to intervene to redirect resident #005.

BSO RPN #107 said that resident #005 needed continuous redirection from staff to prevent injury and maintain the safety of other residents.

DON #102 stated that the interventions to manage residents #005's identified responsive behaviours were not entirely effective and that one-to-one monitoring

was not reinstated due to lack of staffing. (758).

C) A complaint was submitted to the MLTC related to alleged identified responsive behaviours between residents #003 and #006.

Resident #006 had a specified cognitive status and a history of identified responsive behaviours towards resident #003 and other residents.

Resident #006's plan of care documented that the resident was to receive safety checks for their responsive behaviour.

BSO RPN #107 said that the safety checks were implemented to monitor resident #006's identified responsive behaviours and falls and to ensure that resident #006 was not going into other resident's rooms.

There was no evidence of documentation of the safety checks for resident #006.

Resident Care Coordinator (RCC) #119 acknowledged that there were no records of the safety checks for resident #006 for the specified period of time. (743)

The licensee failed to ensure that new interventions were implemented to respond to residents #001's and #005's needs related to their identified responsive behaviours and failed to document residents #001's, #005's and #006's responses to the interventions. [s. 53. (4) (c)]

***Additional Required Actions:***

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

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services**

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

**s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with compliance order (CO) #001 from inspection #2019_800532_0007, issued on August 07, 2019, with a compliance due date of January 30, 2020.

The licensee was ordered to be compliant with LTCHA 2007, s.8(3).

Specifically, the licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the nursing staff of the home, was on duty and present in the home at all times.

RN staffing schedules and payroll records were reviewed post compliance due date, and on an identified date during a specified period of time, there was no RN on duty and present in the home.

According to the Business Manager #125, the scheduled RN for the day shift was not available and the home was not able to find a replacement.

DON #102 said that the home's contingency plan was to call all RNs and if no RN was available, then the ADON or the DON would fill the RN's role.
DON #102 acknowledged that on the identified date, they were not in the building, nor was the former DON.

The licensee failed to ensure that at least one RN who was both an employee of the home and a member of the nursing staff of the home, was always on duty and present in the home at all times. [s. 8. (3)]

***Additional Required Actions:***

**CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

**(A2)**
**The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 003**

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance**

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

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that the licensee's written policy to promote zero tolerance of abuse of residents was complied with.

A critical incident was submitted to the MLTC about the alleged abuse by resident #001 towards residents #002 and #003.

The home's policy titled "Abuse-Resident/Staff", directed staff to immediately report every alleged, suspected or witnessed incidents of abuse of a resident to the appropriate supervisor in the home.

According to the home's documentation in risk management, Dietary Aide (DA) #114 observed the alleged incident between resident #001 and resident #002. Soon afterwards, DA #114 observed the alleged incident between resident #001 and resident #003.

DA #114 said the residents separated without intervention and DA #114 continued to set tables. Later, they observed an incident between resident #001 and resident #003. DA #114 said it was after the second incident that they reported the alleged abuse to the charge nurse.

According to DON #102, the incident of alleged abuse should have been immediately reported.

The licensee failed to ensure that the home's written policy titled "Abuse-Resident/Staff" was complied with, when Dietary Aide #114 failed to immediately report the incident of alleged abuse between resident #001 and resident #002. [s. 20. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee's written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

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

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

**Findings/Faits saillants :**

1. The licensee has failed to protect residents from abuse by anyone.

The following is further evidence to support the compliance order issued on December 13, 2019, during the follow up inspection 2019_793743_0018, with a compliance due date of December 31, 2019.

A) A critical incident was submitted to the MLTC related to an alleged incident of abuse by resident #001 towards residents #002 and #003.

Documentation in PCC indicated that resident #001 had a specified cognitive status and had a history of identified responsive behaviours towards other residents.

The home's documentation indicated that DA #114 observed resident #001 displaying responsive behaviours towards resident #002. The residents separated without intervention and DA #114 continued to set tables. Soon afterwards, DA #114 observed an incident between resident #001 and resident #003.

Resident #003 could not recall the incident; however, they expressed that they disliked when resident #001 displayed an identified responsive behaviour towards them.

According to DON # 102, the interaction between resident #001 and resident #002 was non-consensual.

B) A critical incident  was submitted to the MLTC related to alleged incident of abuse by resident #001 towards resident #004.

Resident #004's clinical records showed that on a specified date, they reported an incident to staff. Resident #004 stated that they were having emotional distress following the incident.

Resident #004's clinical records also documented that resident #004 could not recall the incident and denied having emotional distress soon after the incident occurred. However, a few hours later and again two days after the incident, resident #004 was able to recall the incident when asked by the staff.

On two separate occasions, resident #004 told LTCH inspector about the incident with resident #001 and stated that they were still upset and afraid that it would happen again. Resident #001 expressed concerns that no actions were taken by the home.

LTCH inspector observed that resident #004 was seated at the same table as resident #001.

Resident #001 could not recall the incident. They denied having any interaction with resident #004.

Resident #001's clinical records documented that they had history of displaying an identified responsive behaviour and indicated two previous incidents where resident #001 exhibited the identified responsive behaviour towards other residents.

RN #103 and PSW #108 said that resident #001 had multiple episodes of the identified responsive behaviours.

DON #102 stated that the interventions identified in the resident #001's plan of care did not include monitoring or new interventions.

RN #103 thought that the home did not protect resident #004 from abuse by

resident #001.

The licensee failed to protect residents from abuse by anyone, when they failed to protect residents #002, #003, and #004 from abuse by resident #001. [s. 19. (1)]

**Issued on this 18th day of June, 2020 (A2)**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

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

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

## Amended Public Copy/Copie modifiée du rapport public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | Amended by DANIELA LUPU (758) - (A2) |
| **Inspection No. / No de l'inspection :** | 2020_760758_0005 (A2) |
| **Appeal/Dir# / Appel/Dir#:** | |
| **Log No. / No de registre :** | 016234-19, 021857-19, 023742-19, 024475-19 (A2) |
| **Type of Inspection / Genre d'inspection :** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Jun 18, 2020(A2) |
| **Licensee / Titulaire de permis :** | LaPointe-Fisher Nursing Home, Limited<br>1934 Dufferin Avenue, WALLACEBURG, ON, N8A-4M2 |
| **LTC Home / Foyer de SLD :** | LaPointe-Fisher Nursing Home<br>271 Metcalfe Street, GUELPH, ON, N1E-4Y8 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Dahlia Burt-Gerrans |

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

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

## Ordre(s) de l’inspecteur

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

To LaPointe-Fisher Nursing Home, Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

## 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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**Order # / No d'ordre:** 001

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 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 must be complaint with s. 6.(1) of the Long-Term Care Homes Act, 2007.

Specifically, the licensee must:

A) Ensure that the written plan of care for residents #001, #003, #005, and #006 set out clear directions to staff and others related to the interventions to be implemented when residents #001 and #005 and residents #003 and #006 are displaying identified responsive behaviours towards each other.

B) Ensure that residents #001, #003, #005, #006 and any other resident's care plan, responsive behaviours tool kit and kardex contain consistent information related to the interventions to respond to their identified responsive behaviours.

**Grounds / Motifs :**

1. The licensee has failed to ensure that the written plan of care set out clear directions regarding responsive behaviours interventions to staff and others who provide direct care to the residents.

A) A complaint was received by the Ministry of Long-Term Care (MLTC) regarding an identified responsive behaviour of resident #005 towards resident #001 and other

residents.

Director of Nursing (DON) #102 and Registered Nurse (RN) #103 stated that the interventions related to responsive behaviours were documented in resident plans of care, which included individual care plans, responsive behaviours tool kits and kardex.

Resident #005's plan of care did not contain specific and consistent directions for staff to manage resident #005's identified responsive behaviours towards resident #001 and other residents.

Personal Support Workers (PSW) #104 and #108 stated that staff referred to the care plans, tool kits and kardex for responsive behaviours interventions. However, they stated they did not have clear directions on implementing the interventions.

Resident #001's plan of care did not include specific and clear interventions for staff to manage resident #001's identified responsive behaviours towards resident #005 and other residents.

Behavioural Support Ontario (BSO) Registered Practical Nurse (RPN) #107 stated that the interventions in the plan of care did not provide clear directions to staff regarding the residents' identified behaviours.

DON #102 stated that residents #001's and #005's care plans did not include clear interventions to direct staff to manage their identified responsive behaviours and acknowledged that there were gaps related to care plans reviews. (758).

B) A complaint was submitted to the MLTC related to alleged identified responsive behaviours between residents #003 and #006.

Resident #003 had an identified cognitive status and a history of the identified responsive behaviours towards resident #006.

Resident #006 had an identified cognitive functioning and a history of identified responsive behaviours.

Multiple progress notes documented both residents ongoing identified responsive

behaviours.

On a specified date, residents #003 and #006 were observed displaying the identified responsive behaviour.

DON #102, also the BSO program lead, said that the residents identified responsive behaviours were ongoing.

BSO RPN #107 said that staff were to consult the residents' plans of care and tool kits to find interventions related to residents #003's and #006's identified responsive behaviours.

Resident #003's plan of care did not include specific interventions related to their identified behaviours towards resident #006.

Resident #003's responsive behaviours tool kit informed staff of a specified intervention.

Resident #006's plan of care documented multiple interventions to address their identified responsive behaviours.

PSW #121, #123 and #124 stated that they received conflicting information from the home regarding how to manage the residents' identified responsive behaviours. PSW #123 and #124 also reported that residents #003's and #006's plans of care did not provide clear directions.

BSO RPN #107 acknowledged that the plan of care was confusing.(743)

The licensee failed to ensure the written plan of care provided clear direction to staff regarding the interventions to be implemented when residents #001 and #005 and residents #003 and #006 were displaying identified responsive behaviours. [s. 6. (1) (c)]

The severity of the issue was a level 2, as it was minimal harm to the residents. The scope of the issue was a level 3, as it related to four of four residents reviewed. The home had a level 2 of compliance history. (758)

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

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

## Ordre(s) de l’inspecteur

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

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :** Aug 03, 2020(A1)

## 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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**Order # / No d'ordre:** 002

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, 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;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(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).

**Order / Ordre :**

The licensee must be complaint with r. 53(4) of the O. Reg. 79/10.

Specifically, the licensee must:

A) Ensure that residents #001, #005 and any other resident have their responsive behaviours reassessed and interventions are implemented to respond to their needs.

B) Ensure that residents #001, #005, #006 and any other resident's responses to the interventions related to their responsive behaviours are documented.

**Grounds / Motifs :**

1. The licensee failed to ensure that actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to the interventions were documented.

A) A critical incident was submitted to the MLTC about the alleged abuse of residents #002 and #003 by resident #001.

On a specified date, Dietary Aide (DA) #114 observed resident #001 displaying the identified responsive behaviour towards resident #002. Soon afterwards, DA #114 observed resident #001 displaying the identified responsive behaviour towards resident #003.

Documentation in Point Click Care (PCC) indicated that resident #001 had history of the identified responsive behaviours towards other residents.

Multiple interventions were added to the resident's plan of care to manage the resident's identified responsive behaviours. Resident #001 continued to further exhibit the identified responsive behaviours towards other residents in three separate incidents on identified dates.

i) Review of the resident #001's plan of care found that no new interventions were implemented until after the incident involving residents #002 and #003, when resident #001 was placed on safety checks.

Safety checks records after the incident showed multiple occasions where the safety checks were not documented.

According to DON #102, safety checks were to be completed in their entirety and acknowledged that there were gaps on their completion for resident #001.

DON #102 stated that safety checks were implemented for residents exhibiting the identified responsive behaviours in order to prevent and monitor if the behaviours occurred. For resident #001, safety checks were to be implemented to monitor the identified behaviours.

Resident #001's safety checks on specified dates did not direct staff to record if the resident was exhibiting the identified behaviours.

DON #102 said there should have been a code added to safety checks legend for the identified behaviours; and acknowledged that the safety checks did not capture the resident #001's identified behaviours. (743)

ii) Resident #001's clinical records on a specified date, indicated that the resident was started on an identified medication to assist in the management of a specified

behaviour. A monitoring form was initiated to record the effectiveness of their identified medication.

The form was reviewed and showed incomplete documentation on three identified days.

BSO RPN #107 stated that the form should have been completed in its entirety and acknowledged that there were gaps in the documentation to monitor the effectiveness of the identified medication for resident #001.(758)

B) A critical incident was submitted to the MLTC related to an alleged incident of abuse by resident #001 towards resident #004. The report documented that resident #001 was placed on safety checks as an immediate follow up action.

Resident #001's plan of care showed no evidence indicating that the safety checks were initiated.

DON #102 stated that safety checks for resident #001 were not initiated in the plan of care after the incident.

C) A complaint was received by the MLTC regarding specified responsive behaviours of resident #005 towards resident #001 and other residents.

Resident #005's clinical records documented an ongoing history of the behaviour.

i) Resident #005's progress notes documented that they had the identified responsive behaviours towards resident #001 and other residents and interventions were initiated to include monitoring through safety checks. Progress notes on a specified date, documented that safety checks were to continue until further notice.

DON #102 stated that the direct care staff were to document resident #005's whereabouts on the safety checks forms and the registered staff were to document in the progress notes if the specified responsive behaviour was displayed.

Review of resident #005's safety checks showed incomplete documentation on multiple dates and times over the two months.

ii) Progress notes documented that resident #005 had displayed an identified responsive behaviour on seven different occasions in a two-month period.

RN #103 and PSW #108 said that the responsive behaviours were to be documented on the flow sheets under the behaviours section.

Resident #005's flow sheets showed missing documentation under the behaviours section on three identified dates.

DON #102 stated that the expectation was that safety checks and flow sheets were to be completed in their entirety and acknowledged that there were several gaps in the documentation for residents #005.

iii) Resident #005's clinical records on a specified date indicated that the resident was started on a new medication to manage their identified behaviours. A monitoring form was initiated to record the effectiveness of the new medication.

The form showed incomplete documentation for several hours on multiple days.

BSO RPN #107 stated that staff were expected to fully complete the monitoring form and acknowledged that the effectiveness of interventions and the identified responsive behaviours were not properly monitored for resident #005.

iv) The home initiated additional interventions to manage resident #005's identified responsive behaviours through one-to-one monitoring. One-to-one monitoring was discontinued after a week as it was documented that the resident did not demonstrate the identified responsive behaviours.

Resident #005's care plan documented that multiple interventions to manage resident's identified responsive behaviours were not added prior to the one-to-one monitoring discontinuation, and no new interventions were implemented afterwards.

Progress notes documented that on two specified dates resident #005 continued to exhibit the identified responsive behaviours towards resident #001 and they were very difficult to redirect.

On two identified dates, LTCH inspector observed resident #005 attempting to go into

resident #001's room and pushing resident #001's assistive device. Two PSW staff were needed to intervene to redirect resident #005.

BSO RPN #107 said that resident #005 needed continuous redirection from staff to prevent injury and maintain the safety of other residents.

DON #102 stated that the interventions to manage residents #005's identified responsive behaviours were not entirely effective and that one-to-one monitoring was not reinstated due to lack of staffing. (758).

C) A complaint was submitted to the MLTC related to alleged identified responsive behaviours between residents #003 and #006.

Resident #006 had a specified cognitive status and a history of identified responsive behaviours towards resident #003 and other residents.

Resident #006's plan of care documented that the resident was to receive safety checks for their responsive behaviour.

BSO RPN #107 said that the safety checks were implemented to monitor resident #006's identified responsive behaviours and falls and to ensure that resident #006 was not going into other resident's rooms.

There was no evidence of documentation of the safety checks for resident #006.

Resident Care Coordinator (RCC) #119 acknowledged that there were no records of the safety checks for resident #006 for the specified period of time. (743)

The licensee failed to ensure that new interventions were implemented to respond to residents #001's and #005's needs related to their identified responsive behaviours and failed to document residents #001's, #005's and #006's responses to the interventions. [s. 53. (4) (c)]

The severity of the issue was a level 2, as it was minimal harm to the residents. The scope of the issue was a level 2, as it related to two of four residents reviewed. The home had a level 3 of compliance history that included:
-Voluntary plan of correction (VPC) issued June 26, 2018 (2018_723606_0007)

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

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

## Ordre(s) de l’inspecteur

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

(758)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :** Jul 06, 2020

## 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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**Order # / No d'ordre:** 003

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

**Linked to Existing Order / Lien vers ordre existant:** 2019_800532_0007, CO #001;

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

**Order / Ordre :**

The licensee must be compliant with s.8(3) of the Long-Term Care Homes Act, 2007.

Specifically, the licensee must:

A) Ensure that there is at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff is on duty and present in the home at all times, except as provided for in the regulations.

B) Ensure that the contingency plan is implemented when scheduled staff are unable to work as scheduled.

## 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

**Grounds / Motifs :**

1. The licensee has failed to comply with compliance order (CO) #001 from inspection #2019_800532_0007, issued on August 07, 2019, with a compliance due date of January 30, 2020.

The licensee was ordered to be compliant with LTCHA 2007, s.8(3).

Specifically, the licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the nursing staff of the home, was on duty and present in the home at all times.

RN staffing schedules and payroll records were reviewed post compliance due date, and on an identified date during a specified period of time, there was no RN on duty and present in the home.

According to the Business Manager #125, the scheduled RN for the day shift was not available and the home was not able to find a replacement.

DON #102 said that the home's contingency plan was to call all RNs and if no RN was available, then the ADON or the DON would fill the RN's role.
DON #102 acknowledged that on the identified date, they were not in the building, nor was the former DON.

The licensee failed to ensure that at least one RN who was both an employee of the home and a member of the nursing staff of the home, was always on duty and present in the home at all times. [s. 8. (3)]

The severity level of this issue was determined to be a level 2, as there was minimal harm to the residents. The scope of the issue was a level 3 as widespread. The home had a level 4 history of on-going non-compliance with this section of the Act that included:
-Compliance Order (CO) issued August 8, 2018 (2018_580568_0008)
-CO issued January 16, 2019 (2018_610633_0022)
-Director Referral (DR) and CO issued August 7, 2019 (2019_800532_0007)
-WN issued December 13, 2019 (2019_793743_0018)
(743)

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

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

## Ordre(s) de l’inspecteur

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

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :** Oct 30, 2020(A2)

## 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

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

## Order(s) of the Inspector

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

## 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

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

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

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

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

**Issued on this 18th day of June, 2020 (A2)**

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

**Name of Inspector /**
**Nom de l’inspecteur :** Amended by DANIELA LUPU (758) - (A2)

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

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