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 sous la Loi de 2007 sur les foyers de soins de longue durée

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 1, 2017	2017_626501_0011	016569-16, 024340-16, 026605-16, 027483-16, 027508-16, 027990-16, 028517-16, 028605-16, 028720-16, 031466-16, 033322-16, 033800-16, 000456-17, 001903-17, 002202-17, 002291-17, 002522-17, 003650-17, 003956-17, 003960-17, 004527-17, 004933-17, 005034-17, 005163-17, 005857-17, 006109-17, 006564-17, 006862-17, 006874-17, 007145-17, 007146-17	Critical Incident System

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

Fieldstone Commons Care Community
1000 Ellesmere Road SCARBOROUGH ON M1P 5G2

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

SUSAN SEMEREDY (501), BABITHA SHANMUGANANDAPALA (673), JULIENNE NGONLOGA (502), TILDA HUI (512)

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): March 21, 22, 23, 24, 27, 28, 29, 30, 31, April 3, 4, 5, 6, 7, 10, 11, 12, 13, 18, and 19, 2017.

This inspection was conducted concurrently with two complaint inspections: #2017_634512_0005 and #2017_632502_0006.
Findings of noncompliance related to LTCH Act, 2007, s. 6(1)(c) and s. 6(10)(b) and O.Reg 79/10, s. 68(2)(a) identified in inspection #2017_634512_0005 (intake #001730 -17 and #001810-17) will be issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Assistant Directors of Care (ADOCs), Nurse Managers (NMs), Resident Relations Coordinator (RRC), Director of Resident Programs, Registered Dietitian (RD), Physiotherapist (PT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Activity Aides, Dietary Aides, Scheduling Co-ordinator, students, residents, and Substitute Decision Makers (SDMs).

During the course of the inspection, the inspector(s) observed staff and resident interactions and the provision of care, reviewed health records, complaint and critical incident
record logs, staff training records, meeting minutes for Residents' Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

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

- **13 WN(s)**
- **7 VPC(s)**
- **3 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.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (6) When a resident is admitted to a long-term care home, the licensee shall, within the times provided for in the regulations, ensure that the resident is assessed and an initial plan of care developed based on that assessment and on the assessment, reassessments and information provided by the placement co-ordinator under section 44. 2007, c. 8, s. 6 (6).

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

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

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

On an identified date, the Ministry of Health and Long Term Care (MOHLTC) received a

Critical Incident Report (CIR) related to an incident of alleged abuse. Review of the CIR revealed that during a survey, resident #036 disclosed to a student that someone had assaulted him/her however, no injuries were noted.

Review of resident #036's progress notes revealed the following occurred on identified dates:

-RN #132 documented that resident #036 stated that his/her identified body parts hurt because someone assaulted him/her and he/she fell. On the same day, resident #036 stated that he/she was in another type of facility and he/she was getting a headache.
- Resident #036 stated that he/she could hear crying of children. Resident #036 was provided reality orientation.
-Resident #036 stated that someone was in the bathroom when there was no one there and was provided reality orientation by staff.
-Student #165 documented that resident #036 made a similar statement to the one reported in CIR that someone was assaulting him/her and causing identified injuries. No injuiries were observed by student #165.

Review of resident #036's annual Minimum Data Set (MDS) assessment revealed the resident had an identified medical condition, further noting that resident #036 believes he/she is still in another facility.

Review of resident #036's current written plan of care failed to reveal a focus and intervention related to the identified medical condition.

An interview with PSW #142 revealed resident #036 has a history of thinking he/she was being assaulted.

An interview with student #165 revealed that on an identified date, resident #036 told him/her that someone had assaulted him/her and caused injury. Student #165 further revealed that he/she informed his/her supervisor RN #132, and they both completed an assessment of the resident and found no evidence of injury or distress.

An interview with RPN #166 revealed that upon assessment of resident #036's medical condition from the MDS assessment, the plan of care should have been updated to include this condition.

An interview with RN #132 revealed that if a resident is assessed to have a condition, it

should be updated in the written plan of care. RN #132 stated that resident #036's current written plan of care did not include this identified condition.

An interview with the DOC confirmed that resident #036 was assessed for, and has a history of an identified medical condition. The DOC further confirmed that this was not included in the written plan of care. [s. 6. (1) (a)]

2. 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 resident.

A) A CIR was submitted to the MOHLTC related to resident#008's transfer to the hospital with various conditions on an identified date. The resident's SDM expressed concerns related to the resident's diagnosis upon transfer back to the home. The resident's SDM also contacted the INFOLINE of the MOHLTC and filed a complaint information report regarding similar concerns.

Review of resident #008's written plan of care, revealed the resident was incontinent of bowel requiring an identified size of incontinent product and another size for nights. For incontinence of bladder the resident was described as using an identified size of incontinent product.

Interviews with PSWs #121, #134 and #135 indicated the resident was incontinent of bladder and bowel and was using an identified size product. RPN #120 stated that PSWs would use whatever sizes of incontinent products on residents depending on availability, so sometimes the resident would be using one size of product and sometimes another size. RPN #131 indicated the resident was using an identified size of product and stated the written plan of care was not revised to give clear directions.

Interview with the DOC confirmed that the resident's written plan of care did not set out clear directions to staff who provide direct continence care to resident #008.
PLEASE NOTE: This evidence of non-compliance related to resident #008 was found during inspection #2017_634512_0005.

B) On an identified date, the Ministry of Health and Long Term Care (MOHLTC) received a CIR related to the administration of drugs involving a medication error.

Review of the CIR stated that resident #019 was ordered a specified amount of a medication for an identified number of days, then a reduced dose thereafter. The CIR

further stated that resident #019 continued to receive the original dose after the identified number of days.

Review of the physician's order, stated to increase the medication for a specified time, and then to reduce the medication.

Interviews with RN #153, RN #132, and ADOC #147 revealed that the pharmacy made an error with the medication administration dosage and instructions. ADOC #147 stated that the pharmacy failed to input a stop date on the original order for the medication and therefore, continued to dispense an extra identified amount for this resident.

RN #153, RN #132, and ADOC #147 further stated that during an identified time period, resident #019 received an increased amount of the medication and the nurses administering the medication signed the eMAR as though resident #019 was self-administering the medication as there was no other place to sign.

RN #157, RN #132, and ADOC #147 confirmed in interviews that the written plan of care for resident #019 did not set out clear directions to staff administering the medication.

Interview with the DOC confirmed that the written plan of care did not set out clear directions to staff administering medication to resident #019 for an identified time period. [s. 6. (1) (c)]

3. The licensee has failed to ensure that when a resident is admitted to a long-term care home, within the times provided for in the regulations, an initial plan of care is to be developed based on that assessment and on the assessment, reassessments and information provided by the placement coordinator under section 44.

On an identified date a CIR was submitted to the MOHLTC related to resident to resident abuse. Review of the CIR revealed that resident #018 was observed causing injury to resident #005.

Review of Community Care Access Central (CCAC) admission documentation revealed resident #018 was assessed on an identified date, with a medical history of responsive behaviours. The risk factors were identified and specific behaviours were outlined. The resident was reassessed on an identified date, and his/her medication remain unchanged.

Review of resident #018's written plan of care revealed the resident was admitted to the home on an identified date, with a specific medical condition. Further review of the plan of care revealed that a focus on behaviour and interventions were care planned on an identified date, which was one day after resident #018 abused resident #004 causing injury.

An interview with RN #106 revealed resident #018's responsive behaviours were not included in the initial plan of care, as the resident had not been identified as having such behaviours based on information obtained by the resident's SDM which did not correlate with CCAC documentation. He/she confirmed that the plan of care was not based on the information provided by the CCAC.

An interview with the DOC confirmed that the initial plan of care should have included the CCAC assessment related to resident #018's history of responsive behaviours. [s. 6. (6)]

4. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Review of a CIR submitted to the MOHLTC on an identified date, revealed that on the same day resident #001 was observed standing over resident #002's bedside touching him/her while he/she was lying down in bed sleeping.

Record review also revealed that on an identified date resident #001 was found lying in bed with resident #006 who became upset and tearful. According to the progress note and interview with RN #105 resident #001 did not have one to one staffing at the time of the incident.

Record review revealed resident #001's plan of care stated that a one to one program is to be implemented when the resident is exhibiting an identified behavior. Interviews with RN #106 and the DOC revealed resident #001 is to have one to one staffing during identified shifts related to his/her unpredictable behaviours. Review of the daily roster revealed resident #001 did not have one to one staff on both of the above mentioned days.

Interview with the DOC revealed that it is not always possible to fill one to one staffing requirements. The DOC confirmed that the above incidents most likely would not have occurred if resident #001 had one to one staff and the home had failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan. [s.

6. (7)]

5. On an identified date, the Ministry of Health and Long Term Care (MOHLTC) received a CIR related to abuse. Review of the CIR revealed PSW #103 was abusing resident #014.

Review of resident #014's medical record revealed the resident had identified medical conditions and was hospitalized in the past year. The resident's Cognitive Performance Scale (CPS) indicated no or minor cognitive loss.

While interviewing resident #014 on an identified date, related to the above CIR, the resident revealed to the inspector that he/she did not receive his/her ordered nutritional supplement that same day. Resident #014 stated that he/she receives this supplement to gain weight as he/she had lost weight after a hospitalization. Resident #114 further stated that he/she requested his/her nutritional supplement from PSW #103, his/her primary care provider, prior to leaving the unit. According to the resident, PSW #103 told him/her it was not yet time for the snacks to be offered. When the resident returned to the unit, he/she again asked the PSW for his/her supplement and the PSW told him/her that it was too late as snack time was finished. Resident #103 stated he/she did not receive his/her supplement on the above mentioned date.

According to progress notes the resident felt he/she needed extra nourishment following hospitalization and the Registered Dietitian (RD) ordered the supplement to help maintain weight. Review of the most recent plan of care, under the focus of nutrition, revealed resident #014 is at nutritional risk due to identified medical conditions. Goals for the nutritional focus included maintaining adequate nutritional status and a stable weight, and the interventions included serving the resident a nutritional supplement.

An interview with PSW #103 revealed he/she did not leave the supplement for resident #114 on the above mentioned date because the resident was not available during snack time and it is the practice in the home not to leave food in resident rooms if they are not there. PSW #103 further stated he/she was not aware that the supplement could have been kept in the refrigerator.

An interview with RPN #120 confirmed resident #014 requested his/her supplement upon return to the unit and was aware that PSW #103 did not provide the supplement. RPN #120 confirmed that care was not provided to resident #014 as outlined in the plan of care.

During interviews, day PSWs #136, #137, #139, evening PSWs #144, #121, day RPN #102, and evening RPNs #131 and #138, and RN #125 stated that the home's expectation is that snacks can be saved in the refrigerator for residents who are not available during snack time. Interview with the DOC revealed food should not be left in resident rooms; however, it is the home's expectation that snacks, especially nutritional supplements, be saved in the refrigerator.

Interview with DOC #112 confirmed that the care set out in the plan of care for resident #014 was not provided to the resident as specified in the plan. [s. 6. (7)]

6. Review of a CIR revealed resident #022 was observed by the one to one staff for resident #029 to be walking in the hallway with resident #029 when resident #022 inappropriately touched resident #029. This occurred on an identified date, and one to one staff was then provided for resident #022.

Review of resident #022's progress notes revealed the resident was admitted the same day as the above incident and was determined to have severe cognitive impairment. Review of progress notes from an identified time period, indicated resident #022 was receiving one to one staffing for day and evening shifts.

Review of another CIR revealed resident #029 was observed following resident #022 and holding hands on an identified date. According to the CIR, a private care giver who witnessed the incident, observed resident #022 then inappropriately touched resident #029.

Record review and interview with RN #156 revealed resident #022 and resident #029 have had responsive behaviours. Both residents were provided one to one staff to monitor and provide redirection as needed.

Review of the daily roster for the second incident revealed resident #022 and #029 were to have one to one staff. Review of progress notes for both residents and an interview with Nurse Manager #149 revealed both residents were not provided one to one care.

Interviews with RN #156 and Nurse Manager #149 revealed that if one to one staff had been provided for resident #022 and #029, the incident , most likely would not have occurred.

Interview with the DOC confirmed that the care set out in the plan of care was not provided to resident #022 and #029 as specified in the plan. [s. 6. (7)]

7. A CIR was submitted to the MOHLTC related to alleged resident to resident abuse. Review of the CIR revealed that on an identified date, resident #004 hit resident #031causing resident #031 pain.

Review of resident #004's written plan of care, revealed that resident #004 has responsive behaviours. Further review of the written plan of care revealed one to one staff had been assigned to resident #004 to monitor and prevent significant risk of violence towards others.

Review of the daily roster for the above mentioned identified date, revealed that the staff scheduled to provide one to one for resident #004, had cancelled and was not replaced leaving the resident without one to one monitoring. An interview with Scheduling Coordinator #141 revealed the PSW scheduled to provide one to one monitoring had cancelled and he/she was not able to replace the staff.

Interviews with PSW #116, and RN #126, revealed resident #004 did not have one to one staff during the time of the above mentioned incident. PSW #116 revealed being aware that resident #004 will hit other residents when no one is watching and required close monitoring. However, he/she had left resident #004 and resident #031 without supervision as he/she needed to check on other residents on his/her assignment when the incident happened.

Interviews with RN #126 and the DOC revealed that one to one staff scheduled to monitor resident #004 had cancelled and confirmed that a replacement was not provided to resident #004 on the above mentioned identified date. The DOC confirmed that the care set out in the plan of care was not provided to resident #004 as specified in the plan. [s. 6. (7)]

8. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs change.

A) A CIR was submitted to the MOHLTC related to resident#008's transfer to the hospital with identified medical conditions. The resident's SDM expressed concerns related to the resident's diagnosis upon transfer back to the home. The SDM also contacted the INFOLINE of the MOHLTC and filed a complaint regarding similar concerns.

Review of resident #008's progress notes indicated the resident was observed with altered skin integrity on an identified date. Resident was also noted to have deteriorated in general condition and was not able to feed him/herself like he/she used to. A referral to the registered dietitian (RD) was made and the resident was assessed. On an identified date the resident was documented as becoming weaker. The resident was assessed by the home's attending physician and medication was recorded as effective at times. The resident's family members were contacted by RPN #108 who offered to send the resident to the hospital but was declined by the family. The resident continued to decline. On an identified date, the resident was reported to have a suspected fracture.

Review of resident #008's written plan of care did not reveal strategies to manage the resident's increased fluid intake requirement due to deteriorating conditions.

Review of resident's daily fluid intake summary indicated the resident had a identified servings of fluids over a three day identified period.

Interviews with PSWs #103 and #121 indicated the resident was eating and drinking well. The PSWs stated they had been trying to push fluids to the resident and were not aware that the resident had such low daily fluid intake on the above three days.

During interviews with RPN #102, #108 and #131, the RPNs indicated they receive reports from PSWs if residents are not drinking well. The RPNs stated the night charge nurse would review the daily fluid intake summary of all residents and would alert the day charge nurse for any resident not taking the minimum serving of fluids. The RPNs stated that resident #008 was supposed to have daily fluid intake of at least an identified number of servings. The RPNs were not aware that resident #008 had total daily fluid intakes below what he/she was supposed to have on the above mentioned three days. The RPNs stated resident #008's increased fluid intake requirement should have been included in the resident's written plan of care to manage the resident's changing health condition.

Interview with the DOC confirmed that resident #008 was not assessed and his/her written plan of care updated and revised when his/her daily fluid requirement had changed due to changing health conditions
PLEASE NOTE: This evidence of non-compliance related to resident #008 was found during inspection #2017_634512_0005.

B) A CIR was submitted to the MOHLTC related to resident #011 having a specified amount of falls within a 12-hour period on an identified date. The resident was transferred to the hospital after the last fall and expired at the hospital.

Review of resident #011's admission record indicated the resident had a history of falls and was assessed to be at risk for falls.

Review of resident #011's progress notes revealed the resident had an unwitnessed fall on an identified date. The resident told the nursing staff that he/she had fallen but did not have any injury. Review of the resident's written plan of care, did not reveal the resident's fall history including the above mentioned fall and did not include interventions to manage the resident's risk for falls.

In an interview with PSW #163, the PSW stated on several occasions, the resident was complaining of feeling a certain way. The PSW would then provide an identified intervention and the resident would then be fine. The PSW had informed the charge nurses about the resident's complaint. The PSW was not aware that the resident had a previous fall. An interview with RPN #158 stated he/she was not aware of the resident's previous fall. The RPN stated that as a routine, actual falls had to be included in the written plan of care and interventions set up to address the resident's risk of fall. The RPN stated he/she was not aware why resident #011's fall history was not included in the written plan of care, and why there were no interventions set up to manage the fall risk.

Interview with Physiotherapist #162 and ADOC #122 stated the home's expectation was to include all actual falls and interventions in the resident's written plan of care. Interview with the DOC confirmed that the resident's written plan of care was not revised after the above mentioned fall when the resident's care needs changed. [s. 6. (10) (b)]

9. The licensee has failed to ensure that If the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, different approaches have been considered in the revision of the plan of care

The MOHLTC received three CIRs related to resident #004's responsive behaviours.

Review of the CIRs and resident #004's progress notes revealed multiple incidents of responsive behaviour toward co-residents and staff.

Review of the Behaviour Support Ontario (BSO) notes revealed resident #004's plan of

care had been assessed on a monthly basis and interventions were put in place. Further review of the progress notes revealed the resident had been referred and assessed by a psychogeriatric physician. On an identified date, resident #004 punched a staff member and the resident was transferred to the hospital and returned the same day.

Interview with RN #106 and the DOC stated the home had not initiated a process for a psychiatric leave for resident #004. The DOC confirmed that the home should have considered other resources in the community such as Ontario Shores.

The severity for section 6(7) is actual harm due to pain caused to resident #031. The scope is isolated. The history includes Voluntary Plans of Correction in report #2016_270531_0018 related to Falls Prevention, #2016_405189_0005 related to Personal Support Services, #2015_324567_0006 related to Falls Prevention and Minimizing Restraining and 2014_321501_0015 related to Nutrition and Hydration. Due to the severity of actual harm a compliance order is being issued. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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:
- there is a written plan of care for each resident that sets out the planned care for the resident,
- the plan of care set out clear directions to staff and others who provide direct care to the resident
- when a resident is admitted to a long-term care home, within the times provided for in the regulations, an initial plan of care is to be developed based on that assessment and on the assessment, reassessments and information provided by the placement coordinator under section 44,
- the resident was reassessed and the plan of care reviewed and revised when the resident's care needs change and,
- If the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, different approaches have been considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: 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 home has failed to protect residents from abuse.

Review of a Critical Incident Report (CIR) submitted to the MOHLTC on an identified date, revealed that on the same day resident #001 approached resident #003 in the lounge and touched him/her inappropriately. The residents were separated and resident #003 did not appear to be harmed or concerned. According to the CIR, resident #001's one to one staff was on break and the resident was supposed to be watched by another PSW.

Record review revealed resident #001 had a history of inappropriate behaviours and was being monitored by one to one staff for unpredictable responsive behaviours. Interview with PSW #104 revealed he/she was serving snacks and feeding residents when he/she observed resident #001 approach resident #003. According to PSW #104, the incident happened so fast that he/she was unable to redirect resident #001 and resident #001 touched resident #003 inappropriately. PSW #104 did not think resident #003 was aware of what happened.

Record review revealed resident #001 and #003 both have Cognitive Performance Scores (CPS) indicating moderate cognitive impairment. Interviews with PSW #104, #116, #117 and RN #106 and #111 revealed resident #003 is unable to consent to specified activity and they considered the actions of resident #001 to be that of abuse.

An interview with the DOC confirmed that in the above mentioned incident the home failed to protect resident #003 from abuse. [s. 19. (1)] (501)

2. Review of a CIR submitted to the MOHLTC on an identified date, revealed that on the same day resident #001 was observed standing over the bedside and touching resident

#002 inappropriately while he/she was lying down in bed sleeping. Staff intervened immediately and separated both residents from each other. No injuries were noted and resident #001 was placed on one to one staffing afterwards.

Record review revealed resident #001 had a history of inappropriate behaviours and was being monitored by one to one staff for unpredictable responsive behaviours. An interview with PSW #107 revealed he/she believes the incident happened during shift change but did not witness what happened. Interviews with PSW #115 and RPN #111 revealed they were on duty that day but could not recall the details of the incident. An interview with the DOC revealed that resident #001's one to one was during specific hours during the day shift at that point in time but after that particular incident, the timing for the one to one was changed.

Record review revealed resident #001 has a CPS score indicating moderate cognitive impairment and resident #002 has a CPS indicating moderately severe impairment.

Interviews with PSW #107, 115 and RPN #111 revealed resident #002 is unable to consent to the specified activity and they considered the actions of resident #001 to be that of abuse.

An interview with the DOC confirmed that in the above mentioned incident the home failed to protect resident #002 from abuse. [s. 19. (1)] (501)

3. Review of a CIR submitted to the MOHLTC on an identified date, revealed that on the same day resident #013 touched resident #007 inappropriately. The residents were separated immediately and one to one staff was initiated to closely monitor resident #013.

Record review revealed resident #013 had previously inappropriately touched a resident on an identified date, and was being monitored for responsive behaviours.

According to PSW #100 who witnessed the above incident, resident #007 tried to resist but resident #013 was preventing it. PSW #100 further stated resident #013 got aggressive with him/her when he/she tried to intervene.

Record review revealed resident #013 has a CPS that indicated moderately severe cognitive impairment and resident #007's CPS indicated moderate impairment. Interviews with PSW #151, RN #106, the Resident Relations Coordinator and DOC

revealed resident #007 is unable to consent to the specified activity and they considered the actions of resident #013 to be that of abuse.

An interview with the DOC confirmed that in the above mentioned incident the home failed to protect resident #007 from abuse. [s. 19. (1)] (501)

4. Review of CIR revealed that on an identified date, resident #013 was observed to sit next to resident #020 and touched him/her inappropriately. Staff immediately removed resident #013 from the situation.

The inspector was on the unit at the time of the above incident and observed PSW #100 respond and intervene. According to PSW #100, resident #013 did not have one to one staff and interview with RPN #130 revealed he/she was unaware which PSW might be assigned to resident #013 and where he/she might be. Interview with PSW #129 revealed he/she was assigned to resident #013 and was on break during the above mentioned incident. PSW #129 stated he/she spoke with the day charge nurse, RPN #111, and was granted permission to leave the unit and take a break. Interview with RPN #111 recalled giving PSW #129 permission to take a break and assigned an identified PSW to watch over resident #013. According to RPN #111 and the DOC this PSW stepped away to check on his/her one to one resident and that is when this incident happened.

Record review revealed resident #013 has a CPS that indicated moderately severe cognitive impairment and resident #020's CPS indicated severe cognitive impairment. Interviews with PSW #151, RN #106, and #111 revealed resident #020 cannot defend him/herself and was incapable to consent to the specified activity. The Resident Relations Coordinator and DOC confirmed resident #020 is unable to consent to the specified activity and they considered the actions of resident #013 to be that of abuse.

An interview with the DOC confirmed that in the above mentioned incident the home failed to protect resident #020 from abuse. [s. 19. (1)] (501)

5. Review of a CIR revealed resident #013 touched resident #021 inappropriately while walking down the hallway with his/her one to one staff on an identified date. An interview with ADOC #122 revealed the home considered this to be an act of abuse due to resident #013's previous recent specified inappropriate behaviours with resident #007 and #020 and because all three residents do not have the capacity to consent to the observed touching.

An interview with PSW #150 revealed he/she was assisting another resident to the dining room while providing one to one care for resident #013 when he/she observed resident #013 touch resident #021 inappropriately. PSW #150 admitted that if he/she was not assisting another resident this incident may have been prevented. Interview with RN #126 revealed he/she spoke with PSW #150 and reminded him/her to only take care of their one to one resident and not perform other activities unless he/she speaks to registered staff first.

Record review revealed resident #013 has a CPS indicating moderately severe cognitive impairment and resident #021 has a CPS indicating moderate cognitive impairment. Interviews with PSW #151 and ADOC #122 revealed that due to resident #021's medical condition, he/she is not capable of consenting to the specified activity.

An interview with the DOC confirmed that in the above mentioned incident the home failed to protect resident #021 from abuse. [s. 19. (1)] (501)

6. Review of a CIR revealed resident #022 was observed by the one to one staff for resident #029 to be walking in the hallway with resident #029 when resident #022 suddenly touched resident #029 inappropriately. This occurred on an identified date, and one to one staff was provided for resident #022 who was also started on enhanced monitoring.

Review of resident #022's progress notes revealed the resident was admitted the same day as the above incident and was determined to have a CPS indicating severe cognitive impairment. Review of progress notes from an identified time period, indicates resident #022 was receiving one to one staffing for day and evening shifts.

Review of another CIR revealed resident #029 was observed following resident #022 and touching him/her inappropriately on an identified date. According to the CIR, a private care giver who witnessed the incident, stated resident #022 then touched resident #029 inappropriately. An Interview with Nurse Manager #149 revealed both residents were supposed to have had one to one staff at the time of the incident but this was not provided.

Review of resident #029's progress notes revealed the resident was determined to have a CPS indicating moderate cognitive impairment. Interview with resident #029's SDM revealed he/she was shocked and disturbed that these incidents happened and hopes it

will not happen again.

An interview with Nurse Manager #149 revealed the second incident, was considered abuse.

An interview with the DOC confirmed that in both incidents the home did not protect resident #029 from abuse due to resident #029's inability to consent to the specified activity. [s. 19. (1)] (501)

7. Review of a CIR revealed that on an identified date, a PSW found resident #034 inside resident #003's room and was touching resident #003's inappropriately.

Record review revealed resident #034 has a history of inappropriately touching residents and has a CPS indicating moderate cognitive impairment. Interview with RN #157 revealed he/she did not witness the incident but was told about the incident by a PSW. According to RN #157 resident #003 did not seem in distress until he/she was trying to assess the resident.

Record review revealed resident #003 has a CPS indicating moderate cognitive impairment. Interviews with RN #106 and PSW #115 revealed that because resident #003 is unable to consent to the specified activity, this incident would be considered abuse.

An interview with the DOC confirmed that the home failed to protect resident #003 from abuse. [s. 19. (1)] (501)

8. The licensee has failed to ensure that residents are protected from abuse by anyone.

On an identified date a CIR was submitted to the MOHLTC related to resident to resident abuse. Review of the CIR revealed resident #005 was abused by resident #018 as he/she had wandered in resident #018's room.

Review of resident #005's progress notes revealed on an identified shortly after the above incident, during a physiotherapist assessment, resident #005 complained of pain.

Review resident #005's progress notes revealed several incidents of abuse occurring over an identified period of time.

Review of resident #005's plan of care revealed that he/she exhibited responsive behaviours. Further review of the plan of care revealed staff are directed to conduct hourly safety checks and monitor resident #005's whereabouts all the time.

According to PSW #124, resident #005 is not aware that his/her behaviours sometimes cause aggressive responses by other residents.

Interviews with RN #106, RN #126 and ADOC #147 confirmed that the incident between resident #004 and resident #005 on an identified date, and the incident between resident #005 and resident #018 on an identified date, were abuse, as the interaction resulted in injury to resident #005. Furthermore, ADOC #147 stated that one to one monitoring for residents #004 and #018 was meant to protect resident #005 but it had not been successful.

An interview with DOC #106 confirmed the above incidents and stated that resident #005 was not protected from abuse.

9. A CIR was submitted to the MOHLTC in relation to a resident to resident abuse incident between resident #016 and resident #017 that occurred on an identified date. Resident #016 sustained identified injuries.

Review of the CIR and resident #016's progress notes indicated that on an identified date, resident #016 was sleeping in his/her bed. Resident #016 stated that resident #017 wandered into his/her room and assaulted him/her. Resident #016 called for help. RN #132 was at the nursing station close by and went into resident #016's room to investigate. The two residents were separated and resident #017 was redirected out of the room. Resident #017 was put on one to one monitoring. The police were contacted and a report was submitted to the MOHLTC after hours phone line.

During an interview, the resident gave a re-account of the incident remembering resident #017 coming into his/her room. However resident #016 could not remember being assaulted. He/she stated he/she was scared after the incident, and would feel scared thinking about it afterwards. Interview with resident #016's family member indicated that the resident was traumatized by the incident and would not even want to talk about it.

Interviews with PSWs #133, PSW #136, and RN #132, indicated that resident #017 had been transferred from another unit to the same unit as resident #016. For the period that resident #016 was on the newly transferred unit, he/she was exhibiting responsive

behaviours. The intervention that staff were taking at the time was to redirect resident #017.

An interview with the DOC confirmed that the home did not protect resident #016 from abuse. [s. 19. (1)] (502)

10. The licensee has failed to ensure that residents are protected from abuse.

Review of a CIR submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, revealed family members were concerned that PSW #103 was abusing resident #014 by making identified statements.

Review of resident #014's medical record revealed the resident had identified medical conditions and was hospitalized at one time for an identified medical problem. The resident's Cognitive Performance Scale (CPS) indicated no or minor cognitive loss.

Interview with resident #014's family member revealed PSW #021 made identified statements to the resident. This was brought to the home's attention by the family during a care conference, at which time the family requested that PSW #103 no longer work with resident #014. Interview with the DOC revealed the home prefers to resolve relationships between care givers and residents rather than change staff assignments. As well, the DOC revealed that the home had asked if resident #014 wanted to change care givers and the resident declined.

Interview with the family member revealed the family was not happy about this and did not feel that resident #014 was protected from abuse by PSW #103.

Review of the home's investigation notes regarding the above verbal statements made by PSW #103 revealed the PSW denied making such comments. However, subsequent to also being told by the home that PSW #103 does not perform an identified daily duty, the PSW approached the resident to deny such a claim. Review of the investigation notes and interview with the DOC confirmed PSW #103 was disciplined for reprisal and intimidating resident #014.

An interview with resident #114 revealed that PSW #103 seems to dislike him/her as the PSW treats him/her differently than other residents. The resident gave an example of asking PSW #103 for his/her nutritional supplement prior to going off the unit. According to the resident, PSW #103 told him/her it was not yet time for the snacks to be offered.

When the resident returned to the unit, he/she again asked the PSW for his/her supplement and the PSW told him/her that it was too late as snack time was finished. When asked how this made him/her feel, resident #114 stated he/she was not surprised because he/she knows PSW #103 does not like him/her but it did make him/her feel upset and uncomfortable. Resident #103 stated he/she really enjoys his/her supplement and does not like to miss them.

Review of resident #114's plan of care revealed the resident is to receive a nutritional supplement. According to progress notes the resident felt he/she needed extra nourishment following hospitalization and the RD ordered the supplement to help maintain weight.

An interview with PSW #103 revealed he/she did not leave the supplement for resident #114 on an identified date, because the resident was not available during snack time and it is the practice in the home not to leave food in resident rooms if they are not there. PSW #103 further stated he/she was not aware that the supplement could have been kept in the refrigerator. Interview with RPN #102 revealed PSW #103 has previously saved snacks in the refrigerator for other residents in the past.

An interview with RPN #120 confirmed resident #014 requested his/her supplement upon return to the unit and was aware that PSW #103 did not provide the supplement. RPN #120 further stated that PSW #103 is not fond of resident #014, and that he/she interacts with resident #014 differently than other residents as PSW #103 speaks to resident #014 as if he/she doesn't like him/her. RPN #120 stated that he/she sometimes feels intimidated by PSW #103, because of the way PSW #103 talks and looks at him/her, and that resident #014 may also feel intimidated.

During interviews, day PSWs #136, #137, #139, evening PSWs #144, #121, day RPN #102, and evening RPNs #131 and #138, RN #125 stated that the home's expectation is that snacks can be saved in the refrigerator for residents who are not available during snack time. Interview with the DOC revealed food should not be left in resident rooms but confirmed that it is the home's expectation that snacks, especially nutritional supplements, be saved in the refrigerator.

Interview with DOC #112 confirmed that the above mentioned incidents indicate PSW #103 has been abusing resident #014 and the home plans to reassign the PSW so that he/she will no longer provide care to resident #014. PSW #103 will also receive progressive discipline for his/her actions.

The severity of the abuse for resident #018 is actual harm. The scope is isolated. Section 19(1) was issued with a Voluntary Plan of Correction in inspection #2015_324567_0006 and #2014_321501_0015. Due to severity and compliance history a compliance order is being issued. [s. 19. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations.

A Critical Incident Report was submitted to the MOHLTC related to resident to resident abuse. Review of the CIR revealed that on an identified date, resident #004 hit resident #031 causing resident #031 to experience pain.

Review of resident #004's progress notes revealed multiple altercations between resident #004 and other residents.

Review of resident #004's most recent written plan of care, revealed that resident #004

has responsive behaviours. Further review of the written plan of care revealed one to one staff had been assigned to resident #004 to monitor and prevent significant risk of violence towards others.

PSWs #116 and #124 stated that resident #004 is their regular assignment, when one to one staff is not available and will take care of him/her along with other residents assigned to them during their respective shift, and are not able to provide the same level of supervision as one to one staff. PSW #116 revealed being aware that resident #004 will hit other residents when no one is watching and required close monitoring. However, he/she had left resident #004 and resident #031 without supervision as he/she needed to check on other residents on his/her assignment when the incident described in the CIR happened.

Interviews with RN #106, #126, and #161, stated resident #004 is unpredictable.They stated they could not identify the triggers of his behaviour. The above mentioned staff stated that providing close supervision with one to one staff had been the most efficient in reducing and preventing the number of interactions between resident #004 and other residents.They stated that there is no strategy in place to prevent altercations between resident #004 and other residents when the one to one staff is not available.

Interview with the DOC revealed resident #004 had become a risk to other residents and staff in the building and without one to one staff they would have had more incidents. He/she confirmed that triggers have not been identified for resident #004's behaviours and there is no clear strategy care planned when one-on-one staff is not available. [s. 54. (a)]

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

Review of a CIR revealed that on an identified date, resident #013 was observed to sit next to resident #020 and touched him/her inappropriately. Staff immediately removed resident #013 from the situation.

The inspector was on the unit at the time of the above incident and observed PSW #100 respond and intervene. According to PSW #100, resident #013 did not have one to one staff and interview with RPN #130 revealed he/she was unaware which PSW might be assigned to resident #013 and where he/she might be. Interview with PSW #129

revealed he/she was assigned to resident #013 and was on break during the above mentioned incident. PSW #129 stated he/she spoke with the day charge nurse, RPN #111, and was granted permission to leave the unit and take a break. Interview with RPN #111 recalled giving PSW #129 permission to take a break and assigned an identified PSW to watch over resident #013. According to RPN #111 and the DOC this PSW stepped away to check on his/her one to one resident and that is when this incident happened.

Review of resident #013's progress notes revealed resident #013 had previously inappropriately touched resident #007 on an identified date, and was to have one to one staff to help address responsive behaviours and prevent inappropriate behaviours.

Review of another CIR revealed resident #013 touched resident #021 inappropriately while walking down the hallway with his/her one to one staff on an identified date. An interview with ADOC #122 revealed the home considered this to be an act of abuse due to resident #013's previous recent inappropriate behaviours with resident #007 and #020 and because all three residents do not have the capacity to consent to the observed touching.

An interview with PSW #150 revealed he/she was helping another resident while providing one to one care for resident #013 when he/she observed resident #013 touch resident #021 inappropriately. PSW #150 admitted that if he/she was not helping another resident, this incident may have been prevented. Interview with RN #126 revealed he/she spoke with PSW #150 and reminded him/her to only take care of their one to one resident and not perform other activities unless he/she speaks to registered staff first.

An interview with the DOC stated that the home had identified that resident #013 needed one to one staff to closely monitor resident #013 in order to prevent him/her from inappropriately touching residents. The DOC confirmed that the intervention of one to one staffing for resident #013 did not implement close monitoring for the resident in order to minimize the risk of altercations and potentially harmful interactions between residents. [s. 54. (b)]

3. A CIR was submitted to the MOHLTC in relation to a resident to resident abuse incident between resident #016 and resident #017 that occurred on an identified date. Resident #016 sustained identified injuries.

Review of the CIR and resident #016's progress notes indicated that on an identified date

resident #016 was sleeping in his/her bed. Resident #017 wandered into resident #016's room and disturbed resident #016. Resident #016 started screaming and pulled the call bell for help. Resident #016 stated that resident #017 then tried to assault him/her. RN #132 was at the nursing station close by and went into resident #016's room to investigate. The two residents were separated and resident #017 was redirected out of the room. Resident #017 was put on one to one monitoring provided by the home's PSW for 72 hours. The police were contacted and a report was submitted to the MOHLTC after hours phone line.

Review of resident #017's progress notes indicated the resident was transferred to the unit where the above incident occurred on an identified date. Resident #017 spoke an identified language and had waited years to be transferred to this unit. However, since the transfer on an identified date resident #017 had been observed to have identified responsive behaviours. Review of resident #017's written plan of care did not include focus, goals and interventions to manage resident #017's responsive behaviors.

Interview with RPN #102 indicated resident #017 did not have any history of responsive behaviors prior to the transfer to the new unit. Interviews with PSWs #133 and #136, and RN #132, indicated that since resident #017 was transferred to the new unit, he/she had exhibited an identified behavior. The measure that staff was taking at the time was redirecting. Review of resident #017's progress notes revealed no evidence that internal and external resources were consulted to manage the resident's responsive behaviours.

An interview with the DOC confirmed that steps were not taken to manage resident #017's responsive behavior to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

The severity is actual harm to resident #033 and #017. The scope is isolated and there is no compliance history related to r.54(b). Due to the severity a compliance order is being issued. [s. 54. (b)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to fully respect and promote the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity.

On an identified date, the Ministry of Health and Long Term Care (MOHLTC) received a CIR related to abuse. Review of the CIR revealed PSW #168 refused to provide care with toileting and dressing and had also told resident #030 that he/she was using too many incontinent products. This affected the resident to the extent that he/she reduced his/her fluid intake. Further review of the CIR revealed resident #030 was uncertain whether he/she could call for help and felt he/she was a burden.

Review of resident #030's quarterly Minimum Data Set (MDS) assessments revealed resident #030 is frequently incontinent of bowel and bladder, requires one person physical assistance for toileting and that he/she utilizes incontinence products.

Review of progress notes revealed that on an identified date, during an annual care conference, resident #030 voiced concerns related to assistance with toileting, and the availability of incontinence products.

Review of the written plan of care revealed that staff are directed to assist after each toilet use and incontinent episode, check to make sure that the resident has the supplies he/she needs, and provide the care needed to keep him/her dry and clean. Further review of the written plan of care revealed that resident #030 requires one person assistance with dressing and toileting.

In an interview, resident #030 stated he/she was told by staff that he/she was using too many incontinent products, but did not want to identify the staff member. Resident further stated that this made him/her feel bad, reluctant to call for help, and that he/she

decreased his/her fluids.

Interview with resident #030's SDM confirmed being aware of the comments being made to the resident by PSW #168. The SDM stated that resident #030 informed him/her of reducing his/her fluid intake, and he/she witnessed resident #030 reusing incontinent products even when they didn't seem as though they should be reused.

An interview with PSW #168 revealed he/she told resident #030 that he/she could reuse an incontinent product that was still dry, but denied refusing care or that resident #030 was using too many incontinent products.

An interview with RPN #138 revealed PSW #168 had an issue with resident #030; however, the home's expectation is that if a resident requests to have their continence products changed, it should be changed as per the resident's request. RPN #138 further stated that it is not acceptable to tell a resident that they are using too many incontinent products as it does not maintain their respect and dignity.

An interview with ADOC #122 confirmed that the home's expectation is that a resident's continence product is changed if it is requested by the resident, and that it is not acceptable to tell a resident that they are using too many products. ADOC #122 further confirmed that PSW #168's statements to resident #030 did not fully respect resident #030's dignity. [s. 3. (1) 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 the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity is fully respected and promoted, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every suspected incident of abuse of a resident by anyone that the licensee knows of is immediately investigated.

Review of two CIRs submitted to the MOHLTC on identified dates revealed that there had been witnessed incidents of inappropriate behaviours by resident #001. Review of resident #001's progress notes revealed that resident #001 was also found lying in bed with resident #006 on an identified date, and resident #006 was distressed The note stated there was no one to one staff for resident #001 and the incident would be reported to a Nurse Manager.

Interview with RN #105 revealed the incident was reported to him/her by PSWs who told him/her resident was distressed and he/she reported this to Nurse Manager #118. Interviews with PSWs #116, #117 and #119 revealed they were all working that shift but could not recall the details of what happened. Interview with Nurse Manager #118 revealed he/she does not recall being informed of the incident and had no record of receiving a report regarding this.

An interview with the DOC revealed he/she did recall hearing about the incident but was not aware that resident #006 was distressed. The DOC revealed he/she would have investigated the incident as it would be considered suspected abuse. The DOC confirmed that the home failed to ensure that every suspected incident of abuse was immediately investigated. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every suspected incident of abuse of a resident by anyone that the licensee knows of is immediately investigated., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any abuse of a resident by anyone that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

On an identified date a CIR was submitted to the MOHLTC related to resident to resident abuse. Review of the CIR and progress notes revealed that on an identified date resident #004 hit resident #005. Further review of the progress notes revealed resident #004 was being monitored by one to one staff during the time of incident.

Further review of resident #005's progress noted revealed that on another date, resident #004 hit resident #005, resulting in pain on resident #005's identified body parts. Resident #005's skin assessment after the incident revealed an injury on an identified body part.

In an interview, RN #106 stated that he/she had treated the second incident as abuse as it resulted in injury to resident #005, and had reported it to the Nurse Manager.

An interview with the DOC revealed the abuse took place and should have been reported. He/she confirmed that the incident was not reported to the Director, as required by the legislation, and the Nurse Manager is no longer working in the home. [s. 24. (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 person who had reasonable grounds to suspect that any abuse of a resident by anyone that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A CIR was submitted to the MOHLTC regarding an incident reported on an identified date, when resident #012 was injured and was transferred to the hospital. The resident returned to the home on the same day as the resident was put on bed rest.

Review of the resident's progress notes revealed the resident had two hospital stays during identified time periods. The resident was noted to have altered skin integrity on an identified date. Review of the list of weekly wound assessments indicated assessments were not conducted for four identified weeks.

Interview with PSW #160 stated that the resident started to have altered skin integrity since the resident returned from the hospital and then the altered skin integrity became worse after the hospital stay a month later. Interview with RPN #159 indicated evening registered nursing staff were doing dressing changes on the resident's altered skin integrity and was not aware that the weekly wound assessment were not being conducted for the resident on the above mentioned dates.

An interview with the DOC, who is also the lead for the skin and wound program, confirmed that the home's expectation was to conduct weekly wound assessments for residents exhibiting altered skin integrity and that the assessments were not conducted for resident #012 for the above mentioned dates. [s. 50. (2) (b) (iv)]

2. A CIR was submitted to the MOHLTC regarding an incident reported on an identified date, when resident #009 was found with injury after being dressed for a medical appointment.

Review of the resident #009's written plan of care revealed the resident had a diagnosis of an identified skin condition. There was a focus, goals and interventions set up to address this condition.

Interviews with PSW # 142, RN #132 and RN #156 indicated the resident was admitted on an identified date, with altered skin integrity on an identified body part which worsened. Registered nursing staff on day shift were doing dressing changes.

Review of the resident's written plan of care dated of an identified date, and the one on admission did not reveal any management strategies including weekly wound assessment to address the resident's different areas of altered skin integrity. Review of the resident's list of assessments conducted did not reveal any weekly wound assessment conducted on the resident since the setting up of his/her admission written plan of care. Weekly wound assessments were not conducted 24 times for one wound, and three times for another wound.

Interviews with RNs #132, #153 and #156 indicated weekly wound assessments were not conducted for the resident's altered skin integrity on the above mentioned dates. RN #132 indicated that he/she when coming on duty usually did not check to see which resident was due to have weekly wound assessments, but would do assessments indicated by the computer for that particular day. An interview with the DOC confirmed that weekly wound assessment should have been conducted for the resident #009's altered skin integrity for the above mentioned dates. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the nutrition and hydration programs include the identification of any risks related to nutrition care and dietary services and hydration and the implementation of policies and procedures related to nutrition and dietary services and hydration.

A) On an identified date the MOHLTC received a CIR related to abuse. Review of the CIR revealed PSW #168 told resident #030 he/she was using too many incontinent products. This affected the resident to the extent that he/she reduced his/her fluid intake. Further review of the CIR revealed that resident #030 was uncertain whether he/she could call for help and felt he/she was a burden.

A review of the home's Hydration & Nutrition Monitoring policy, policy # VII-I-10.00, dated January 2015, stated that PSWs are to immediately report when a resident's fluid intake is below the intake amounts specified on the resident's care plan for three consecutive days. The policy further stated that registered staff are to review daily for undesirable intake trends and gaps over a 72-hour period, assess for signs and symptoms of dehydration and refer to the Registered Dietitian if indicated.

Review of resident #030's fluid flowsheet revealed resident #030's minimum fluid requirement is a specified number of servings per day. Review of the flowsheet further revealed that on three consecutive days, he/she did not meet their identified requirement.

Review of the progress notes and plan of care failed to reveal completed assessments for hydration for resident #030. Interview with resident #030 revealed that he/she decreased his/her fluid intake as he/she was told by staff that he/she was using too many incontinent products. Interview with resident #030's SDM revealed that resident #030 had informed him/her of reducing his/her fluid intake.

Interview with PSW #168 and #169 revealed that PSWs record resident's fluid intake, and that if a resident is not drinking enough fluids, the home's expectation is that it is brought to the attention of the registered staff.

Interview with RPN #138 revealed that staff record fluid intakes and if a resident is not meeting the recommended servings of fluids, the PSWs should inform the registered staff, and the registered staff should complete an assessment, and make a referral to the Registered Dietitian if required. RPN #138 further stated that the PSWs should have reported that resident #030 did not meet the recommended number of fluid servings on the above mentioned three consecutive days, nothing was initiated to address the risk for dehydration, and the home's policy was not followed.

An interview with ADOC #122 confirmed that on the above mentioned three consecutive days, resident #030 did not meet his/her recommended number of fluid servings. He/she

further stated that during the annual care conference, resident #030 informed the home that he/she had reduced his/her fluid intake. ADOC #122 stated resident #030 should have been assessed for dehydration according to the home's Hydration and Nutrition Monitoring policy.

B) A CIR was submitted to the MHLTC related to resident#008's transfer to the hospital with identified medical conditions on an identified date. The resident's SDM expressed concerns related to the resident's diagnosis upon transfer back to the home. The resident's SDM also contacted the INFOLINE of the MOHLTC and filed a complaint information report regarding similar concerns.

Review of resident #008's progress notes indicated the resident was observed with altered skin integrity on an identified date. On an identified date, the resident's condition changed. The resident was assessed by the home's attending physician and treatment was prescribed. On an identified date, the resident was reported to have a an identified injury. The resident was transferred to hospital on an identified date.

Review of the RD's assessment on an identified date, revealed the resident was having poor intake. Intervention recorded was for PSW to monitor intake, and did not include strategies to manage the resident's increased fluid intake requirement due to the presence of altered skin integrity and elevated temperatures. The assessment also did not include the daily total fluid requirement for the resident.

Review of resident #008's written plan of care date did not reveal strategies to manage the resident's increased fluid intake requirement due to the presence of altered skin integrity and elevated temperatures, and did not include the daily total fluid requirement for the resident.

Review of resident's daily fluid intake summary indicated the resident had identified servings of fluid on three consecutive identified days. One serving of fluids was explained on the summary report as containing 125 millilitre of fluids.

Interviews with PSWs #103 and #121 indicated the resident was eating and drinking well.The PSWs stated they had been trying to push fluids to the resident and were not aware that the resident had such low daily fluid intake on three consecutive identified days.

During interviews with RPN #102, #108 and #131, the RPNs indicated they receive

reports from PSWs if residents are not drinking well. The RPNs stated the night charge nurse would review the daily fluid intake summary of all residents and would alert the day charge nurse for any resident not taking the minimum serving of fluids. The RPNs stated that resident #008 was supposed to have an identified number of fluid servings. The RPNs were not aware that resident #008 had total daily fluid intake below what he/she was supposed to have on the above mentioned three consecutive days. The RPNs stated resident #008's increased fluid intake requirement should have been included in the resident's written plan of care to manage the resident's changing health condition.

During an interview, RD #115 indicated the assessment on resident #008 was conducted by the former RD. RD #115 started working at the home after the resident was admitted into the hospital. RD #115 was not aware of the resident's daily fluid intake requirement as it was not documented in the assessment conducted by the former RD nor in resident #008's written plan of care.

Interview with the DOC confirmed that resident #008 was not provided with the daily minimum fluid intake on the above mentioned dates and his/her written plan of care was not updated and revised with her additional fluid intake requirement due to the presence of altered skin integrity and elevated temperatures. The DOC agreed that the home's nutrition care and hydration program provided to resident #008 did not include the identification of risks related to nutrition care and hydration, and the implementation of interventions to mitigate and manage those risks.
PLEASE NOTE: This evidence of non-compliance related to resident #008 was found during inspection #2017_634512_0005. [s. 68. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the nutrition and hydration programs include the identification of any risks related to nutrition care and dietary services and hydration and the implementation of policies and procedures related to nutrition and dietary services and hydration, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

On an identified date, the Ministry of Health and Long Term Care (MOHLTC) received a CIR related to the administration of drugs involving a medication error. Review of the CIR revealed that resident #019 was ordered an identified medication in an identified amount for a specific number of days, then a reduced dose thereafter. The CIR stated that resident #019 continued to receive the original dose after the specific number of days.

Review of the physician's order stated to increase the specific medication for an identified period of time, and then to reduce the medication. Review of the Electronic Medication Administration Record (eMAR) revealed that resident #019 received the increased dose for an identified period of time and then resident #019 self-administered the reduced dose unsupervised during an identified period of time.

During interviews RN #153, RN #132, and ADOC #147 stated that during an identified period of time, resident #019 received the increased dose of medication instead of the reduced dose that was ordered by the physician, and the nurses administering the medication signed the eMAR as resident #019 self-administering the medication as there was no other place to sign. No nursing staff brought the self-administering error to pharmacy's attention until an identified date.

RN #153, RN #132, and ADOC #147 acknowledged that the pharmacy made an error with the medication administration dosage and instructions. ADOC #147 stated that the pharmacy failed to input a stop date on the order made on an identified date; therefore, continued to dispense an extra identified amount of medication for this resident. The pharmacy had also wrongly indicated that the medication was to be self-administered from an identified date.

RN #157, RN #132, and ADOC #147 confirmed that resident #019 received a higher dose of the identified medication than what was ordered by the prescriber; therefore the administered drug was not in accordance with the direction for use specified by the physician. An interview with the DOC confirmed that the medication was not administered to resident #019 in accordance with the directions for use specified by the physician. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #10: 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 for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments, interventions and the resident's responses are documented.

Review of a CIR revealed a PSW found resident #034 on an identified date, inside resident #003's room and was touching him/her inapprorpriately.

Record review revealed resident #034 has a history of responsive behaviours and likes to touch residents and talk close to their face. Interview with RN #106 revealed resident #034 was on one to one monitoring for responsive behaviours. Record review for resident #034 revealed that one to one monitoring was discontinued as of an identified date; however, there was no reassessment found in his/her medical record. Interview with RN #106 could not explain why there was no reassessment.

Interview with the DOC revealed residents who are one to one monitoring are discussed at Behaviour Support Ontario (BSO) meetings on a monthly basis. Previously, the BSO team had not been documenting formal reassessments and the home has identified this as a gap in their process. The home now documents what occurs in these meetings in a formal manner and places these notes in the residents' medical record.

The DOC indicated he/she thought the BSO team did not feel that one to one monitoring for resident #034 was warranted as the resident was having fewer behaviour issues. Interview with the DOC confirmed there was no documentation that resident #034 was reassessed when his one to one monitoring was no longer necessary. [s. 53. (4) (c)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of the suspected or witnessed incident of abuse that caused distress to the resident that caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

Review of two CIRs submitted to the MOHLTC on identified dates revealed that there had been witnessed incidents of inappropriate behaviours by resident #001.

In reviewing resident #001's progress notes, it was further revealed that resident #001 was found lying in bed with resident #006 on an identified date, and resident #006 was in distress. The note stated there was no one to one staff for resident #001 and the incident would be reported to a Nurse Manager.

Interview with RN #105 revealed he/she wrote the progress note but did not witness the incident and was only told that the resident had been in distress. According to RN #105, resident #006 was not distressed when he/she completed an assessment of the resident. The RN also revealed he/she reported the incident to Nurse Manager #118 but had not contacted anyone else, including the resident's SDM. Interview with Nurse Manager #118 revealed he/she did not recall the incident being reported to him/her and most likely would have contacted the SDM.

Interview with the DOC confirmed that he/she was not aware that resident #006 was distressed by this above mentioned incident and confirmed that the home failed to immediately notify resident #006's SDM after becoming aware of a suspected incident of abuse that caused distress to the resident. [s. 97. (1) (a)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

On an identified date, a CIR was submitted to the MOHLTC related to resident to resident abuse. Review of the CIR revealed that resident #005 was abused by resident #018. Resident #005 sustained injuries.

Review of resident #005's progress notes revealed on an identified date, during an assessment resident #005 complained of pain and had difficulty ambulating.

An interview with ADOC #147 stated that the incident was not reported to the police force.

An Interview with the DOC revealed resident #018 had assaulted resident #005 as the interaction resulted in injury. He/she confirmed that the home had not reported the alleged abuse to the police force. [s. 98.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following analysis and follow-up actions:
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.

On an identified date a was submitted to the MOHLTC related to abuse. Review of the CIR report revealed that resident #004 hit residents #005 and #006 without injury.

Further review of the CIR revealed that the MOHLTC had directed the home to amend the CIR to include any history of physical aggression by resident #004 towards other residents during the past six months, including dates and injuries sustained. The home was also directed to include specific strategies and actions planned to prevent recurrence.

Review of the Ministry of Health and Long Term Care Critical Incident System portal (MOHLTC-CIS) revealed that the above mentioned CIR had not been amended as requested by the MOHLTC.

An interview with the DOC confirmed the above CIR had not been amended to include specific planned strategies and actions to prevent recurrence. [s. 104. (1) 4.]

2. A CIR was submitted to the MOHLTC related to a fall incident that occurred on an identified date, regarding resident #010 who sustained an injury. The resident was transferred to the hospital and returned to the home the next day with no report of injury. The MOHLTC requested an amendment to be made by the home to include post-fall interventions to prevent occurrence.

During an interview, ADOC #122 indicated the amendment request from the MOHLTC was not sent. The ADOC forwarded the amendment to the MOHLTC after speaking with the inspector and provided a copy.

Interview with the DOC confirmed that the home did not provide the required information to the MOHLTC to include the analysis of the incident and follow-up short and long term action to correct the situation and prevent recurrence. [s. 104. (1) 4.]

Issued on this 13th day of June, 2017

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

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN SEMEREDY (501), BABITHA SHANMUGANANDAPALA (673), JULIENNE NGONLOGA (502), TILDA HUI (512)
Inspection No. / No de l'inspection :	2017_626501_0011
Log No. / Registre no:	016569-16, 024340-16, 026605-16, 027483-16, 027508-16, 027990-16, 028517-16, 028605-16, 028720-16, 031466-16, 033322-16, 033800-16, 000456-17, 001903-17, 002202-17, 002291-17, 002522-17, 003650-17, 003956-17, 003960-17, 004527-17, 004933-17, 005034-17, 005163-17, 005857-17, 006109-17, 006564-17, 006862-17, 006874-17, 007145-17, 007146-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 1, 2017
Licensee / Titulaire de permis :	2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP 302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8
LTC Home / Foyer de SLD :	

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Fieldstone Commons Care Community
1000 Ellesmere Road, SCARBOROUGH, ON, M1P-5G2

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Lorraine Gibson

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To 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP, 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)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, implement and submit a plan to ensure that care set out in the plan of care is provided to the residents as specified in the plan including but not limited to the following:

1. Residents who have been identified to require one to one staff monitoring for high risk behaviors will have this intervention implemented as outlined in the plan of care.

2. Residents who require dietary supplements will receive their supplements as outlined on the plan of care.

For all the above, as well as for any other elements included in the plan, please include who will be responsible for implementing, as well as a timeline that corresponds to the compliance order date for achieving compliance, for each part of the plan.

This plan is to be submitted via email to inspector susan.semeredy@ontario.ca by June 16, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Review of a CIR submitted to the MOHLTC on an identified date, revealed that on the same day resident #001 was observed standing over resident #002's bedside touching him/her while he/she was lying down in bed sleeping.

Record review also revealed that on an identified date resident #001 was found lying in bed with resident #006 who became upset and tearful. According to the progress note and interview with RN #105 resident #001 did not have one to one staffing at the time of the incident.

Record review revealed resident #001's plan of care stated that a one to one program is to be implemented when the resident is exhibiting an identified behavior. Interviews with RN #106 and the DOC revealed resident #001 is to have one to one staffing during identified shifts related to his/her unpredictable behaviours. Review of the daily roster revealed resident #001 did not have one to one staff on both of the above mentioned days.

Interview with the DOC revealed that it is not always possible to fill one to one staffing requirements. The DOC confirmed that the above incidents most likely would not have occurred if resident #001 had one to one staff and the home had failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan. [s. 6. (7)]

2. On an identified date, the Ministry of Health and Long Term Care (MOHLTC) received a CIR related to abuse. Review of the CIR revealed PSW #103 was abusing resident #014.

Review of resident #014's medical record revealed the resident had identified medical conditions and was hospitalized in the past year. The resident's Cognitive Performance Scale (CPS) indicated no or minor cognitive loss.

While interviewing resident #014 on an identified date, related to the above CIR, the resident revealed to the inspector that he/she did not receive his/her ordered nutritional supplement that same day. Resident #014 stated that he/she receives this supplement to gain weight as he/she had lost weight after a hospitalization. Resident #114 further stated that he/she requested his/her nutritional supplement from PSW #103, his/her primary care provider, prior to leaving the unit. According to the resident, PSW #103 told him/her it was not yet time for the snacks to be offered. When the resident returned to the unit, he/she again asked the PSW for his/her supplement and the PSW told him/her that it was too late as snack time was finished. Resident #103 stated he/she did not receive his/her supplement on the above mentioned date.

According to progress notes the resident felt he/she needed extra nourishment

following hospitalization and the Registered Dietitian (RD) ordered the supplement to help maintain weight. Review of the most recent plan of care, under the focus of nutrition, revealed resident #014 is at nutritional risk due to identified medical conditions. Goals for the nutritional focus included maintaining adequate nutritional status and a stable weight, and the interventions included serving the resident a nutritional supplement.

An interview with PSW #103 revealed he/she did not leave the supplement for resident #114 on the above mentioned date because the resident was not available during snack time and it is the practice in the home not to leave food in resident rooms if they are not there. PSW #103 further stated he/she was not aware that the supplement could have been kept in the refrigerator.

An interview with RPN #120 confirmed resident #014 requested his/her supplement upon return to the unit and was aware that PSW #103 did not provide the supplement. RPN #120 confirmed that care was not provided to resident #014 as outlined in the plan of care.

During interviews, day PSWs #136, #137, #139, evening PSWs #144, #121, day RPN #102, and evening RPNs #131 and #138, and RN #125 stated that the home's expectation is that snacks can be saved in the refrigerator for residents who are not available during snack time. Interview with the DOC revealed food should not be left in resident rooms; however, it is the home's expectation that snacks, especially nutritional supplements, be saved in the refrigerator.

Interview with DOC #112 confirmed that the care set out in the plan of care for resident #014 was not provided to the resident as specified in the plan. [s. 6. (7)]

3. Review of a CIR revealed resident #022 was observed by the one to one staff for resident #029 to be walking in the hallway with resident #029 when resident #022 inappropriately touched resident #029. This occurred on an identified date, and one to one staff was then provided for resident #022.

Review of resident #022's progress notes revealed the resident was admitted the same day as the above incident and was determined to have severe cognitive impairment. Review of progress notes from an identified time period, indicated resident #022 was receiving one to one staffing for day and evening shifts.

Review of another CIR revealed resident #029 was observed following resident #022 and holding hands on an identified date. According to the CIR, a private care giver who witnessed the incident, observed resident #022 then inappropriately touched resident #029.

Record review and interview with RN #156 revealed resident #022 and resident #029 have had responsive behaviours. Both residents were provided one to one staff to monitor and provide redirection as needed.

Review of the daily roster for the second incident revealed resident #022 and #029 were to have one to one staff. Review of progress notes for both residents and an interview with Nurse Manager #149 revealed both residents were not provided one to one care.

Interviews with RN #156 and Nurse Manager #149 revealed that if one to one staff had been provided for resident #022 and #029, the incident , most likely would not have occurred.

Interview with the DOC confirmed that the care set out in the plan of care was not provided to resident #022 and #029 as specified in the plan. [s. 6. (7)]

4. A CIR was submitted to the MOHLTC related to alleged resident to resident abuse. Review of the CIR revealed that on an identified date, resident #004 hit resident #031causing resident #031 pain.

Review of resident #004's written plan of care, revealed that resident #004 has responsive behaviours. Further review of the written plan of care revealed one to one staff had been assigned to resident #004 to monitor and prevent significant risk of violence towards others.

Review of the daily roster for the above mentioned identified date, revealed that the staff scheduled to provide one to one for resident #004, had cancelled and was not replaced leaving the resident without one to one monitoring. An interview with Scheduling Coordinator #141 revealed the PSW scheduled to provide one to one monitoring had cancelled and he/she was not able to replace the staff.

Interviews with PSW #116, and RN #126, revealed resident #004 did not have one to one staff during the time of the above mentioned incident. PSW #116

revealed being aware that resident #004 will hit other residents when no one is watching and required close monitoring. However, he/she had left resident #004 and resident #031 without supervision as he/she needed to check on other residents on his/her assignment when the incident happened.

Interviews with RN #126 and the DOC revealed that one to one staff scheduled to monitor resident #004 had cancelled and confirmed that a replacement was not provided to resident #004 on the above mentioned identified date. The DOC confirmed that the care set out in the plan of care was not provided to resident #004 as specified in the plan. [s. 6. (7)]

The severity for section 6(7) is actual harm due to pain caused to resident #031. The scope is isolated. The history includes Voluntary Plans of Correction in report #2016_270531_0018 related to Falls Prevention, #2016_405189_0005 related to Personal Support Services, #2015_324567_0006 related to Falls Prevention and Minimizing Restraining and 2014_321501_0015 related to Nutrition and Hydration. Due to the severity of actual harm a compliance order is being issued. [s. 6. (11) (b)]
(502)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that residents are protected from abuse. The plan shall include, but not be limited to the following:
1. In consultation with the medical director and the psychogeriatric experts, develop a plan to ensure that all residents are protected from abuse by resident #001, #013, #022 and #034.
2. Develop and implement interventions for residents #001, #013, #022 and #034's abusive behavior to ensure residents are safe from their inappropriate touching, behavior and remarks.
3. Ensure staff are aware of the plans of care for resident #001, #013, #022 and #034.
4. Develop a process to monitor the interventions that have been developed for resident #001, #013, #022 and #034 to ensure that they have been implemented.
5. Provide re-education and training to all staff in the home on the home's policy to promote zero tolerance of abuse and neglect of residents including what constitutes abuse, retaliation and whistle blowing protection.

For all the above, please include who will be responsible for implementing, as well as a timeline that corresponds to the compliance order date for achieving compliance, for each part of the plan.

This plan is to be submitted via email to inspector susan.semeredy@ontario.ca by June 16, 2017.

Grounds / Motifs :

1. The home has failed to protect residents from abuse.

Review of a Critical Incident Report (CIR) submitted to the MOHLTC on an identified date, revealed that on the same day resident #001 approached resident #003 in the lounge and touched him/her inappropriately. The residents were separated and resident #003 did not appear to be harmed or concerned. According to the CIR, resident #001's one to one staff was on break and the resident was supposed to be watched by another PSW.

Record review revealed resident #001 had a history of inappropriate behaviours and was being monitored by one to one staff for unpredictable responsive behaviours. Interview with PSW #104 revealed he/she was serving snacks and feeding residents when he/she observed resident #001 approach resident #003. According to PSW #104, the incident happened so fast that he/she was unable to redirect resident #001 and resident #001 touched resident #003 inappropriately. PSW #104 did not think resident #003 was aware of what happened.

Record review revealed resident #001 and #003 both have Cognitive Performance Scores (CPS) indicating moderate cognitive impairment. Interviews with PSW #104, #116, #117 and RN #106 and #111 revealed resident #003 is unable to consent to specified activity and they considered the actions of resident #001 to be that of abuse.

An interview with the DOC confirmed that in the above mentioned incident the home failed to protect resident #003 from abuse. [s. 19. (1)] (501)

2. Review of a CIR submitted to the MOHLTC on an identified date, revealed that on the same day resident #001 was observed standing over the bedside and touching resident #002 inappropriately while he/she was lying down in bed sleeping. Staff intervened immediately and separated both residents from each other. No injuries were noted and resident #001 was placed on one to one staffing afterwards.

Record review revealed resident #001 had a history of inappropriate behaviours and was being monitored by one to one staff for unpredictable responsive behaviours. An interview with PSW #107 revealed he/she believes the incident happened during shift change but did not witness what happened. Interviews with PSW #115 and RPN #111 revealed they were on duty that day but could not recall the details of the incident. An interview with the DOC revealed that

resident #001's one to one was during specific hours during the day shift at that point in time but after that particular incident, the timing for the one to one was changed.

Record review revealed resident #001 has a CPS score indicating moderate cognitive impairment and resident #002 has a CPS indicating moderately severe impairment.

Interviews with PSW #107, 115 and RPN #111 revealed resident #002 is unable to consent to the specified activity and they considered the actions of resident #001 to be that of abuse.

An interview with the DOC confirmed that in the above mentioned incident the home failed to protect resident #002 from abuse. [s. 19. (1)] (501)

3. Review of a CIR submitted to the MOHLTC on an identified date, revealed that on the same day resident #013 touched resident #007 inappropriately. The residents were separated immediately and one to one staff was initiated to closely monitor resident #013.

Record review revealed resident #013 had previously inappropriately touched a resident on an identified date, and was being monitored for responsive behaviours.

According to PSW #100 who witnessed the above incident, resident #007 tried to resist but resident #013 was preventing it. PSW #100 further stated resident #013 got aggressive with him/her when he/she tried to intervene.

Record review revealed resident #013 has a CPS that indicated moderately severe cognitive impairment and resident #007's CPS indicated moderate impairment. Interviews with PSW #151, RN #106, the Resident Relations Coordinator and DOC revealed resident #007 is unable to consent to the specified activity and they considered the actions of resident #013 to be that of abuse.

An interview with the DOC confirmed that in the above mentioned incident the home failed to protect resident #007 from abuse. [s. 19. (1)] (501)

4. Review of CIR revealed that on an identified date, resident #013 was

observed to sit next to resident #020 and touched him/her inappropriately. Staff immediately removed resident #013 from the situation.

The inspector was on the unit at the time of the above incident and observed PSW #100 respond and intervene. According to PSW #100, resident #013 did not have one to one staff and interview with RPN #130 revealed he/she was unaware which PSW might be assigned to resident #013 and where he/she might be. Interview with PSW #129 revealed he/she was assigned to resident #013 and was on break during the above mentioned incident. PSW #129 stated he/she spoke with the day charge nurse, RPN #111, and was granted permission to leave the unit and take a break. Interview with RPN #111 recalled giving PSW #129 permission to take a break and assigned an identified PSW to watch over resident #013. According to RPN #111 and the DOC this PSW stepped away to check on his/her one to one resident and that is when this incident happened.

Record review revealed resident #013 has a CPS that indicated moderately severe cognitive impairment and resident #020's CPS indicated severe cognitive impairment. Interviews with PSW #151, RN #106, and #111 revealed resident #020 cannot defend him/herself and was incapable to consent to the specified activity. The Resident Relations Coordinator and DOC confirmed resident #020 is unable to consent to the specified activity and they considered the actions of resident #013 to be that of abuse.

An interview with the DOC confirmed that in the above mentioned incident the home failed to protect resident #020 from abuse. [s. 19. (1)] (501)

5. Review of a CIR revealed resident #013 touched resident #021 inappropriately while walking down the hallway with his/her one to one staff on an identified date. An interview with ADOC #122 revealed the home considered this to be an act of abuse due to resident #013's previous recent specified inappropriate behaviours with resident #007 and #020 and because all three residents do not have the capacity to consent to the observed touching.

An interview with PSW #150 revealed he/she was assisting another resident to the dining room while providing one to one care for resident #013 when he/she observed resident #013 touch resident #021 inappropriately. PSW #150 admitted that if he/she was not assisting another resident this incident may have been prevented. Interview with RN #126 revealed he/she spoke with PSW #150

and reminded him/her to only take care of their one to one resident and not perform other activities unless he/she speaks to registered staff first.

Record review revealed resident #013 has a CPS indicating moderately severe cognitive impairment and resident #021 has a CPS indicating moderate cognitive impairment. Interviews with PSW #151 and ADOC #122 revealed that due to resident #021's medical condition, he/she is not capable of consenting to the specified activity.

An interview with the DOC confirmed that in the above mentioned incident the home failed to protect resident #021 from abuse. [s. 19. (1)] (501)

6. Review of a CIR revealed resident #022 was observed by the one to one staff for resident #029 to be walking in the hallway with resident #029 when resident #022 suddenly touched resident #029 inappropriately. This occurred on an identified date, and one to one staff was provided for resident #022 who was also started on enhanced monitoring.

Review of resident #022's progress notes revealed the resident was admitted the same day as the above incident and was determined to have a CPS indicating severe cognitive impairment. Review of progress notes from an identified time period, indicates resident #022 was receiving one to one staffing for day and evening shifts.

Review of another CIR revealed resident #029 was observed following resident #022 and touching him/her inappropriately on an identified date. According to the CIR, a private care giver who witnessed the incident, stated resident #022 then touched resident #029 inappropriately. An Interview with Nurse Manager #149 revealed both residents were supposed to have had one to one staff at the time of the incident but this was not provided.

Review of resident #029's progress notes revealed the resident was determined to have a CPS indicating moderate cognitive impairment. Interview with resident #029's SDM revealed he/she was shocked and disturbed that these incidents happened and hopes it will not happen again.

An interview with Nurse Manager #149 revealed the second incident, was considered abuse.

An interview with the DOC confirmed that in both incidents the home did not protect resident #029 from abuse due to resident #029's inability to consent to the specified activity. [s. 19. (1)] (501)

7. Review of a CIR revealed that on an identified date, a PSW found resident #034 inside resident #003's room and was touching resident #003's inappropriately.

Record review revealed resident #034 has a history of inappropriately touching residents and has a CPS indicating moderate cognitive impairment. Interview with RN #157 revealed he/she did not witness the incident but was told about the incident by a PSW. According to RN #157 resident #003 did not seem in distress until he/she was trying to assess the resident.

Record review revealed resident #003 has a CPS indicating moderate cognitive impairment. Interviews with RN #106 and PSW #115 revealed that because resident #003 is unable to consent to the specified activity, this incident would be considered abuse.

An interview with the DOC confirmed that the home failed to protect resident #003 from abuse. [s. 19. (1)] (501)

8. The licensee has failed to ensure that residents are protected from abuse by anyone.

On an identified date a CIR was submitted to the MOHLTC related to resident to resident abuse. Review of the CIR revealed resident #005 was abused by resident #018 as he/she had wandered in resident #018's room.

Review of resident #005's progress notes revealed on an identified shortly after the above incident, during a physiotherapist assessment, resident #005 complained of pain.

Review resident #005's progress notes revealed several incidents of abuse occurring over an identified period of time.

Review of resident #005's plan of care revealed that he/she exhibited responsive behaviours. Further review of the plan of care revealed staff are directed to conduct hourly safety checks and monitor resident #005's whereabouts all the

time.

According to PSW #124, resident #005 is not aware that his/her behaviours sometimes cause aggressive responses by other residents.

Interviews with RN #106, RN #126 and ADOC #147 confirmed that the incident between resident #004 and resident #005 on an identified date, and the incident between resident #005 and resident #018 on an identified date, were abuse, as the interaction resulted in injury to resident #005. Furthermore, ADOC #147 stated that one to one monitoring for residents #004 and #018 was meant to protect resident #005 but it had not been successful.

An interview with DOC #106 confirmed the above incidents and stated that resident #005 was not protected from abuse.

9. A CIR was submitted to the MOHLTC in relation to a resident to resident abuse incident between resident #016 and resident #017 that occurred on an identified date. Resident #016 sustained identified injuries.

Review of the CIR and resident #016's progress notes indicated that on an identified date, resident #016 was sleeping in his/her bed. Resident #016 stated that resident #017 wandered into his/her room and assaulted him/her. Resident #016 called for help. RN #132 was at the nursing station close by and went into resident #016's room to investigate. The two residents were separated and resident #017 was redirected out of the room. Resident #017 was put on one to one monitoring. The police were contacted and a report was submitted to the MOHLTC after hours phone line.

During an interview, the resident gave a re-account of the incident remembering resident #017 coming into his/her room. However resident #016 could not remember being assaulted. He/she stated he/she was scared after the incident, and would feel scared thinking about it afterwards. Interview with resident #016's family member indicated that the resident was traumatized by the incident and would not even want to talk about it.

Interviews with PSWs #133, PSW #136, and RN #132, indicated that resident #017 had been transferred from another unit to the same unit as resident #016. For the period that resident #016 was on the newly transferred unit, he/she was exhibiting responsive behaviours. The intervention that staff were taking at the

time was to redirect resident #017.

An interview with the DOC confirmed that the home did not protect resident #016 from abuse. [s. 19. (1)] (502)

10. The licensee has failed to ensure that residents are protected from abuse.

Review of a CIR submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, revealed family members were concerned that PSW #103 was abusing resident #014 by making identified statements.

Review of resident #014's medical record revealed the resident had identified medical conditions and was hospitalized at one time for an identified medical problem. The resident's Cognitive Performance Scale (CPS) indicated no or minor cognitive loss.

Interview with resident #014's family member revealed PSW #021 made identified statements to the resident. This was brought to the home's attention by the family during a care conference, at which time the family requested that PSW #103 no longer work with resident #014. Interview with the DOC revealed the home prefers to resolve relationships between care givers and residents rather than change staff assignments. As well, the DOC revealed that the home had asked if resident #014 wanted to change care givers and the resident declined.

Interview with the family member revealed the family was not happy about this and did not feel that resident #014 was protected from abuse by PSW #103.

Review of the home's investigation notes regarding the above verbal statements made by PSW #103 revealed the PSW denied making such comments. However, subsequent to also being told by the home that PSW #103 does not perform an identified daily duty, the PSW approached the resident to deny such a claim. Review of the investigation notes and interview with the DOC confirmed PSW #103 was disciplined for reprisal and intimidating resident #014.

An interview with resident #114 revealed that PSW #103 seems to dislike him/her as the PSW treats him/her differently than other residents. The resident gave an example of asking PSW #103 for his/her nutritional supplement prior to going off the unit. According to the resident, PSW #103 told him/her it was not

yet time for the snacks to be offered. When the resident returned to the unit, he/she again asked the PSW for his/her supplement and the PSW told him/her that it was too late as snack time was finished. When asked how this made him/her feel, resident #114 stated he/she was not surprised because he/she knows PSW #103 does not like him/her but it did make him/her feel upset and uncomfortable. Resident #103 stated he/she really enjoys his/her supplement and does not like to miss them.

Review of resident #114's plan of care revealed the resident is to receive a nutritional supplement. According to progress notes the resident felt he/she needed extra nourishment following hospitalization and the RD ordered the supplement to help maintain weight.

An interview with PSW #103 revealed he/she did not leave the supplement for resident #114 on an identified date, because the resident was not available during snack time and it is the practice in the home not to leave food in resident rooms if they are not there. PSW #103 further stated he/she was not aware that the supplement could have been kept in the refrigerator. Interview with RPN #102 revealed PSW #103 has previously saved snacks in the refrigerator for other residents in the past.

An interview with RPN #120 confirmed resident #014 requested his/her supplement upon return to the unit and was aware that PSW #103 did not provide the supplement. RPN #120 further stated that PSW #103 is not fond of resident #014, and that he/she interacts with resident #014 differently than other residents as PSW #103 speaks to resident #014 as if he/she doesn't like him/her. RPN #120 stated that he/she sometimes feels intimidated by PSW #103, because of the way PSW #103 talks and looks at him/her, and that resident #014 may also feel intimidated.

During interviews, day PSWs #136, #137, #139, evening PSWs #144, #121, day RPN #102, and evening RPNs #131 and #138, RN #125 stated that the home's expectation is that snacks can be saved in the refrigerator for residents who are not available during snack time. Interview with the DOC revealed food should not be left in resident rooms but confirmed that it is the home's expectation that snacks, especially nutritional supplements, be saved in the refrigerator.

Interview with DOC #112 confirmed that the above mentioned incidents indicate PSW #103 has been abusing resident #014 and the home plans to reassign the

PSW so that he/she will no longer provide care to resident #014. PSW #103 will also receive progressive discipline for his/her actions.

The severity of the abuse for resident #018 is actual harm. The scope is isolated. Section 19(1) was issued with a Voluntary Plan of Correction in inspection #2015_324567_0006 and #2014_321501_0015. Due to severity and compliance history a compliance order is being issued. [s. 19. (1)]
(673)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 18, 2017

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

1. The licensee shall ensure that there are strategies in place to prevent altercations between resident #004 and other residents when no staff are available for one to one monitoring for resident #004.
2. The licensee shall ensure that staff providing one to one monitoring for resident #013 do not participate in providing care to other residents unless authorized by registered staff.
3. The licensee shall ensure that there are interventions in place to minimize the risk of altercations between resident #017 and other residents.

Grounds / Motifs :

1. The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations.

A Critical Incident Report was submitted to the MOHLTC related to resident to resident abuse. Review of the CIR revealed that on an identified date, resident #004 hit resident #031 causing resident #031 to experience pain.

Review of resident #004's progress notes revealed multiple altercations between resident #004 and other residents.

Review of resident #004's most recent written plan of care, revealed that resident #004 has responsive behaviours. Further review of the written plan of care revealed one to one staff had been assigned to resident #004 to monitor and prevent significant risk of violence towards others.

PSWs #116 and #124 stated that resident #004 is their regular assignment, when one to one staff is not available and will take care of him/her along with other residents assigned to them during their respective shift, and are not able to provide the same level of supervision as one to one staff. PSW #116 revealed being aware that resident #004 will hit other residents when no one is watching and required close monitoring. However, he/she had left resident #004 and resident #031 without supervision as he/she needed to check on other residents on his/her assignment when the incident described in the CIR happened.

Interviews with RN #106, #126, and #161, stated resident #004 is unpredictable.They stated they could not identify the triggers of his behaviour. The above mentioned staff stated that providing close supervision with one to one staff had been the most efficient in reducing and preventing the number of interactions between resident #004 and other residents.They stated that there is no strategy in place to prevent altercations between resident #004 and other residents when the one to one staff is not available.

Interview with the DOC revealed resident #004 had become a risk to other residents and staff in the building and without one to one staff they would have had more incidents. He/she confirmed that triggers have not been identified for resident #004's behaviours and there is no clear strategy care planned when one-on-one staff is not available. [s. 54. (a)]

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

Review of a CIR revealed that on an identified date, resident #013 was observed to sit next to resident #020 and touched him/her inappropriately. Staff immediately removed resident #013 from the situation.

The inspector was on the unit at the time of the above incident and observed PSW #100 respond and intervene. According to PSW #100, resident #013 did

not have one to one staff and interview with RPN #130 revealed he/she was unaware which PSW might be assigned to resident #013 and where he/she might be. Interview with PSW #129 revealed he/she was assigned to resident #013 and was on break during the above mentioned incident. PSW #129 stated he/she spoke with the day charge nurse, RPN #111, and was granted permission to leave the unit and take a break. Interview with RPN #111 recalled giving PSW #129 permission to take a break and assigned an identified PSW to watch over resident #013. According to RPN #111 and the DOC this PSW stepped away to check on his/her one to one resident and that is when this incident happened.

Review of resident #013's progress notes revealed resident #013 had previously inappropriately touched resident #007 on an identified date, and was to have one to one staff to help address responsive behaviours and prevent inappropriate behaviours.

Review of another CIR revealed resident #013 touched resident #021 inappropriately while walking down the hallway with his/her one to one staff on an identified date. An interview with ADOC #122 revealed the home considered this to be an act of abuse due to resident #013's previous recent inappropriate behaviours with resident #007 and #020 and because all three residents do not have the capacity to consent to the observed touching.

An interview with PSW #150 revealed he/she was helping another resident while providing one to one care for resident #013 when he/she observed resident #013 touch resident #021 inappropriately. PSW #150 admitted that if he/she was not helping another resident, this incident may have been prevented. Interview with RN #126 revealed he/she spoke with PSW #150 and reminded him/her to only take care of their one to one resident and not perform other activities unless he/she speaks to registered staff first.

An interview with the DOC stated that the home had identified that resident #013 needed one to one staff to closely monitor resident #013 in order to prevent him/her from inappropriately touching residents. The DOC confirmed that the intervention of one to one staffing for resident #013 did not implement close monitoring for the resident in order to minimize the risk of altercations and potentially harmful interactions between residents. [s. 54. (b)]

3. A CIR was submitted to the MOHLTC in relation to a resident to resident

abuse incident between resident #016 and resident #017 that occurred on an identified date. Resident #016 sustained identified injuries.

Review of the CIR and resident #016's progress notes indicated that on an identified date resident #016 was sleeping in his/her bed. Resident #017 wandered into resident #016's room and disturbed resident #016. Resident #016 started screaming and pulled the call bell for help. Resident #016 stated that resident #017 then tried to assault him/her. RN #132 was at the nursing station close by and went into resident #016's room to investigate. The two residents were separated and resident #017 was redirected out of the room. Resident #017 was put on one to one monitoring provided by the home's PSW for 72 hours. The police were contacted and a report was submitted to the MOHLTC after hours phone line.

Review of resident #017's progress notes indicated the resident was transferred to the unit where the above incident occurred on an identified date. Resident #017 spoke an identified language and had waited years to be transferred to this unit. However, since the transfer on an identified date resident #017 had been observed to have identified responsive behaviours. Review of resident #017's written plan of care did not include focus, goals and interventions to manage resident #017's responsive behaviors.

Interview with RPN #102 indicated resident #017 did not have any history of responsive behaviors prior to the transfer to the new unit. Interviews with PSWs #133 and #136, and RN #132, indicated that since resident #017 was transferred to the new unit, he/she had exhibited an identified behavior. The measure that staff was taking at the time was redirecting. Review of resident #017's progress notes revealed no evidence that internal and external resources were consulted to manage the resident's responsive behaviours.

An interview with the DOC confirmed that steps were not taken to manage resident #017's responsive behavior to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

The severity is actual harm to resident #033 and #017. The scope is isolated and there is no compliance history related to r.54(b). Due to the severity a compliance order is being issued. [s. 54. (b)]

(512)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 16, 2017

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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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 1st day of June, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Susan Semeredy

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