Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 13, 2019	2019_776613_0016	026429-17, 033597-18, 033764-18, 001478-19, 010773-19	Complaint

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Weston Terrace Care Community
2005 Lawrence Avenue West TORONTO ON M9N 3V4

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

LISA MOORE (613), COREY GREEN (722), SHELLEY MURPHY (684), SYLVIE BYRNES (627)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 27 - 31, 2019.

The following complaints were inspected during this inspection:

Two complaints that were submitted to the Director regarding the provisions of care for falls prevention and management;

One complaint that was submitted to the Director regarding allegations of improper care and neglect;

One complaint that was submitted to the Director regarding allegations of staff to resident abuse; and

One complaint that was submitted to the Director regarding allegations that the substitute decision-maker was not notified of a change in condition.

A concurrent Critical Incident Inspection #2019_776613_0017 was also conducted with this inspection.

During the course of the inspection, the inspector(s) spoke with the Regional Director of Operations (RDO), Executive Director (ED), Acting Director of Care (Acting DOC), Assistant Director of Cares (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and family members.

The Inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, internal investigation files, video surveillance, human resource files, and licensee policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **3 WN(s)**
- **1 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

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

A complaint was submitted to the Director, alleging improper care of resident #001.

Inspector #627 interviewed the complainant who stated that they had visited the home, after a meal service and had found resident #001, alone in a dining room, with food all over them. The complainant stated that this had angered them; therefore, they had taken a video and pictures of the incident, which they would provide to the Inspector.

Inspector #627 reviewed the video provided to them by the complainant and observed resident #001 sleeping in their mobility aid in a dining room, the tables had been cleaned and no staff appeared in the dining room. One of the photographs provided to the Inspector by the complainant showed a clock marking a specific time.

A review of resident #001's progress note, written by RN #118, indicated that at a specific time, the complainant had been upset to find resident #001 in the dining room, along, with "messed up food" on their clothes. The writer had apologized for the incident.

A review of resident #001's care plan, in effect at the time of the incident, indicated for the focus of falls that resident #001 was not to be left in their room unattended and that the resident should always be in front of the nursing station for close monitoring, with their mobility aid positioned in a certain way when not participating in an activity.

A review of the licensee's policy titled "Documentation-Plan of Care", (#VII-C-10.90), last revised April 2019, indicated that PSWs were to provide care as specified in the resident's plan of care.

During an interview with RN #118, they stated that they had been present when the complainant had complained that resident #001 had been left, unattended in the dining room. RN #118 stated that they had spoken to PSW #129, who had informed them that Activity Aid #130 had been assisting the resident to eat, then they had left to get a cloth so that they could clean resident #001. They were coming to get resident #001 when they saw the complainant taking pictures. The RN stated that there had been a lack of communication; the Activity Aid should have notified a staff member that they were leaving. The RN acknowledged that care had not been provided as per the care plan.

During an interview with the ADOC #100, they stated that they felt the incident was a misunderstanding and miscommunication between the family, the activity staff, and the PSW. The ADOC further stated that the activity staff should have communicated to the staff when they were leaving the dining room, after having assisted the resident, to ensure that the resident would not be left alone. They acknowledged that care was not provided to the resident as per resident #001's care plan.

2. A complaint was submitted to the Director, alleging improper care of resident #001.

A review resident #001's care plan, in effect at the time of the inspection, identified that the resident always wore adaptive aids.

The Inspector observed resident #001 in front of the nursing station, in their mobility aid, with a safety device attached to their clothing. The Inspector observed that the resident was not wearing the adaptive aids.

During an interview with PSW #120, they stated that they had been resident #001's primary caregiver for a period of time, and they could not recall the resident wearing the adaptive aids. PSW #120 further stated that perhaps the adaptive aids had not been replaced.

During an interview with PSW #121, they stated that they had been resident #001's primary caregiver and that the resident had been wearing the adaptive aids.

During an interview with RN #126, they stated that resident #001 was at risk for falls, and the adaptive aids were one of the interventions to mitigate their risk of injury, and that the resident should have been wearing them.

During an interview with the DOC, they stated that the intervention remained in place, resident #001 was to have the adaptive aids and that PSW staff were expected to follow the resident's care plan. The DOC stated that the PSW staff should have brought forth that the resident's adaptive aids were missing.

3. Inspector #627 reviewed a CI report that was submitted to the Director, regarding a fall which caused a significant change to resident #016. The CI report indicated that resident #016 had an unwitnessed fall which resulted with an injury.

During an interview with resident #016's substitute decision-maker (SDM), they stated that resident #016 had two further falls after this incident, which they found to be unacceptable. For this reason, the Physician and the SDM had decided to have the resident receive a specific intervention, until further assessment.

A review of resident #016's current care plan indicated that the resident was to have specific monitoring due to resident #016's behaviours and that the resident was at risk for injury.

The Acting DOC provided the Inspector with the daily event reports for a specific time period, which indicated the hours worked providing specific monitoring to resident #016. The Inspector, along with the Acting DOC identified the following times when specific monitoring was not provided to resident #016:

-Eight specific dates where the home was unable to provide specific monitoring to resident #016 for three to eight hours during a 24 hour period.
-Two specific dates where the DOC was unable to determine which shift had been covered with specific monitoring during a 24 hour period.
-One specific date where there was no specific monitoring for resident #016 during a 24 hours period.

During interviews with PSW #110 and #113 separately, they stated that they were providing specific monitoring to resident #016. Both PSWs stated that they had started their shift and no one had been providing specific monitoring. [s. 6. (7)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with related to an incident of abuse involving resident #003.

Inspector #722 reviewed a Critical Incident (CI) report that was submitted to the Director, related to an allegation of staff-to-resident abuse involving resident #003. A complaint was also received by resident #003's substitute decision-maker (SDM), related to this incident.

Inspector #722 reviewed video recordings of two specific incidents that were captured on a concealed camera that was placed in resident #003's room. The first video recording was from a specific date and time, where PSW #102 was observed roughly pushing resident #003 from a standing position into a chair. The second video was from another specific date and time, where PSW #102 was rough with the resident while removing a soiled continence care product from their hand, raised their fist in an aggressive and threatening manner on two occasions while the resident was lying in bed, and pointed their finger aggressively at the resident's face. When the PSW raised their fist above the resident, resident #003 raised their hands in a defensive gesture.

During an interview with the Executive Director (ED), they confirmed that they were notified of these incidents on a specific date, that the video clips were received from resident #003's SDM, and that PSW #102 was the staff member captured in both video

recordings.

Inspector #722 interviewed resident #003's SDM, who confirmed that they had placed the video recording device in resident #003's room, and that they had provided a copy of the video recordings to the ED, of the home, via email on a specific date, after reporting the incident to the police. During the interview, the SDM indicated that they felt that there was no follow up related to this incident, that resident #003 and/or the family members did not receive any offer of emotional support after the incident of abuse was identified, and that none of the direct care staff on the floor seemed to be aware of what had happened to the resident.

A review of the licensee's internal investigation file, related to this incident of abuse, included the following:

- A copy of the CI report that was submitted to the Director.
- A copy of the typed letter addressed to PSW #102, dated on a specific date, and signed by the Director of Care (DOC), which indicated that PSW #102 had been abusive toward resident #003, failed to provide care in a manner that was compliant with the licensee's policies.
- Typed notes related to the investigation, which included employment information about PSW #102, a summary of the incident, a list of allegations against PSW #102 related to provision of care and abuse, and a list of resident rights that were violated.
- Typed notes from a meeting that took place on a specific date, with PSW #102, which was attended by the DOC, ADOC #100, an interviewer, and a union representative. The interview notes indicated that information was gathered from PSW #102 related to their work history, the care they provided to resident #003, and the specific incidents that involved resident #003 on two specific dates.
- Typed notes for a meeting, that occurred with PSW #111, who was working on the shift with PSW #102 on two specific dates. The notes indicated that ADOC #100, the DOC, and a union representative were also present at the meeting. The notes indicated that PSW #102 was asked questions about the care they provided to resident #003 during the shifts on two specific dates; PSW #111 was not asked any questions related to any allegation of abuse or mistreatment of resident #003.

Inspector #722 reviewed the health records for resident #003. There were no progress notes that identified that any incidents had occurred involving resident #003 during the shifts on specific dates. There were no entries identified in resident #003's plan of care related to these incidents of abuse, including any emotional support provided by services

available in the home (e.g., social work); and no notes identified from the social worker, pastor, or any other qualified person which indicated that the resident/family were provided emotional support related to the incident. A head-to-toe assessment was identified in the health record that was completed by RN #104 on a specific date, but did not include any indication of the resident's emotional status.

During an interview with RN #104, they confirmed that they were working on the specific date and shift, that the Director of Care (DOC) had requested that the RN complete a head-to-toe assessment for resident #003. RN #104 indicated that they were not informed why they were being asked to complete the assessment on resident #003; they stated that they completed their head-to-toe assessment on resident #003, as directed and as per the instrument available in Point Click Care (PCC). RN #104 confirmed that they did not assess the resident's overall safety and emotional status. RN #104 also indicated that they were not informed of any incident during the previous shift involving resident #003, and that they provided care as usual for the resident on their shift.

During an interview with PSW #128, they indicated that they had provided care to resident #003 on many occasions, and that the resident had been in their primary care assignment. The PSW indicated that they had no knowledge of any incidents of abuse that occurred that involved resident #003.

A review of the licensee's policy titled, "Prevention of Abuse & Neglect of a Resident", (#VIIG-10.00) Current Revision: December 2018, which was provided by the Acting DOC, who verified that it was the licensee's policy in place, when the incident occurred. The policy indicated the following:

- The charge nurse/nurse would check the resident's condition to assess his/her safety and emotional and physical well-being.
- Update the plan of care as appropriate, ensuring that direct care team members were made aware of current resident status.
- The Executive Director or designate initiated the investigation by requesting that anyone aware of or involved in the situation write, sign, and date a statement accurately describing the event, reiterating anonymity and protection against retaliation.
- The alleged abuser was also asked to write, sign, and date a statement of the event.
- The written statements were obtained as close to the time of the event as possible.
- The Executive Director or designate interviewed the resident, other residents, and/or persons who may have any knowledge of the situation.
- Support and/or counselling would be offered to all victims of alleged abuse/neglect and

the alleged abuser; the resident/family were offered emotional support and provided with a list of internal resources, including the social worker, pastoral care, and external local resources as available.

During an interview with the Executive Director (ED), they indicated that the video evidence was provided to the home that indicated PSW #102 had abused resident #003 on a specific date, when they were rough with the resident, raised their fist in a threatening manner, and aggressively pointed their finger at resident #003. The ED confirmed that PSW #102 was the staff member identified in the video. The ED indicated that the PSW was immediately removed from duties pending findings from the investigation.

The ED indicated that they wanted to keep the incident quiet, and that they did not notify any direct care staff in the resident home area (RHA) where resident #003 resided about what had occurred on specific dates. The ED indicated that an investigation was initiated immediately upon becoming aware of the incident of abuse, and was completed on a specific date, after management of the home interviewed PSW #111. The ED confirmed that they did not attempt to interview any other residents in the resident home area where PSW #102 worked about the incident, and did not interview any other staff members about potential incidents of abuse involving PSW #102 and/or resident #003. The ED also confirmed that they did not get a written, dated and signed statement from PSW #102 that described the event in their own words; nor did they get a written, dated and signed statement from PSW #111, who was working with PSW #102 during the time of the incident. The ED confirmed that there was no other documentation available related to the incident, aside from the material available in the investigation file, as described above.

The ED indicated that they were not aware of any support and/or counselling being offered to resident #003 or their family members related to their emotional well-being, in terms of internal resources, or involvement with a social worker, pastoral care, and/or external local resources as available.

Inspector #722 interviewed the licensee's Regional Director of Operations (RDO), who also confirmed that there was no written statement obtained from PSW #102 as part of the investigation, that there was no documentation available which indicated that any staff had been interviewed related to the incident, and that there was no documentation in the resident's health record regarding the incident. The RDO indicated that the licensee's Vice President (VP) had spoken at length with resident #003's SDM, and

offered support and assistance with the resident's move to another facility; however, the RDO confirmed that the VP was not a social worker or psychologist, and was not aware of any internal/external resources offered to resident #003 or their family members in terms of their emotional well-being after the abuse. [s. 20. (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 LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to report to the Director the results of an investigation for a witnessed incident of staff-to-resident abuse involving resident #003; and failed to report every action taken in response to the witnessed incident of abuse.

Inspector #722 reviewed a Critical Incident (CI) report that was submitted to the Director, related to an allegation of staff-to-resident abuse involving resident #003. Refer to WN #2 for further details.

A review of the CI report that was submitted, described this incident of staff-to-resident abuse, and how the incident came to the attention of management in the home. The report described the resident and staff involved, and indicated that the following actions were taken:

- Staff removed from duties pending investigation
- Ministry of Health and Long-Term Care notified
- Head to toe assessment completed on the resident
- Family conference with residents POA
- Incident report completed

- The Regional Manager and the home's Support Partner notified

A review of the licensee's internal investigation file that was provided by ADOC #100 related to this incident, which included the following:
- A copy of the CIS report that was submitted to the Director on a specific date.
- A copy of the typed letter addressed to PSW #102, dated on a specific date, and signed by the Director of Care (DOC), which indicated that PSW #102 had been abusive toward resident #003, failed to provide care in a manner that was compliant with the licensee's policies.
- Typed notes related to the investigation, which included employment information about PSW #102, a summary of the incident, a list of allegations against PSW #102 related to provision of care and abuse, and a list of resident rights that were violated.
- Typed notes from a meeting that took place on a specific date, with PSW #102, which was attended by the DOC, ADOC #100, an interviewer, and a union representative. The interview notes indicated that information was gathered from PSW #102 related to their work history, the care they provided to resident #003, and the specific incidents that involved resident #003 on specific dates.
- Typed notes for a meeting that occurred on a specific date, with PSW #111, who was working on the shift with PSW #102 on specific dates. The notes indicated that ADOC #100, the DOC, and a union representative were also present at the meeting. The notes indicated that PSW #102 was asked questions about the care they provided to resident #003 during the shift on specific dates.

During an interview with the ED, they confirmed that they were notified of these incidents on a specific date, that the video clips were received from resident #003's SDM via email, and that PSW #102 was the staff member captured in both video recordings. The ED reported that the investigation into the incident was commenced immediately. The ED initially indicated that the investigation into the incident was completed on a specific date, the same day that the CI report was initially submitted by the home. However, the ED acknowledged that the meeting with PSW #102 on a specific date, as well as the meeting with PSW #111 on a specific date, were part of the home's investigation into this incident. The ED also acknowledged that staff in the home had been provided re-training related to the home's policy on prevention of abuse and neglect and mandatory reporting. The ED acknowledged that the CIS report was not amended to report results of the investigation for these incidents of staff-to-resident abuse to the Director, as well as actions taken related to the incident. [s. 23. (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 they report to the Director the results of every investigation undertaken under clause (1) (a) and every action taken under clause (1) (b), to be implemented voluntarily.

Issued on this 14th day of June, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Long-Term Care 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) : LISA MOORE (613), COREY GREEN (722), SHELLEY MURPHY (684), SYLVIE BYRNES (627)

Inspection No. /
No de l'inspection : 2019_776613_0016

Log No. /
No de registre : 026429-17, 033597-18, 033764-18, 001478-19, 010773-19

Type of Inspection /
Genre d'inspection: Complaint

Report Date(s) /
Date(s) du Rapport : Jun 13, 2019

Licensee /
Titulaire de permis : 2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8

LTC Home /
Foyer de SLD : Weston Terrace Care Community
2005 Lawrence Avenue West, TORONTO, ON, M9N-3V4

Michael Bastian

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

Ministère 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

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

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:

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

Ministère 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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (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 must be compliant with s. 6 (7) of the LTCHA.

Specifically the licensee must:

A) Ensure that resident #001 is provided care as per their current care plan.

B) Ensure that resident #016 is provided one on one care daily, as per their care plan.

Grounds / Motifs :

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

A complaint was submitted to the Director, alleging improper care of resident #001.

Inspector #627 interviewed the complainant who stated that they had visited the home, after a meal service and had found resident #001, alone in a dining room, with food all over them. The complainant stated that this had angered them; therefore, they had taken a video and pictures of the incident, which they would provide to the Inspector.

Inspector #627 reviewed the video provided to them by the complainant and observed resident #001 sleeping in their mobility aid in a dining room, the tables had been cleaned and no staff appeared in the dining room. One of the photographs provided to the Inspector by the complainant showed a clock marking a specific time.

A review of resident #001's progress note, written by RN #118, indicated that at a specific time, the complainant had been upset to find resident #001 in the dining room, along, with "messed up food" on their clothes. The writer had apologized for the incident.

A review of resident #001's care plan, in effect at the time of the incident, indicated for the focus of falls that resident #001 was not to be left in their room unattended and that the resident should always be in front of the nursing station for close monitoring, with their mobility aid positioned in a certain way when not participating in an activity.

A review of the licensee's policy titled "Documentation-Plan of Care", (#VII-C-10.90), last revised April 2019, indicated that PSWs were to provide care as specified in the resident's plan of care.

During an interview with RN #118, they stated that they had been present when the complainant had complained that resident #001 had been left, unattended in the dining room. RN #118 stated that they had spoken to PSW #129, who had informed them that Activity Aid #130 had been assisting the resident to eat, then they had left to get a cloth so that they could clean resident #001. They were coming to get resident #001 when they saw the complainant taking pictures. The RN stated that there had been a lack of communication; the Activity Aid should have notified a staff member that they were leaving. The RN acknowledged that care had not been provided as per the care plan.

During an interview with the ADOC #100, they stated that they felt the incident was a misunderstanding and miscommunication between the family, the activity staff, and the PSW. The ADOC further stated that the activity staff should have communicated to the staff when they were leaving the dining room, after having assisted the resident, to ensure that the resident would not be left alone. They acknowledged that care was not provided to the resident as per resident #001's care plan.

2. A complaint was submitted to the Director, alleging improper care of resident #001.

A review resident #001's care plan, in effect at the time of the inspection, identified that the resident always wore adaptive aids.

The Inspector observed resident #001 in front of the nursing station, in their mobility aid, with a safety device attached to their clothing. The Inspector observed that the resident was not wearing the adaptive aids.

During an interview with PSW #120, they stated that they had been resident #001's primary caregiver for a period of time, and they could not recall the resident wearing the adaptive aids. PSW #120 further stated that perhaps the adaptive aids had not been replaced.

During an interview with PSW #121, they stated that they had been resident #001's primary caregiver and that the resident had been wearing the adaptive aids.

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During an interview with the DOC, they stated that the intervention remained in place, resident #001 was to have the adaptive aids and that PSW staff were expected to follow the resident's care plan. The DOC stated that the PSW staff should have brought forth that the resident's adaptive aids were missing.

3. Inspector #627 reviewed a CI report that was submitted to the Director, regarding a fall which caused a significant change to resident #016. The CI report indicated that resident #016 had an unwitnessed fall which resulted with an injury.

During an interview with resident #016's substitute decision-maker (SDM), they stated that resident #016 had two further falls after this incident, which they found to be unacceptable. For this reason, the Physician and the SDM had decided to have the resident receive a specific intervention, until further assessment.

A review of resident #016's current care plan indicated that the resident was to

have specific monitoring due to resident #016's behaviours and that the resident was at risk for injury.

The Acting DOC provided the Inspector with the daily event reports for a specific time period, which indicated the hours worked providing specific monitoring to resident #016. The Inspector, along with the Acting DOC identified the following times when specific monitoring was not provided to resident #016:

-Eight specific dates where the home was unable to provide specific monitoring to resident #016 for three to eight hours during a 24 hour period.
-Two specific dates where the DOC was unable to determine which shift had been covered with specific monitoring during a 24 hour period.
-One specific date where there was no specific monitoring for resident #016 during a 24 hours period.

During interviews with PSW #110 and #113 separately, they stated that they were providing specific monitoring to resident #016. Both PSWs stated that they had started their shift and no one had been providing specific monitoring.

The severity of this issue was determined to be a level 2, as there was minimal minimal harm or risk to the residents. The scope was determined to be a level 2, as it related to two out of three residents reviewed. The home had a level 3 compliance history, as they had ongoing non-compliance history that included:

-Voluntary Plan of Correction (VPC) issued December 21, 2018 (2018_634513_0014);
-VPC issued September 7, 2018 (2018_484646_0011);
-VPC issued January 11, 2018 (2017_525596-0019);
-VPC issued February 17, 2017 (2017_370649 _0002);
-VPC issued February 15, 2017 (2017_370649_0001);
-VPC issued February 1, 2016 (2016_337581_0001)

(627)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jul 31, 2019

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

Ministère 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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 20 (1) of the LTCHA.

Specifically the licensee must:

A) Ensure that their written policy to promote zero tolerance of abuse and neglect of residents is complied with at all times by management and all staff.

B) Ensure that the Charge Nurse checks the resident's condition to assess their safety and emotional and physical well-being and updates the resident's care plan as appropriate, ensuring that direct care team members are made aware of the current resident status.

C) Ensure that the Executive Director or designate conducts an immediate investigation, interviews all involved in the incident and maintains written statements and documentation, as close to the time of the incident as possible.

D) Ensure the resident who has been abused/neglected, the resident/family is offered emotional support/counselling and provided with a list of internal resources, including the social worker, pastoral care, and external local resources as described in the licensee's written policy to promote zero tolerance of abuse.

Grounds / Motifs :

1. The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with related to an

incident of abuse involving resident #003.

Inspector #722 reviewed a Critical Incident (CI) report that was submitted to the Director, related to an allegation of staff-to-resident abuse involving resident #003. A complaint was also received by resident #003's substitute decision-maker (SDM), related to this incident.

Inspector #722 reviewed video recordings of two specific incidents that were captured on a concealed camera that was placed in resident #003's room. The first video recording was from a specific date and time, where PSW #102 was observed roughly pushing resident #003 from a standing position into a chair. The second video was from another specific date and time, where PSW #102 was rough with the resident while removing a soiled continence care product from their hand, raised their fist in an aggressive and threatening manner on two occasions while the resident was lying in bed, and pointed their finger aggressively at the resident's face. When the PSW raised their fist above the resident, resident #003 raised their hands in a defensive gesture.

During an interview with the Executive Director (ED), they confirmed that they were notified of these incidents on a specific date, that the video clips were received from resident #003's SDM, and that PSW #102 was the staff member captured in both video recordings.

Inspector #722 interviewed resident #003's SDM, who confirmed that they had placed the video recording device in resident #003's room, and that they had provided a copy of the video recordings to the ED, of the home, via email on a specific date, after reporting the incident to the police. During the interview, the SDM indicated that they felt that there was no follow up related to this incident, that resident #003 and/or the family members did not receive any offer of emotional support after the incident of abuse was identified, and that none of the direct care staff on the floor seemed to be aware of what had happened to the resident.

A review of the licensee's internal investigation file, related to this incident of abuse, included the following:

- A copy of the CI report that was submitted to the Director.

- A copy of the typed letter addressed to PSW #102, dated on a specific date, and signed by the Director of Care (DOC), which indicated that PSW #102 had been abusive toward resident #003, failed to provide care in a manner that was compliant with the licensee's policies.
- Typed notes related to the investigation, which included employment information about PSW #102, a summary of the incident, a list of allegations against PSW #102 related to provision of care and abuse, and a list of resident rights that were violated.
- Typed notes from a meeting that took place on a specific date, with PSW #102, which was attended by the DOC, ADOC #100, an interviewer, and a union representative. The interview notes indicated that information was gathered from PSW #102 related to their work history, the care they provided to resident #003, and the specific incidents that involved resident #003 on two specific dates.
- Typed notes for a meeting, that occurred with PSW #111, who was working on the shift with PSW #102 on two specific dates. The notes indicated that ADOC #100, the DOC, and a union representative were also present at the meeting. The notes indicated that PSW #102 was asked questions about the care they provided to resident #003 during the shifts on two specific dates; PSW #111 was not asked any questions related to any allegation of abuse or mistreatment of resident #003.

Inspector #722 reviewed the health records for resident #003. There were no progress notes that identified that any incidents had occurred involving resident #003 during the shifts on specific dates. There were no entries identified in resident #003's plan of care related to these incidents of abuse, including any emotional support provided by services available in the home (e.g., social work); and no notes identified from the social worker, pastor, or any other qualified person which indicated that the resident/family were provided emotional support related to the incident. A head-to-toe assessment was identified in the health record that was completed by RN #104 on a specific date, but did not include any indication of the resident's emotional status.

During an interview with RN #104, they confirmed that they were working on the specific date and shift, that the Director of Care (DOC) had requested that the RN complete a head-to-toe assessment for resident #003. RN #104 indicated that they were not informed why they were being asked to complete the assessment on resident #003; they stated that they completed their head-to-toe

assessment on resident #003, as directed and as per the instrument available in Point Click Care (PCC). RN #104 confirmed that they did not assess the resident 's overall safety and emotional status. RN #104 also indicated that they were not informed of any incident during the previous shift involving resident #003, and that they provided care as usual for the resident on their shift.

During an interview with PSW #128, they indicated that they had provided care to resident #003 on many occasions, and that the resident had been in their primary care assignment. The PSW indicated that they had no knowledge of any incidents of abuse that occurred that involved resident #003.

A review of the licensee's policy titled, "Prevention of Abuse & Neglect of a Resident", (#VIIG-10.00) Current Revision: December 2018, which was provided by the Acting DOC, who verified that it was the licensee's policy in place, when the incident occurred. The policy indicated the following:

- The charge nurse/nurse would check the resident's condition to assess his/her safety and emotional and physical well-being.
- Update the plan of care as appropriate, ensuring that direct care team members were made aware of current resident status.
- The Executive Director or designate initiated the investigation by requesting that anyone aware of or involved in the situation write, sign, and date a statement accurately describing the event, reiterating anonymity and protection against retaliation.
- The alleged abuser was also asked to write, sign, and date a statement of the event.
- The written statements were obtained as close to the time of the event as possible.
- The Executive Director or designate interviewed the resident, other residents, and/or persons who may have any knowledge of the situation.
- Support and/or counselling would be offered to all victims of alleged abuse/neglect and the alleged abuser; the resident/family were offered emotional support and provided with a list of internal resources, including the social worker, pastoral care, and external local resources as available.

During an interview with the Executive Director (ED), they indicated that the video evidence was provided to the home that indicated PSW #102 had abused

resident #003 on a specific date, when they were rough with the resident, raised their fist in a threatening manner, and aggressively pointed their finger at resident #003. The ED confirmed that PSW #102 was the staff member identified in the video. The ED indicated that the PSW was immediately removed from duties pending findings from the investigation.

The ED indicated that they wanted to keep the incident quiet, and that they did not notify any direct care staff in the resident home area (RHA) where resident #003 resided about what had occurred on specific dates. The ED indicated that an investigation was initiated immediately upon becoming aware of the incident of abuse, and was completed on a specific date, after management of the home interviewed PSW #111. The ED confirmed that they did not attempt to interview any other residents in the resident home area where PSW #102 worked about the incident, and did not interview any other staff members about potential incidents of abuse involving PSW #102 and/or resident #003. The ED also confirmed that they did not get a written, dated and signed statement from PSW #102 that described the event in their own words; nor did they get a written, dated and signed statement from PSW #111, who was working with PSW #102 during the time of the incident. The ED confirmed that there was no other documentation available related to the incident, aside from the material available in the investigation file, as described above.

The ED indicated that they were not aware of any support and/or counselling being offered to resident #003 or their family members related to their emotional well-being, in terms of internal resources, or involvement with a social worker, pastoral care, and/or external local resources as available.

Inspector #722 interviewed the licensee's Regional Director of Operations (RDO), who also confirmed that there was no written statement obtained from PSW #102 as part of the investigation, that there was no documentation available which indicated that any staff had been interviewed related to the incident, and that there was no documentation in the resident's health record regarding the incident. The RDO indicated that the licensee's Vice President (VP) had spoken at length with resident #003's SDM, and offered support and assistance with the resident's move to another facility; however, the RDO confirmed that the VP was not a social worker or psychologist, and was not aware of any internal/external resources offered to resident #003 or their family

members in terms of their emotional well-being after the abuse.

The severity of this issue was determined to be actual harm/risk to the residents and the scope of the issue was a level 1. The home had a level 3 history, as they had a non-compliance with this section of the LTCHA that included:

-Voluntary Plan of Correction (VPC) issued April 19, 2016 (2016_229213_0012).

(613)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 13th day of June, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Moore

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