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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 21, 2016 | 2016_433625_0005 | 002738-14, 003662-14, 007319-14, 007904-14, 008177-14, 008363-14, 008374-14, 002402-15, 004009-15, 015871-15, 033868-15, 035733-15, 007431-16 | Critical Incident System |

### Licensee/Titulaire de permis

2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 INVESTMENT LP
302 Town Centre Blvd. Suite #200 MARKHAM ON L3R 0E8

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

Muskoka Shores Care Community
200 KELLY DRIVE GRAVENHURST ON P1P 1P3

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

KATHERINE BARCA (625), JULIE KUORIKOSKI (621), SHEILA CLARK (617)

### 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): April 4th to 8th, 11th to 15th, 19th to 22nd and 25th to 29th, 2016.**

**A Complaint Inspection was conducted concurrently with this inspection.**

**For details and additional findings of non-compliance, please refer to Complaint Inspection report #2016_433625_0004.**

**Logs completed during this inspection were:**
**- 002738-14, 007319-14, 008177-14, 008363-14, 008374-14, 002402-15 and 033868-15 related to Critical Incident System reports submitted for staff to resident abuse;**
**- 003662-14 and 007431-16 related to Critical Incident System reports submitted for resident to resident abuse;**
**- 004009-15 related to a Critical Incident System report submitted for resident neglect;**
**- 015871-15 related to a Critical Incident System report submitted for a visitor to staff interaction;**
**- 007904-14 related to a Critical Incident System report submitted for an unexpected resident death; and**
**- 035733-15 related to a Critical Incident System report submitted for an incident that caused an injury to a resident for which the resident was taken to hospital that resulted in a significant change in the resident's health condition.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Directors of Care (DOCs), Associate Director of Care (ADOC), Case Manager (CM), Environmental Services Supervisor (ESS), Maintenance staff, Housekeeping staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PWSs), Resident Resources Coordinator (RRC), Education Coordinator, Office Manager, pharmacy service provider's Accounts Receivable Clerk, Regional Supervising Coroner, residents and family members.**

**The Inspectors also reviewed resident health care records, various home's policies and procedures, employee training records, employee files, home's investigation files and maintenance records. Inspectors completed observations of residents, observed the provision of care and services to residents, observed resident and staff interactions, meal services and conducted a tour of resident care areas.**

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

**Falls Prevention**
**Hospitalization and Change in Condition**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**

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

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

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

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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, without in any way restricting the generality of

the duty provided for in section 19, there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with.

A Critical Incident System (CIS) report was submitted to the Director for an incident of verbal abuse of resident #008 by PSW #153 which occurred on a specific date in the fall of 2015. The report identified that PSW #153 spoke profanely to resident #008.

Ontario Regulation 79/10 defines verbal abuse as any form of verbal communication of a threatening or intimidating nature, or any form of verbal communication of a belittling or degrading nature, which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

The home's policy "Prevention of Abuse & Neglect of a Resident – VII-G-10.00" revised January 2015, provided that all residents had the right to dignity, respect and freedom from abuse and neglect, and that abuse and neglect would not be tolerated in any circumstance by anyone.

A review of the home's investigation notes by Inspector #621 identified that PSWs #123 and #124 observed PSW #153 offer resident #008 menu choices for the supper meal. The documentation indicated that the resident stated that they did not need to choose one of the options presented because they had their own meal already chosen. It was also recorded that, when PSW #153 looked into the issue with the dietary staff and was told that the resident had their own diet, PSW #153 was overheard making a profane statement towards the resident. The home determined, from its investigation, that the PSW had verbally abused resident #008.

A review of the employee file for PSW #153 identified a letter dated five days after the incident of verbal abuse in the fall of 2015, which confirmed that verbal abuse had occurred on the specific date in the fall of 2015, when PSW #153 made a profane statement towards resident #008, as confirmed by two witnesses.

During an interview with DOC #108, they reported to Inspector #621 that their expectation with respect to the treatment of residents by staff within the home, was that every resident had the right to be protected from abuse. DOC #108 reported that results of the investigation determined that two staff witnessed PSW #153 verbally abuse resident #008, and PSW #153 admitted that they spoke to resident #008 with language that would constitute verbal abuse. [s. 20. (1)]

2. A CIS report was submitted to the Director one day after an incident was reported to the home in the winter of 2016, and was related to an incident of verbal abuse of resident #008 by PSW #103. The incident was witnessed by a visiting external consultant team and was reported to the Assistant Director of Care by the team one day after the incident occurred.

The home's policy "Prevention of Abuse & Neglect of a Resident – VII-G-10.00" revised January 2015, indicated that all employees, volunteers, agency staff, private duty caregivers, contracted service providers, residents and families were required to immediately report any suspected or known incident of abuse or neglect to the Director of the Ministry of Health and Long-Term Care and the Executive Director or designate in charge of the home.

A review by Inspector #621 of the home's internal investigation identified that the visiting external consultant team witnessed incidents of abuse from PSW #103 to resident #008 on three specific dates during the winter of 2015, which occurred within an eight day period, and notified the home's management of the incidents one day after witnessing the third incident. The investigation file also identified that RPN #114, nursing student #129, PSW #101 and PSW #104 had witnessed the abuse of resident #008 by PSW #103 on these dates, but had not reported or acted on the witnessed abuse at the time of each occurrence.The results of the home's internal investigation found that PSW #103's actions constituted verbal and emotional abuse to resident #008, and that that abuse had occurred on multiple occasions, was witnessed by multiple staff, and that the resident had endured the abuse until an external consultant intervened and reported the abuse to the home.

During an interview with Inspector #621 on April 27, 2016, ADOC #122 confirmed that the home's staff had witnessed the abuse of resident #008 on the three specific dates during the winter of 2015, and had not notified the Director or the home's Executive Director or designate at the time of the abuse, but should have. [s. 20. (1)]

3. A CIS report was submitted to the Director for an incident of staff to resident abuse/neglect that occurred on a specific date in the fall of 2014. The report indicated that PSW #102 verbally and emotionally abused residents #005 and #006 and refused to provide required assistance to the residents.

Inspector #625 reviewed the home's policy "Abuse and Neglect Resident – V3-010" revised April 2013, which was in place on the specific date in the fall of 2014, and

identified that:
- all residents had the right to dignity, respect, and freedom from abuse and neglect, the organization had zero tolerance of resident abuse and neglect, and abuse and neglect were not tolerated in any circumstance by anyone;
- if any employee witnessed an incident, or had knowledge of an incident, that constituted resident abuse or neglect, all staff were responsible to immediately stop the abusive situation and intervene immediately; remove the resident from the abuser of remove the abuser from the resident; and immediately inform the Director of Administration [the current Executive Director position] and/or Charge Nurse; and
- the Charge Nurse was then to check the resident's condition to assess safety, emotional and physical well-being and document the current resident status on the resident's record.

Inspector #625 reviewed the home's investigation file for the incident which identified, from several sources, that PSW #102 refused to assist residents #005 and #006 with personal care when the residents requested assistance, misused their authority and imposed restrictions on resident #006, called resident #005 names, used an "intimidating tone" when speaking to resident #005, removed resident #005's hands from a door handle and stated "In this job you have to use force", and yelled at the resident #005.

The investigation file identified that PSW #149 was present during the incidents that occurred on the specific date in the fall of 2014, and witnessed PSW #102 repeatedly abuse and neglect resident #005.

During an interview conducted by Inspector #625 on April 28, 2016, DOC #108 confirmed that PSW #102 abused and neglected residents #005 and #006 as outlined in the home's investigation file. When questioned by Inspector #625, the DOC stated that PSW #149 reported the abuse to the DOC the same day that it had it occurred. The DOC did not indicate that the PSW immediately stopped the abuse and intervened, or immediately reported the abuse to the Executive Director and/or Charge Nurse as outlined in the home's policy. The DOC #108 also acknowledged that the incident and follow-up were not documented in the resident's record in the progress notes, but that it should have been as was indicated in the home's policy. [s. 20. (1)]

4. A CIS report was submitted to the Director on a specific date in the summer of 2014, for an incident of resident to resident physical abuse that occurred three days prior involving resident #011.

Inspector #625 reviewed the home's policy "Abuse and Neglect Resident – V3-010" revised April 2013, which was in place on the specific date in the summer of 2014, and identified that:
- all residents had the right to dignity, respect, and freedom from abuse and neglect, the organization had zero tolerance of resident abuse and neglect, and abuse and neglect were not tolerated in any circumstance by anyone;
- if any employee witnessed an incident, or had knowledge of an incident, that constituted resident abuse or neglect, all staff were responsible to immediately stop the abusive situation and intervene immediately; remove the resident from the abuser of remove the abuser from the resident; and immediately inform the Director of Administration [the current Executive Director position] and/or Charge Nurse;
- the Charge Nurse would provide support to the staff member to immediately notify the Ministry of Health and Long-Term Care using the ACTION Line outside of normal business hours;
- the Charge Nurse would inform the Power of Attorney for Care of family member immediately of the alleged abuse if the incident caused harm, pain, or distress to the resident, or communicate with the families within 12 hours for all incidents; and
- the Charge Nurse was to check the resident's condition to assess safety, emotional and physical well-being and document the current resident status on the resident's record.

During a review of resident #011's health care record by Inspector #625, a progress note dated a specific date in the summer of 2015 was identified, that indicated that PSW #151 witnessed residents #011 and #042 as the PSW walked into a bathroom, that the residents appeared to be engaged in a specific activity, that the PSW called RPN #157 for assistance at 1945 hours. The note also indicated that RPN #157 informed RN #143 of the incident and that the RN stated "management can inform both parties family tomorrow morning".

During an interview with Inspector #625 on April 28, 2016, RN #143 referred to the home's current policy "Prevention of Abuse & Neglect of a Resident – VII-G-10.00" last revised January 2015, which was consistent with relevant aspects of the home's policy "Abuse and Neglect Resident – V3-010" revised April 2013. From the current policy, RN #143 determined that the RN's role as Charge Nurse included providing support to a staff member in reporting abuse to the Director. The RN stated that the policy indicated that the staff member was to call immediately but that the policy was related to "general abuse" and not "sexual abuse" specifically. When Inspector #625 asked the RN about meeting the timelines for reporting to the resident's substitute decision-maker or family, RN #143 stated that the home's Social Worker had the skill set to notify families and that

"we pass something this sensitive to them with their skill". The RN stated that the families would have been notified by RN #143 who would have informed the nurse on the night shift, who would have informed the nurse on the day shift, who would have informed management to notify the families.

During an interview with Inspector #625 on April 28, 2016, the DOC #108 reviewed the MOHLTC Licensee Reporting Sexual Abuse decision tree and stated that the incident should have been reported to the Director by RN #143, the Charge Nurse at the time. The DOC also stated that the Charge Nurse's role should have been followed as detailed in the home's policy, and not deferred for management to fulfill the next day. [s. 20. (1)]

5. A CIS report was submitted to the Director on a specific date in the summer of 2014, related to an incident of alleged verbal abuse of resident's #001, #002 and #003 by RPN #100. The report identified that, four days prior, PSW #160 overheard RPN #100 yell and witnessed resident #002 report to PSW #161 that RPN #100 had yelled at and been mean to residents #002 and #003. The report also identified that resident #003 was told by a PSW to report their concerns to the office.

The home's policy "Abuse and Neglect Resident – V3-010" revised April 2013, was in place on the specific date in the summer of 2014, and indicated that all employees, volunteers, agency staff, private duty caregivers, contracted service providers, residents and families were required to immediately report any suspected or known incident of abuse or neglect to the Director of the Ministry of Health and Long-Term Care and the Director of Administration [the current the Executive Director position] or designate in charge of the home. The policy also indicated that the Charge Nurse was to document the current resident status on the resident's record.

During an interview with the DOC, they stated that they believed they were notified by a letter written to the DOC by PSW #160. The DOC stated that the RN on duty had also been made aware of the incident at the time it occurred and attended the unit. The DOC acknowledged that the home's staff did not follow the home's abuse policy related to notification of the ED or reporting to the Director.

During an interview on April 21, 2016 with Inspector #621, the Executive Director confirmed that staff had not followed the home's abuse policy with respect to notification of the appropriate ED designate or the Director. [s. 20. (1)]

***Additional Required Actions:***

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

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**WN #2: 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. (9) The licensee shall ensure that the following are documented:**
**1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).**

**Findings/Faits saillants :**

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

A CIS report was submitted to the Director for a fall that occurred on a specific date in the winter of 2015, when resident #020 was taken to hospital and which resulted in a significant change in the resident's health status. The report also identified that the resident stated they fell and hit a body part on a dresser while going to the washroom and had experienced a significant number of falls in the several months prior to the fall on the specific date in the winter of 2015. The CIS report identified that, at the time of the fall, resident #020 did not use a specific type of fall prevention equipment due to the resident's actions related to the equipment, the resident used a mobility device with a different specific piece of fall prevention equipment, and required the assistance of staff for an aspect of use of the mobility device.

(a) A review of resident #020's care plan completed on a specific date in the fall of 2015, which was the current care plan at the time of the fall on a specific date in the winter of 2015, indicated that the resident used no assistive device for ambulation, that staff were to encourage the resident to use one specific assistive device from the bathroom to the bed, that the resident did not require the assistance of staff during a certain aspect of mobility and was able to independently perform one specific activity of daily living.

A review by Inspector #625 of resident #020's health care record included documentation which indicated that the resident required staff assistance for a specific aspect of mobility, used assistive devices for mobility and used a personal assistance services device (PASD) as follows:
- a physiotherapy quarterly assessment dated a specific date in the summer of 2015, that indicated the resident did not require staff assistance with two specific aspects of mobility using a piece of equipment, but that supervision with one specific aspect of mobility was recommended;
- a physiotherapy quarterly assessment dated a specific date in the summer of 2015, that identified that the resident did not require staff assistance with two specific aspects of mobility and used an assistive device for mobility;
- a progress note dated a specific date in the fall of 2015, that indicated the resident used an different assistive device for mobility;
- progress notes dated a specific date in the fall of 2015, that indicated the resident's mobility had decreased and staff spoke to the resident several times related to accessing staff assistance with one specific aspect of mobility and one specific activity; and
- a progress note dated a specific date in the fall of 2015, indicating that specific piece of fall prevention equipment was applied to the resident's mobility device to provide staff with time to assist the resident before the resident attempted to a certain aspect of mobility independently.

During an interview on April 8, 2016 with Inspector #625, RPN #116 stated that resident #020's care plan completed on a specific date in the fall of 2015 reflected that the resident used no assistive devices for ambulation, that the intervention had been initiated on a specific date in the spring of 2014, and had not been updated to reflect the resident's use of a specific mobility device in 2015, or the use of a different mobility device in the fall of 2015. The RPN stated that the use of the two mobility devices were listed elsewhere in the resident's health care record, in progress notes, which provided information that contradicted the care plan completed on a specific date in the fall of 2015, and in place at the time of the resident's fall on a specific date in the winter of 2015.

During an interview with Inspector #625 on April 11, 2016, ADOC #122 stated that, at the time of resident #020's fall on a specific date in the winter of 2015, the resident used assistive devices for mobility, specifically a two assistive devices, contrary to what was written in the care plan; that resident #020 did not complete a specific aspect of mobility independently as was listed in the care plan, but required the assistance staff; and that the resident did not perform one specific activity of daily living independently as was listed in the care plan, but required assistance of staff. The ADOC stated that the care plan had not provided clear direction to the staff with respect to the resident's use of an assistive device and mobility.

(b) A review by Inspector #625 of resident #020's care plan completed on a specific date in the spring of 2016, identified that, due to the resident's actions related to a specific piece of fall prevention equipment, the equipment could not be used for this resident. The same care plan also identified that the specific piece of fall prevention equipment was to be used for the resident.

During an interview with Inspector #625 on April 8, 2016, PSW #117 stated that resident #020 had used the specific piece of fall prevention equipment in the past, but as a result of the resident's actions related to the equipment, the use of the equipment had ceased.

During an interview with Inspector #625 on April 11, 2016, RPN #147 stated that the care plan intervention listing the use of the specific piece of fall prevention equipment for resident #020 should not have been entered as the resident was not using the equipment at that time.

During an interview with Inspector #625 on April 8, 2016, RPN #116 stated that the specific piece of fall prevention equipment was not used with resident #020 due to the resident's actions related to the equipment, and the intervention indicating that the resident used the equipment was confusing. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

A CIS report was submitted to the Director on a specific date in the winter of 2016. The report identified that resident #017 exhibited responsive behaviours, with two residents, on five occasions, from a specific date in the winter of 2016 to a specific date 16 days later.

A review by Inspector #625 of resident #017's flow sheets identified that an hourly safety intervention, where staff were required to document that the intervention was implemented with respect to resident #017, was initiated on a specific date in a specific month in the winter of 2016. Further review of the flow sheets indicated that the hourly intervention was not completed:
- two out of 24 times, seven days after the intervention was initiated, or eight per cent of the time;
- six out of 24 times, eight days after the intervention was initiated, or 25 per cent of the time;
- four out of 24 times, nine days after the intervention was initiated, or 17 per cent of the time;
- two out of 24 times, 13 days after the intervention was initiated, or eight per cent of the time; and
- six out of 24 times, 14 days after the intervention was initiated, or 25 per cent of the time.

During an interview with Inspector #625 on April 12, 2016, DOC #108 stated that not all hourly interventions were signed for by Personal Support Workers in resident #017's flow sheet report for a specific month in the winter of 2016. The DOC confirmed that, on two consecutive dates in the month, which were dates when incidents of inappropriate responsive behaviours involving resident #017 had occurred, the flow sheet did not contain documentation to indicate that the hourly intervention was completed. [s. 6. (9) 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 that there is a written plan of care for resident #020 that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

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

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible.

A CIS report was submitted to the Director on a specific date in the winter of 2016. The report identified three occasions of responsive behaviours that involved residents #018 and #017 on three separate dates, over a 15 day period.

Inspector #625 reviewed resident #018's health care record, including progress notes dated on four specific dates in the winter of 2016, that identified the resident had entered co-residents' rooms and, on three of the occasions, had been present during and/or engaged in inappropriate responsive behaviours involving resident #017.

A review of internal incident reports identified a report for an incident dated a specific date in the winter of 2016, that detailed inappropriate responsive beahviours exhibited towards resident #018 by resident #017 outside of the nursing station.

Resident Assessment Instrument - Minimum Data Set assessments completed on specific dates in the winter of 2015 and the spring of 2016, indicated that resident #018 exhibited responsive behaviours that were not easily altered.

A review by Inspector #625 of resident #018's care plans dated specific dates in the winter of 2015 and the spring of 2016, identified that both care plans contained no interventions related to the specific responsive behaviours exhibited by the resident.

The home's policy "Responsive Behaviours Management – VII-F-10.20" revised January 2015, was reviewed by Inspector #625 and indicated that registered staff would coach front line staff about interventions identified on resident care plans, and would strategize with them on additional interventions required, or on the effectiveness of interventions.

During an interview with Inspector #625 on April 12, 2016, ADOC #122 acknowledged that resident #018's care plan in place at the time of the incidents of abuse had not been updated in response to responsive behaviours exhibited by the resident that placed the resident at risk. The ADOC stated that there was nothing in place in resident #018's care plan related to any of the incidents that occurred in 2016 involving the resident.

During an interview with Inspector #625 on April 12, 2016, DOC #108 stated that resident #018's care plan had not been updated in response to the incidents that occurred on three specific dates in the winter of 2016, over a 15 day period. [s. 53. (4) (b)]

2. A CIS report was submitted to the Director on a specific date in the winter of 2016. The report identified two occasions of responsive behaviours that involved residents #022 and #017 on a specific date in the winter of 2016.

Inspector #625 reviewed resident #022's health care record, including two progress notes dated a specific date in the winter of 2016 and a specific date in the spring of 2016, 2016, that identified the resident had engaged in inappropriate responsive behaviours involving resident #017, including specific responsive behaviours in common areas of the home, in the presence of others.

A review by Inspector #625 of resident #022's care plan included an intervention initiated on a specific date in the winter of 2016, that indicated staff were to monitor the resident closely for inappropriate behaviour with co-residents. The intervention did not indicate what specific behaviour was being monitored, any strategies in place to reduce the occurrence of the inappropriate behaviour, or what staff were to do should inappropriate behaviour occur.

The home's policy "Responsive Behaviours Management – VII-F-10.20" revised January 2015, was reviewed by Inspector #625 and indicated that registered staff would coach front line staff about interventions identified on resident care plans, and would strategize with them on additional interventions required, or on the effectiveness of interventions.

During an interview with Inspector #625 on April 12, 2016, ADOC #122 stated that resident #022's care plan had not been updated with respect to the inappropriate responsive behaviours demonstrated by the resident.

During an interview with Inspector #625 on April 12, 2016, DOC #108 confirmed that the only update to resident #022's care plan had been completed on a specific date in the winter of 2016, to address a health condition and instructed staff to monitor the resident closely for inappropriate behaviour with co-residents. The DOC was not able to locate any interventions or strategies in the care plan that specifically addressed the inappropriate behaviours exhibited by the resident. [s. 53. (4) (b)]

3. A CIS report was submitted to the Director on a specific date in the summer of 2014, for an incident of resident to resident abuse involving resident #011 that occurred three days prior. The report indicated that resident #013 and resident #011 had an interaction where resident #013 sustained an injury. Refer to WN #5, finding two for additional details.

Inspector #625 reviewed resident #011's health care record including progress notes, that identified incidents of responsive behaviours exhibited by resident #011 towards other residents on four specific dates in the summer of 2014.

A review by the Inspector of the care plan for resident #011 effective a specific date in the fall of 2014, identified that an intervention related to resident #011's responsive behaviours exhibited towards other residents had been removed. The care plan contained three separate references to the resident's responsive behaviours, all of which were related to employee safety, none of which referenced interventions to maintain the safety of other residents in the home.

During an interview with Inspector #625 on April 21, 2016, Case Manager #131 stated that neither resident #011's care plan updated on a specific date in the spring of 2014, nor the care plan updated on a specific date in the winter of 2014, had been revised to meet the resident's needs related to responsive behaviours, that the care plans did not provide direction to the staff to provide care that the resident needed related to responsive behaviours, and that the care plan updated on a specific date in the winter of 2014, did not identify the interaction that occurred with the resident and other residents and the interventions needed to address them. [s. 53. (4) (b)]

***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, for residents #011, #018 and #022 demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home**

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

**s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:**
**2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and were kept closed and locked when they were not supervised by staff.

While touring the home, Inspector #625 observed doors leading to non-residential areas to be opened and unsupervised.

On April 11, 2016, Inspector #625 observed the door to the nursing station opened and unsupervised.

Inspector #625 interviewed Assistant Director of Care #122 about the door and they stated that the doors to nursing stations should be kept closed and locked when staff were not present.

On April 28, 2016, Inspector #625 observed the door to the nursing station opened and unsupervised for five minutes. The door was held open with a magnetic door stop and a hand written sign was posted on the door that read "door to remain closed when staff aren't available".

Inspector #625 interviewed Director of Care #108 about the door and they stated that the door to nursing stations should be kept closed and locked when staff were not in the nursing stations. [s. 9. (1) 2.]

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

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

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A CIS report was submitted to the Director for an incident of staff to resident abuse/neglect that occurred on a specific date in the winter of 2014. The report indicated that PSW #102 verbally and emotionally abused residents #005 and #006 and refused to provide required assistance to the residents.

Ontario Regulation 79/10 defines:
(a) emotional abuse as any threatening, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident;
(b) physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain;
(c) verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident; and
(d) neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Inspector #625 reviewed resident #006's care plan in place on the date of the incident. The care plan identified that resident #006 required the assistance of staff and the use of mobility equipment and an assistive device for a specific activity of daily living (ADL).

Inspector #625 reviewed the home's investigation file for the incident which included signed statements from resident #006 and several staff members who confirmed that abuse had occurred on the specific date of the incident. The statements indicated that PSW #102 refused to assist residents #005 and #006 with an ADL when the residents requested assistance, misused their authority and imposed restrictions on resident #006, called resident #005 derogatory names, used an "intimidating tone" when speaking to resident #005, removed resident #005's hands from a door handle and stated "In this job you have to use force", and yelled at resident #005.

The investigation file contained a summary table compiled by the home which identified that PSW #102 had been involved in additional incidents of abuse, neglect and improper care of residents on six previous occasions over a period of years. Records present detailed one inappropriate interaction with residents and three improper care incidents. Further, a letter of discipline dated a specific date in the winter of 2014, outlined that PSW #102 had not abided by the home's Resident Abuse and Neglect Policy with

respect to physical, verbal and emotional abuse, had violated the Residents' Bill of Rights, and had removed residents' decision-making power.

During an interview with Inspector #625, resident #006 stated that they recalled that PSW #102 had refused to toilet residents #005 and #006, that the resident had reported the PSW, and that the PSW had been generally disrespectful to the resident.

During an interview with Inspector #625 on April 28, 2016, DOC #108 stated that PSW #102 had abused residents #005 and #006 on a specific date in the fall of 2014, and had a history of abusing residents dating back years prior, as detailed in the home's investigation file. The DOC stated that the PSW had been issued specific discipline after the final report of staff to resident abuse involving PSW #102 that occurred on a specific date in the fall of 2014. [s. 19. (1)]

2. A CIS report was submitted to the Director on a specific date in the summer of 2014, for an incident of resident to resident abuse that occurred three days prior. The report indicated that resident #013 and resident #011 had an interaction where resident #013 sustained an injury.

A review by Inspector #625 of resident #013's health care record included two progress notes dated a specific date in the summer of 2014, that contained the details identified in the CIS report. The progress notes indicated that resident #013 pointed at resident #011, identified resident #011 specifically by name, and stated that resident #011 had exhibited responsive behaviours towards resident #013 resulting in an injury.

A review of resident #011's health care records included progress notes that identified incidents of responsive behaviours had occurred by resident #011 towards other residents, prior to the incident that occurred in the CIS report as follows:
- during the month prior to the incident, when a resident was found injured and alleged that resident #011 exhibited responsive behaviours towards them;
- during the month of the incident, when resident #011 was accused by two co-residents to have exhibited responsive behaviours towards them; and
- during the month of the incident, when resident #011 exhibited responsive behaivours towards a co-resident.

Inspector #625 reviewed a table, compiled by the home, that listed six interactions involving resident #011 and other residents, five of which were not identified in the resident's progress notes. The interactions occurred prior to incident, between 11 and

one month prior to the incident. The table identified that resident #011 had exhibited specific responsive behaviours towards other residents.

Inspector #625 reviewed external referrals related to resident #011's responsive behaviours which included a summary dated a specific date in the fall of 2013, from an external consultant team, that indicated the consultation had occurred on a specific date in the fall of 2013 as the resident had a history of responsive behaviours.The summary indicated that the staff reported resident #011 was not exhibiting any responsive behaviours at that time. A summary dated the spring of 2015 from a second external consultant, indicated a consultation had occurred on on a specific date in the winter of 2015, to address responsive behaviours towards staff and co-residents and to aid in the management of inappropriate behaviour related to a specific resident. The summary identified that the resident's progress notes reflected that the number of incidents of a specific type of responsive behaviour, and the level of risk, had decreased as staff had become more familiar with the resident's triggers.

During an interview with Inspector #625 on April 28, 2016, Resident Relations Coordinator (RRC) #115 stated that resident #011 would exhibit responsive behviours to other residents, and that this had occurred with increasing frequency, until the resident was sent to hospital. The RRC stated that an external consultant had discharged resident #011 a specific date in the fall of 2013; and that an external consultant had been involved from a specific date in the fall of 2015 until a specific date in the winter of 2015. The RRC did not identify any external consultants contacted between the specific dates from the fall of 2013 to the spring of 2015, despite multiple incidents of interactions involving resident #011 during this period, and the resident's known history of responsive behaviours.

During an interview with Inspector #625 on April 28, 2016, DOC #108 stated that the residents involved in the incidents with resident #011 included several different residents. The DOC stated that they had been concerned about ongoing responsive behaviours exhibited by resident #011 and had identified, after a period of time, that when resident #011 exhibited certain actions, interventions were required. The DOC also identified that there were times when the resident exhibited responsive behaviours without any advanced warning. The DOC stated that the only external consultation that had occurred prior to the incident in the summer of 2014, was from an external consultant over 55 days in the fall of 2013. The DOC stated that consultation from one external consultants had occurred in the winter to spring of 2015, and from a second external consultant from the spring to summer of 2015. The DOC did not identify any external consultants contacted

between specific dates in the the fall of 2013 and the winter of 2015, despite multiple incidents of interactions involving resident #011 during this period, and the resident's known history of responsive behaviours.

A review by Inspector #625 of resident #011's care plan in effect for the period of time from a specific date in the summer of 2014 to a specific date in the fall of 2014, identified four separate references to the resident's responsive behaviours. Three of the references were related to staff interactions with the resident. One of the references contained an intervention, located under an unrelated focus, that provided direction to staff related to resident #011's responsive behaviours and ensuring the safety of other residents. The intervention had been added to the care plan, six days after the incident identified in the CIS report, despite the resident's documented history of responsive behaviours exhibited towards residents prior to that date. The care plan focus that identified the resident exhibited a behaviour, related to a history of responsive behaviours, did not include interventions to ensure the safety of other residents in the home.

A review by the Inspector of the care plan effective a specific date in the fall of 2014, identified that the incorrectly placed intervention related to resident #011's responsive behaviours exhibited towards residents had been removed. The care plan contained three separate references to the resident's behaviours, all of which were related to employee safety, none of which referenced interventions to maintain the safety of other residents in the home.

During an interview with Inspector #625 on April 21, 2016, Case Manager #131 confirmed that the incident occurred on a specific date in the summer of 2014, and stated that, neither the care plan effective on a specific date in the summer of 2014, nor the care plan effective on a specific date in the fall of 2014, had been revised to meet the resident's needs with respect to the behaviours detailed in the CIS report. The Case Manager also stated that the care plan updated on the specific date in the fall of 2014, did not identify the interactions that occurred with the resident and other residents, and the interventions needed to address these interactions. [s. 19. (1)]

3. A CIS report was submitted to the Director on a specific date in the summer of 2014, for an incident of resident to resident abuse involving resident #011. Refer to WN #5, finding two for additional details.

During a review of resident #011's health care record by Inspector #625, a progress note was reviewed dated a specific date in the summer of 2015, that indicated a PSW

witnessed residents #011 and #042 appearing to engage in a specific activity. The PSW called an RPN for assistance and the RPN. The staff removed resident #042 from the area and took resident #011 to their room and assisted the resident. The progress note indicated that the RPN informed RN #143 of the incident.

Inspector #625 identified relevant components which preceded this incident as follows:

(a) A review of resident #011's health care record identified a pattern of inappropriate responsive behaviour involving residents #011 and #042 that occurred prior to, and after, the incident that occurred in the summer of 2015, which included:
- an assessment from an external consultant dated a specific date in the winter of 2015, that identified a referral to another consultant was made to develop interventions related to inappropriate responsive behaviours including multiple incidents of witnessed inappropriate behaviours, including where resident #042 sought out resident #011 to the extent that resident #042 caused resident #011 to become irritated;
- a progress notes from an external consultant dated a specific date in the spring of 2015, that identified staff observed resident #042's exhibiting inappropriate responsive behaviours towards resident #011's, while the two residents were outside of the dining room; and
- progress notes that detailed resident #011's interactions with resident #042 including on four specific dates over a 14 day period, in the summer of 2015, when inappropriate responsive behaviours occurred.

(b) A review of resident #011's health care record identified that the resident had a specific heath condition and included:
- a RAI-MDS assessment completed in the fall of 2015 that indicated resident #011 had certain characteristics related to their health condition;
- a progress note from an external consultant dated a specific date in the summer of 2015, that indicated resident #011 had a specific health condition; and
- an assessment from an external consultant dated a specific date in the winter of 2015, that stated resident #011 had specific diagnosis and level of cognitive functioning.

During an interview with Inspector #625 on April 28, 2016, Resident Relations Coordinator (RRC) #115 reviewed the MOHLTC Licensee Reporting of Sexual Abuse Decision Tree and stated that resident #011 was not capable, could not consent to a specific activity, would have no ability to understand the process of engaging in a specific activity, and would not know who to seek out to engage in such activity. The RRC also stated that resident #042 could not consent to the activity, follow through on the thought

process of engaging in the activity, that the resident had instigated a specific activity with resident #011 and that the resident continued to attempt to engage in a specific activity with others.

During an interview with Inspector #625 on April 28, 2016, DOC #108 stated that neither resident had the capacity to consent to a specific activity that occurred on the specific date in the summer of 2015.

(c) A review of resident #011's health care record identified that the resident exhibited behaviours which made them vulnerable and required intervention by staff which included:
- an assessment from an external consultant dated a specific date in the winter of 2015, that indicated resident #011's room was located beside resident #042's room resulting in the two residents often in close proximity of each other and the staff's efforts to manage the behaviours which consisted of redirecting the resident away from one another;
- a progress note from an external consultant dated a specific date in the summer of 2015, that indicated resident #011 exhibited a specific responsive behaviour, and that staff continued to redirect the residents;
- progress notes that identified resident #011 exhibited a specific responsive behaviour over the summer of 2015; and
- a Resident Assessment Instrument (RAI)-Minimum Data Set (MDS) assessment completed in the fall of 2015, that indicated resident #011 exhibited respoonsive behaivours that were not easily altered.

A review by Inspector #625 of resident #011's care plans effective on specific dates in the summer and fall of 2015, identified no interventions related to the resident's specific responsive behaviours included in any of the care plans.

During an interview with Inspector #625 on April 28, 2016, DOC #108 stated that staff tried to keep residents #011 and #042 separated but resident #011 exhibited a specific responsive behaviour which made that difficult.

Inspector #625 also identified that staff who discovered and responded to the incident of abuse that occurred on a specific date in the summer of 2015, involving residents #011 and #042, did not identify or respond to the incident as outlined in the home's abuse policy.

The home's policy "Prevention of Abuse & Neglect of a Resident – VII-G-10.00", last

revised January 2015, indicated that:
- if an employee witnessed an incident, or had any knowledge of an incident, that constituted resident abuse or neglect, they were to immediately inform the Charge Nurse in the home.
- the Charge Nurse was required to then provide support to the staff member to immediately notify the Ministry of Health and Long-Term Care (MOHLTC) using the ACTION Line outside of normal business hours;
- the Charge Nurse was required to inform the substitute decision-maker or family member immediately of the alleged abuse if the incident caused harm, pain, or distress to the resident, or within 12 hours for all incidents.

During an interview with Inspector #625 on April 28, 2016, PSW #151 confirmed witnessing residents #011 and #042 engaged in a specific activity, in another resident's bathroom, while resident #011 sat on the toilet. The PSW stated that they did not know what reporting was done with respect to this incident, and that they had not recognized it as a specific type of abuse at the time of the incident as they thought that the specific type of abuse was when someone forced themself on another person.

During an interview with Inspector #625 on April 28, 2016, RN #143 stated that they did not recognize the incident as abuse at the time that it occurred as both residents exhibited certain cognitive traits and neither resident set out to intentionally abuse the other in a specific way. During the interview, the Inspector questioned RN #143 regarding the Charge Nurse's role in responding to reported abuse. The RN was not able to locate the home's abuse policy independently or the Ministry of Health and Long-Term Care Reporting of Abuse decision trees to respond to the Inspector's questions related to the role of the Charge Nurse in responding to resident abuse. The RN stated that they would recognize physical abuse involving resident #011 and that the home's policy "Prevention of Abuse & Neglect of a Resident" referred to "general abuse" and not "sexual abuse" specifically. The RN acknowledged that they had not adhered to the home's abuse policy, including phoning the ACTION line and notifying resident #011's family as the policy indicated was required.

During an interview with Inspector #625 on April 28, 2016, DOC #108 stated that the incident between residents #011 and #042 that occurred on  a specific date in the summer of 2015, constituted abuse as per the MOHLTC Licensee Reporting of Sexual Abuse Decision Tree and the definition of sexual abuse in Ontario Regulation 79/10. The DOC stated that neither resident had been able to consent to the specific activity that occurred, and that the Charge Nurse should have adhered to the home's abuse policy

when they were notified of the abuse. [s. 19. (1)]

4. A CIS report was submitted to the Director on a specific date in the winter of 2015, related to an incident of verbal abuse of resident #008 by PSW #103 that was witnessed by the visiting external consultant team and reported to the Assistant Director of Care the day before the report was submitted to the Director.

Ontario Regulation 79/10 includes in the definition of verbal abuse, any form of verbal communication of a threatening or intimidating nature, or any form of verbal communication of a belittling or degrading nature, which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident. Emotional abuse is defined as any threatening, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A review by Inspector #621 of the home's internal investigation identified that the visiting external consultant team witnessed incidents on three separate days, over a 13 days period in the winter of 2015, as follows:
- during breakfast PSW #103 was observed speaking to resident #008 in a loud, short and aggressive tone when the resident was sleeping at the dining room table;
- during lunch PSW #103 called resident a derogatory name while passing the resident in the dining room;
- during lunch resident #008 was observed attempting to speak with PSW #103 in a manner loud enough to hear across the dining room, and PSW #103 did not respond and acted as though they did not hear the resident;
- during lunch resident #008 was not offered show plates;
- during lunch the resident attempted to speak with PSW #013 and, when they asked if they were being served last that day, PSW #103 responded "Yes, you are. Are you surprised you're served last the way you are always bugging people. You should always be served last"; and
- during lunch when resident #008 was observed eating quickly, PSW #103 was reported to have said "Are you sure you couldn't shovel anymore in there?".

The investigation file also identified that, on February 10, 2015, the home interviewed RPN #114, nursing student #129, PSW #101 and PSW #104 who had worked on the three dates that the abuse was witnessed. These interviews documented in the investigation file verified that:
- RPN #114 witnessed PSW #103 raise their tone of voice and become rude when

speaking with resident #008, and not present show plates at meal times to the resident;
- nursing student #129 witnessed PSW #103 speak in a rude, aggressive and short tone of voice with the resident;
- PSW #101 witnessed PSW #103 never offer the resident show plates at meals; and
- PSW #104 witnessed PSW #103 be rude to the resident often, and purposely ignore the resident when the resident spoke to the PSW.

The investigation file also contained an interview with PSW #103 and the home's management, where the PSW acknowledged that they had already been spoken to about their tone of voice with residents, and that they ignored resident #008.

The results of the home's internal investigation found that PSW #103's actions constituted verbal and emotional abuse to resident #008, and that that abuse had occurred on multiple occasions, was witnessed by multiple staff, and that the resident had endured the abuse until an external consultant intervened and reported the abuse to the home.

A review of PSW #103's employee file identified six previous incidents of abuse towards residents for which PSW #103 received various levels of discipline. The file identified that PSW #103 had threatened to assault, verbally abused, persistently verbally abused, force fed and intimidated residents dating back over a significant period of time. Further, on a specific date in the winter of 2015, PSW #103 received disciplinary action for being rude, intimidating, belittling, ignoring and not treating all residents equally, which the home identified as emotional abuse, verbal abuse and neglect of residents.

During an interview with ADOC #122, they reported to Inspector #621 that their expectations with respect to the treatment of residents by staff within the home, was that every resident had the right to be protected from abuse. The ADOC reported that results of the investigation identified that staff from the visiting external consultant team and four unit staff witnessed several incidents of PSW #103 verbally and emotionally abusing resident #008.

No further action will be taken in regards to this non-compliance as there is currently an outstanding compliance order from Critical Incident Inspection #2016_298557_0004 related to s.19. (1). [s. 19. (1)]

**WN #6: 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 substitute decision-maker and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially have been detrimental to the resident' s health or well-being.

A CIS report was submitted to the Director on a specific date in the summer of 2014, for an incident of resident to resident abuse involving resident #011.

During a review of resident #011's health care record by Inspector #625, a progress note dated a specific date in the summer of 2015 was identified, that indicated that PSW #151 witnessed residents #011 and #042 as the PSW walked into a bathroom, that the residents appeared to be engaged in a specific activity, that the PSW called RPN #157 for assistance at 1945 hours. The note also indicated that RPN #157 informed RN #143 of the incident and that the RN stated "management can inform both parties family tomorrow morning". A progress note dated the day after the incident at 1151 hours, indicated that RPN #156 contacted resident #011's substitute decision-maker to inform them of the incident that occurred the previous day.

During an interview with Inspector #625 on April 28, 2016, RN #143 stated that because of the sensitivity of the incident, notification of resident #011's substitute decision-maker would be done by the home's Social Worker who had the skill set to notify families. When asked who was notified of the incident and how, the RN stated that they did not know who was notified of the incident and how, but believed they would have informed the nurse on the night shift, who would have informed the nurse on the day shift, who would have informed management to make the required notification. [s. 97. (1) (b)]

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

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

**s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):**
**2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).**

**s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:**
**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. 107 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as was possible in the circumstance, of an unexpected or sudden death, including a death resulting from an accident or suicide.

Inspector #625 reviewed a CIS report which was submitted to the Director on a specific date in the fall of 2014 at 1653 hours, 26 hours after an unexpected death occurred. The report indicated that resident #019 was found deceased at 1430 hours on the date before the report was submitted, two hours after a choking incident occurred in the dining room.

A review of reports submitted to the Director, made through the After Hours Pager, uncovered no record of a report submitted to the Director related to resident #019's unexpected death on a specific date in the winter of 2014. [s. 107. (1) 2.]

2. The licensee has failed to make a report to the Director in writing, informing the Director of an unexpected or sudden death, including a death resulting from an accident or suicide, within 10 days of becoming aware of the incident, or sooner if required by Director, that included specified criteria. The criteria required in the report included analysis and follow-up action, including the immediate actions that had been taken to

prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence.

Inspector #625 reviewed a CIS report which was submitted to the Director for an unexpected death that occurred on a specific date in the winter of 2014. The report indicated that, during a meal, resident #019 turned grey in colour and was not able to clear oral secretions independently. The resident was moved to the television room by staff for monitoring and, two hours after the incident in the dining room, a PSW found the resident deceased. The report was amended on 57 days after the incident occurred, and the home's responses to the questions of "What immediate actions have been taken to prevent recurrence?" and "What long-term actions are planned to correct this situation and prevent recurrence?" were "N/A" and "Awaiting [medical investigation and report]", respectively.

During interviews by Inspector #625 with RPN #114 and Assistant Director of Care #122, it was determined that no formal monitoring of resident #019 occurred between the time of the choking incident and the time the resident was found deceased two hours later, but that formal monitoring and ongoing assessment of the resident's status should have occurred. This information was applicable to include in the report to the Director as an immediate action that was taken to prevent recurrence, but was not submitted in the report within 10 days, or at the time of the final amendment to the report, 57 days after the incident.

During an interview with Inspector #625 on April 4, 2016, DOC #108 stated that the home did not have a copy of the death certificate or medical investigation reports, despite the CIS report indicating that completion of long-term actions to correct the situation and prevent recurrence were awaiting the investigation and reports. The home had not submitted to the Director long-term actions planned to correct the situation and prevent recurrence within 10 days. Further, 17 months following the incident, the report continued to indicate that completion of long-term actions to correct the situation and prevent recurrence was awaiting these reports. [s. 107. (4) 4.]

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**

**Issued on this 23rd day of October, 2016**

**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

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|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | KATHERINE BARCA (625), JULIE KUORIKOSKI (621), SHEILA CLARK (617) |
| **Inspection No. / No de l'inspection :** | 2016_433625_0005 |
| **Log No. / Registre no:** | 002738-14, 003662-14, 007319-14, 007904-14, 008177-14, 008363-14, 008374-14, 002402-15, 004009-15, 015871-15, 033868-15, 035733-15, 007431-16 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Oct 21, 2016 |
| **Licensee / Titulaire de permis :** | 2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 INVESTMENT LP<br>302 Town Centre Blvd., Suite #200, MARKHAM, ON, L3R-0E8 |
| **LTC Home / Foyer de SLD :** | Muskoka Shores Care Community<br>200 KELLY DRIVE, GRAVENHURST, ON, P1P-1P3 |
| | Angela Coutts |

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

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

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To 2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 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) (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 shall ensure that, without in any way restricting the generality of the duty provided for in section 19, 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.

Specifically, the licensee shall ensure that the home's staff are knowledgeable as to their role(s) in responding to and reporting alleged, suspected or witnessed resident abuse or neglect.

**Grounds / Motifs :**

1. The licensee has failed to ensure that, without in any way restricting the generality of the duty provided for in section 19, there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with.

A Critical Incident System (CIS) report was submitted to the Director on a specific date in the summer of 2014, related to an incident of alleged verbal abuse of resident's #001, #002 and #003 by RPN #100. The report identified that, four days prior to the submission of the report, PSW #160 overheard RPN #100 yell and witnessed resident #002 report to PSW #161 that RPN #100 had yelled at and been mean to residents #002 and #003. The report also identified that resident #003 was told by a PSW to report their concerns to the office.

The home's policy "Abuse and Neglect Resident – V3-010" revised April 2013, was in place on the specific date in the summer of 2014, and indicated that all

employees, volunteers, agency staff, private duty caregivers, contracted service providers, residents and families were required to immediately report any suspected or known incident of abuse or neglect to the Director of the Ministry of Health and Long-Term Care and the Director of Administration [the current the Executive Director position] or designate in charge of the home. The policy also indicated that the Charge Nurse was to document the current resident status on the resident's record.

During an interview with the DOC, they stated that they believed they were notified by a letter written to the DOC by PSW #160. The DOC stated that the RN on duty had also been made aware of the incident at the time it occurred and attended the unit. The DOC acknowledged that the home's staff did not follow the home's abuse policy related to notification of the ED or reporting to the Director.

During an interview on April 21, 2016 with Inspector #621, the Executive Director confirmed that staff had not followed the home's abuse policy with respect to notification of the appropriate ED designate or the Director. (625)

2. A CIS report was submitted to the Director on a specific date in the summer of 2014, for an incident of resident to resident physical abuse that occurred three days prior involving resident #011.

Inspector #625 reviewed the home's policy "Abuse and Neglect Resident – V3-010" revised April 2013, which was in place on the specific date in the summer of 2014, and identified that:
- all residents had the right to dignity, respect, and freedom from abuse and neglect, the organization had zero tolerance of resident abuse and neglect, and abuse and neglect were not tolerated in any circumstance by anyone;
- if any employee witnessed an incident, or had knowledge of an incident, that constituted resident abuse or neglect, all staff were responsible to immediately stop the abusive situation and intervene immediately; remove the resident from the abuser of remove the abuser from the resident; and immediately inform the Director of Administration [the current Executive Director position] and/or Charge Nurse;
- the Charge Nurse would provide support to the staff member to immediately notify the Ministry of Health and Long-Term Care using the ACTION Line outside of normal business hours;
- the Charge Nurse would inform the Power of Attorney for Care of family

member immediately of the alleged abuse if the incident caused harm, pain, or distress to the resident, or communicate with the families within 12 hours for all incidents; and
- the Charge Nurse was to check the resident's condition to assess safety, emotional and physical well-being and document the current resident status on the resident's record.

During a review of resident #011's health care record by Inspector #625, a progress note dated a specific date in the summer of 2015 was identified, that indicated that PSW #151 witnessed residents #011 and #042 as the PSW walked into a bathroom, that the residents appeared to be engaged in a specific activity, that the PSW called RPN #157 for assistance at 1945 hours. The note also indicated that RPN #157 informed RN #143 of the incident and that the RN stated "management can inform both parties family tomorrow morning".

During an interview with Inspector #625 on April 28, 2016, RN #143 referred to the home's current policy "Prevention of Abuse & Neglect of a Resident – VII-G-10.00" last revised January 2015, which was consistent with relevant aspects of the home's policy "Abuse and Neglect Resident – V3-010" revised April 2013. From the current policy, RN #143 determined that the RN's role as Charge Nurse included providing support to a staff member in reporting abuse to the Director. The RN stated that the policy indicated that the staff member was to call immediately but that the policy was related to "general abuse" and not "sexual abuse" specifically. When Inspector #625 asked the RN about meeting the timelines for reporting to the resident's substitute decision-maker or family, RN #143 stated that the home's Social Worker had the skill set to notify families and that "we pass something this sensitive to them with their skill". The RN stated that the families would have been notified by RN #143 who would have informed the nurse on the night shift, who would have informed the nurse on the day shift, who would have informed management to notify the families.

During an interview with Inspector #625 on April 28, 2016, the DOC #108 reviewed the MOHLTC Licensee Reporting Sexual Abuse decision tree and stated that the incident should have been reported to the Director by RN #143, the Charge Nurse at the time. The DOC also stated that the Charge Nurse's role should have been followed as detailed in the home's policy, and not deferred for management to fulfill the next day. (625)

3. A CIS report was submitted to the Director for an incident of staff to resident

abuse/neglect that occurred on a specific date in the fall of 2014. The report indicated that PSW #102 verbally and emotionally abused residents #005 and #006 and refused to provide required assistance to the residents.

Inspector #625 reviewed the home's policy "Abuse and Neglect Resident – V3-010" revised April 2013, which was in place on the specific date in the fall of 2014, and identified that:
- all residents had the right to dignity, respect, and freedom from abuse and neglect, the organization had zero tolerance of resident abuse and neglect, and abuse and neglect were not tolerated in any circumstance by anyone;
- if any employee witnessed an incident, or had knowledge of an incident, that constituted resident abuse or neglect, all staff were responsible to immediately stop the abusive situation and intervene immediately; remove the resident from the abuser of remove the abuser from the resident; and immediately inform the Director of Administration [the current Executive Director position] and/or Charge Nurse; and
- the Charge Nurse was then to check the resident's condition to assess safety, emotional and physical well-being and document the current resident status on the resident's record.

Inspector #625 reviewed the home's investigation file for the incident which identified, from several sources, that PSW #102 refused to assist residents #005 and #006 with personal care when the residents requested assistance, misused their authority and imposed restrictions on resident #006, called resident #005 names, used an "intimidating tone" when speaking to resident #005, removed resident #005's hands from a door handle and stated "In this job you have to use force", and yelled at the resident #005.

The investigation file identified that PSW #149 was present during the incidents that occurred on the specific date in the fall of 2014, and witnessed PSW #102 repeatedly abuse and neglect resident #005.

During an interview conducted by Inspector #625 on April 28, 2016, DOC #108 confirmed that PSW #102 abused and neglected residents #005 and #006 as outlined in the home's investigation file. When questioned by Inspector #625, the DOC stated that PSW #149 reported the abuse to the DOC the same day that it had it occurred. The DOC did not indicate that the PSW immediately stopped the abuse and intervened, or immediately reported the abuse to the Executive Director and/or Charge Nurse as outlined in the home's policy. The DOC #108

also acknowledged that the incident and follow-up were not documented in the resident's record in the progress notes, but that it should have been as was indicated in the home's policy. (625)

4. A CIS report was submitted to the Director one day after an incident was reported to the home in the winter of 2016, and was related to an incident of verbal abuse of resident #008 by PSW #103. The incident was witnessed by a visiting external consultant team and was reported to the Assistant Director of Care by the team one day after the incident occurred.

The home's policy "Prevention of Abuse & Neglect of a Resident – VII-G-10.00" revised January 2015, indicated that all employees, volunteers, agency staff, private duty caregivers, contracted service providers, residents and families were required to immediately report any suspected or known incident of abuse or neglect to the Director of the Ministry of Health and Long-Term Care and the Executive Director or designate in charge of the home.

A review by Inspector #621 of the home's internal investigation identified that the visiting external consultant team witnessed incidents of abuse from PSW #103 to resident #008 on three specific dates during the winter of 2015, which occurred within an eight day period, and notified the home's management of the incidents one day after witnessing the third incident. The investigation file also identified that RPN #114, nursing student #129, PSW #101 and PSW #104 had witnessed the abuse of resident #008 by PSW #103 on these dates, but had not reported or acted on the witnessed abuse at the time of each occurrence.The results of the home's internal investigation found that PSW #103's actions constituted verbal and emotional abuse to resident #008, and that that abuse had occurred on multiple occasions, was witnessed by multiple staff, and that the resident had endured the abuse until an external consultant intervened and reported the abuse to the home.

During an interview with Inspector #621 on April 27, 2016, ADOC #122 confirmed that the home's staff had witnessed the abuse of resident #008 on the three specific dates during the winter of 2015, and had not notified the Director or the home's Executive Director or designate at the time of the abuse, but should have. (625)

5. A CIS report was submitted to the Director for an incident of verbal abuse of resident #008 by PSW #153 which occurred on a specific date in the fall of

2015. The report identified that PSW #153 spoke profanely to resident #008.

Ontario Regulation 79/10 defines verbal abuse as any form of verbal communication of a threatening or intimidating nature, or any form of verbal communication of a belittling or degrading nature, which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

The home's policy "Prevention of Abuse & Neglect of a Resident – VII-G-10.00" revised January 2015, provided that all residents had the right to dignity, respect and freedom from abuse and neglect, and that abuse and neglect would not be tolerated in any circumstance by anyone.

A review of the home's investigation notes by Inspector #621 identified that PSWs #123 and #124 observed PSW #153 offer resident #008 menu choices for the supper meal. The documentation indicated that the resident stated that they did not need to choose one of the options presented because they had their own meal already chosen. It was also recorded that, when PSW #153 looked into the issue with the dietary staff and was told that the resident had their own diet, PSW #153 was overheard making a profane statement towards the resident. The home determined, from its investigation, that the PSW had verbally abused resident #008.

A review of the employee file for PSW #153 identified a letter dated five days after the incident of verbal abuse in the fall of 2015, which confirmed that verbal abuse had occurred on the specific date in the fall of 2015, when PSW #153 made a profane statement towards resident #008, as confirmed by two witnesses.

During an interview with DOC #108, they reported to Inspector #621 that their expectation with respect to the treatment of residents by staff within the home, was that every resident had the right to be protected from abuse. DOC #108 reported that results of the investigation determined that two staff witnessed PSW #153 verbally abuse resident #008, and PSW #153 admitted that they spoke to resident #008 with language that would constitute verbal abuse.

The decision to issue a compliance order was based on the severity which resulted in actual harm. The scope demonstrated a pattern of occurrence involving eight residents. The home does not have a compliance history in this

area. (625)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Nov 30, 2016

## 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 21st day of October, 2016**

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

**Name of Inspector /**
**Nom de l'inspecteur :** Katherine Barca

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