Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Apr 22, 2020	2019_780699_0025 (A3)	001618-18, 028400-18, 012635-19, 013723-19, 016672-19, 016673-19, 018409-19, 019349-19, 019506-19, 019508-19, 019818-19, 019819-19, 020570-19, 020750-19, 021421-19, 023109-19	Critical Incident System

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

Midland Gardens Care Community
130 Midland Avenue SCARBOROUGH ON M1N 4E6

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

Amended by PRAVEENA SITTAMPALAM (699) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance order #002 due date changed to July 31, 2020.

Issued on this 22nd day of April, 2020 (A3)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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

Amended by PRAVEENA SITTAMPALAM (699) - (A3)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 19-22, 25-29, December 2-6, 9-11, 2019.

The following Critical Incident System (CIS) intakes were inspected during this inspection:

-Log #019818-19 (CIS 2789-000107-19): related to multiple resident neglect;

-log #020750-19 (CIS 2789-000111-19): related to staff to resident sexual abuse;

-log #019819-19 (2789-000108-19), 013723-19 (no CIS): related to staff to resident verbal abuse;

-log #028400-18 (CIS 2789-000094-18), 001618-18 (CIS 2789-000004-18): related to financial abuse;

-log #019349-19 (CIS 2789-000103-19), 023109-19 (CIS 2789-000119-19): related to unexpected death;

-log #016672-19 (2789-000090-19), 020570-19 (2789-000112-19), 018409-19 (2789-000099-19): related to resident to resident abuse; and

-log #016673-19 (2789-000089-19), 019506-19 (2789-000105-19), 019508-19 (2789-000106-19), 012635-19 (2789-000074-19), 021421-19 (2789-000113-19): related to staff to resident physical abuse.

A Compliance Order (CO) related to LTCHA, 2007, c.8, s. 6 (7), identified in concurrent inspection 2019_780699_0024 (Log #019507-19, 022259-19) will be issued in this report.

A VPC under LTCHA, 2007, s. 23 (1)(a), identified in concurrent inspection 2019_780699_0024 (log #019507-19, 022259-19) will be issued in this report.

A Written Notification (WN) under LTCHA, 2007, s. 24 (1), identified in concurrent inspection 2019_780699_0024 (log #019507-19, 022259-19) will be issued in this report.

A WN under O.Reg 79/10, r. 8 (1)(b), identified in concurrent inspection 2019_780699_0024 (log #014792-19) will be issued in this report.

A VPC under O.Reg 79/10, r. 50 (2) (b) (iv), identified in this inspection (log # 020570-19) will be issued under Complaint inspection 2019_780699_0024 concurrently inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Interim ED, Director of Care (DOC), and Assistant Director of Care (ADOC); and, Nurse managers (NM), Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Dietitian (RD), Director of Environmental Services (ES), Personal Support Workers (PSW), residents, substitute decision makers (SDM) and family members.

During the course of the inspection, the inspector(s) conducted observation of staff and resident interactions and the provision of care, reviewed resident health records, staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Snack Observation

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

- **11 WN(s)**
- **2 VPC(s)**
- **5 CO(s)**
- **1 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 O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the substitute decision-makers (SDMs) for residents #033, #042, #043, and #045 were notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

a. A CIS report was submitted to the Director related to an allegation of neglect that involved residents #033, #042, and #043. The CIS report indicated that all three residents' SDMs were notified of the incident.

The progress notes were reviewed for residents #033, #042, and #043, which indicated that all three residents' SDMs had been notified of the incident, but there were no notes that indicated that they had been notified of the results of the investigation related to the alleged neglect.

The investigation file was reviewed, and no notes were identified in the investigation file that indicated that any of the residents' SDMs had been notified of the results of the investigation.

ADOC #134 was interviewed and indicated that they were responsible for the investigation into the allegations of neglect that involved residents #033, #042, and #043. They confirmed that the investigation was completed. The ADOC confirmed that none of the residents' SDMs had been notified of the results of the investigation immediately upon its completion.

b. A CIS report was submitted to the Director which indicated that there was a suspicion of staff-to-resident physical abuse involving PSW #154.

The CIS report indicated that the resident's SDM was notified of the suspected abuse.

ADOC #134 was interviewed and verified that an investigation was initiated. The ADOC also indicated that they conducted the investigation, along with Interim ED #130, and that the investigation was concluded. They confirmed that at the time of this inspection, resident #045's SDM had not been notified of the results of the investigation. [s. 97. (2)]

Additional Required Actions:

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

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

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 the policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's Prevention of Abuse and Neglect of a Resident policy, Policy # VII-G-10.00, Current Revision: April 2019, was reviewed, and indicated the following:
-All team members are required to report immediately any suspected or known incident of abuse or neglect to the provincial health authorities and the Executive Director or designate in charge of the care community;
- the Executive Director or designate, at the time of immediate notification, initiates 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 is also asked to write, sign, and date a statement of the

event;
- the written statements are obtained as close to the time of the event as possible; and
- the Executive Director or designate interviews the resident, other residents, and/or persons who may have any knowledge of the situation.

a. A CIS report was submitted to the Director related to an allegation of neglect involving residents #033, #042, and #043 that occurred during a specific shift.

Review of the home's staff schedule for a specific date, indicated the following:
- PSWs #131 and #132 worked the shift on the unit where the three residents resided; PSW #131 was assigned to provide care to residents #033 and #042, and PSW #132 was assigned to provide care to resident #043.
- PSWs #146 and #133 worked a shift on the unit where the three residents resided; PSW #146 was assigned to provide care to residents #033 and #042, and PSW #133 was assigned to provide care to resident #043.
- RPN #162 was the charge nurse during the one shift shift, and RN #120 was the charge nurse during the another shift.
- RN #135 was the nurse manager on duty during a different shift.

RN #120 was interviewed and confirmed that they were the charge nurse working on the unit where residents #033, #042, and #043 resided during a specific shift. They confirmed that PSWs #133 and #146 notified them that the residents' incontinence products were soiled at the beginning of their shift. They acknowledged that the PSWs were concerned that the resident had been neglected during the shift before, and indicated that they notified RN #135, the nurse manager on duty, of the alleged neglect. RN #135 confirmed during an interview that they were notified of the alleged neglect and reported it to the MLTC via the after-hours InfoLine.

The investigation documentation was reviewed and included three separate typed interview notes for interviews with PSWs #131, #132, and #133. Inspector #722 did not identify any written statements in the investigation file by any staff who may have been aware of or involved in the situation, including PSWs #131 and #132. There was also no documentation related to interviews with RPN #162, RN #120, or RN #135.

ADOC #134 confirmed during an interview that they were responsible for conducting the investigation related to the allegation of neglect towards residents

#033, #042, and #043. They also confirmed that they did not interview staff who would have had knowledge of the incident, including PSW #146, RPN #162, RN #120, and RN #135.

b. A CIS report was submitted to the Director which indicated that there was a suspicion of staff-to-resident physical abuse involving PSW #154.

Review of the CIS report, progress notes, and the home's incident reports indicated that PSW #154 notified RPN #117 of an altered skin integrity above resident #045's identified part of their body. On another day, PSW #155 notified RN #145 of a larger altered skin integrity on resident #045's identified part of their body. RN #145 completed a head-to-toe assessment, completed an incident report, and notified former DOC #101 who also assessed the resident and identified an additional altered skin integrity on different part of the resident's body.

The investigation file related to this incident was provided by the home, and included the typed notes from four separate staff interviews, where interim ED #130 interviewed PSW #154, RPN #117, RN #145 and PSW #155. ADOC #134 was also present for the meetings with PSW #154 and RPN #117.

The investigation file did not include any written, signed, and dated statements by any staff identified in the CIS report related to this incident, including PSW #154. There were no other interviews identified for any staff on any other shifts between a specific period of time.

The ADOC indicated that they and Interim ED #130 were responsible for the investigation. They confirmed that they did not interview all staff who may have had knowledge of an incident of physical abuse toward resident #045. Specifically, they indicated that the abuse could have occurred over the weekend prior to the identified date and none of the weekend staff were interviewed.

The ADOC acknowledged that there were no written statements from any staff involved in the two incidents of suspected abuse and neglect described above because they thought that management were not permitted to request staff to write and sign statements about such incidents. The ADOC acknowledged that the home's Prevention of Abuse and Neglect of a Resident policy was not complied with.

Please refer to the grounds provided for Written Notification #8 issued pursuant to LTCHA, s. 23. (1).

Please refer to the grounds provided for Written Notification #9 issued pursuant to LTCHA, s. 24. (1). [s. 20. (1)]

Additional Required Actions:

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

(A3)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the development and implementation of resident #027's plan of care so that their assessments are integrated, consistent with and complement each other.

A CIS report was submitted to the Director regarding an altercation between residents #027 and #028. Review of the CIS report indicated that resident #028 was walking past resident #027, and resident #027 reached out and exhibited a responsive behaviour toward resident #028, resulting in an injury.

Review of resident #027’s clinical health record showed that resident #027 was cognitively impaired.

Review of resident #027’s progress notes showed that on two separate days, the resident a specific exhibited behaviour towards other residents.

Review of resident #027's care plan with full revision history had an intervention in place related to this identified responsive behaviour.

Review of the progress notes showed that the external consultant recommended additional interventions for the resident's behaviour.

Further review of the care plan and progress notes did not indicate that the above-mentioned recommendations by external consultant were implemented or alternate interventions were discussed with the interdisciplinary team.

In an interview with behavioural support outreach (BSO) nurse #115, they indicated that they would have huddles with the staff regarding residents with behaviours and discuss any recommendations or interventions to be implemented. They further indicated that it was the responsibility of the registered staff to implement the recommendations and they would follow up with staff.

In an interview with RPN #145 they indicated that resident #027's intervention was implemented, however if other resident's wander near the resident, the resident would still exhibit this behaviour. They indicated they were not aware of the external consultant's recommendations and stated that the BSO nurse would communicate any recommendations from the consultant to them. They indicated they were not aware of the BSO's recommendation until a specific date as the BSO nurse came to discuss it with them.

In an interview with ADOC #134, they indicated that for resident #027, there was a risk that resident #027 exhibit their responsive behaviour towards other residents. They further stated that they would determine whether or not the resident would require the above-mentioned recommendations and go through the appropriate assessments. ADOC #134 stated that the plan of care for resident #027 would have to be re-evaluated with different interventions for resident #027's behaviour. [s. 6. (4) (b)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #032, #033, #034, #037 and #016, as specified in the plan.

a. A CIS report related to a suspected incident of abuse of resident #032 was submitted to the Director.

Review of the CIS report and the home's investigation notes indicated that at the

beginning of a specific shift, resident #032 was exhibiting a specific responsive behaviour. PSW #123 tried to provide care to the resident twice without success. When PSW #123 observed resident #032 had a bowel movement, PSWs #123 and #124 changed the resident when the resident continued to exhibit their responsive behaviour. Resident #032 accidentally hit themselves during care which caused injury.

Review of the home's investigation notes showed that both PSW #123 and #124 stated that resident #032 was exhibiting specific responsive behaviours, and the resident hit themselves.

PSWs #123 and #124 were not available for interview as they were no longer working in the home at the time of the inspection.

Review of resident #032's care plan indicated staff to leave and re-approach the resident at a later time if the resident was exhibiting a specific responsive behaviour.

In an interview, ADOC #134 acknowledged staff should have left resident #032 and re-approach when the resident was exhibiting a specific responsive behaviour as indicated in the resident's care plan.

b. A CIS report related to a suspected incident of abuse of resident #033 was submitted to the Director.

Review of the home's investigation notes showed that PSW #123 stated that during the morning care in October 2019, resident #033 was exhibiting responsive behaviour, and the resident hit PSW #125 during care.

PSWs #123 was not available for interview as they were no longer working in the home at the time of the inspection.

In an interview, PSW #125 stated during care on October 2019, resident #033 was exhibiting responsive behaviours, and hit PSW #125 during care. PSW #125 further stated that they continued to provide care to resident #033.

Review of resident #033's care plan completed on August 2019, indicated that when the resident was exhibiting responsive behaviours, staff to leave the resident alone and re-approach at a later time to improve compliance.

In an interview, ADOC #134 acknowledged staff should have left resident #033 and re-approach when the resident was exhibiting responsive behaviours to care as indicated in the resident's care plan.

c. A CIS report related to a suspected incident of abuse of resident #034 was submitted to the Director.

Review of the CIS report indicated that an altered skin integrity was observed on a specific area of resident #034's body.

Review of the home's investigation notes showed PSW #123 stated that resident #034 was exhibiting responsive behaviour during care. RPN #126 stated they assisted PSWs #123 and #125 to change resident #034 as the resident was exhibiting responsive behaviour. Nurse Manger #129 stated RPN #126 told them resident #034 it was difficult to change them.

PSW #123 and RPN #126 were not available for interview as they were no longer working in the home at the time of the inspection.

In an interview, PSW #125 stated that resident #034 was cooperative during care on the identified date. PSW #125 stated they did not hit the resident causing the altered skin integrity on the body during care.

Review of resident #034's care plan indicated that staff are to leave and re-approach the resident at a later time if the resident was exhibiting responsive behaviour.

In an interview, ADOC #134 acknowledged staff should have left resident #034 and re-approached when the resident was exhibiting responsive behaviour as indicated in the resident's care plan.

d. The home reported an incident that involved resident #037 through the after hours emergency number to the Director. The home submitted a CIS report related to the improper/incompetent treatment to resident #037 to the Director.

Review of the CIS report and progress notes for resident #037, and an interview with RPN #152 indicated that PSW #153 reported to RPN #152 that earlier that morning, they observed resident #037 was covered with an identified substance.

PSW #153 changed the resident as they were concerned about the resident's skin condition. Resident #037 refused to be changed, and PSW #153 continued to clean the resident while the resident was exhibiting a responsive behaviour towards the PSW. PSW #153 told RPN #152 that they had to hold the resident's hand in order to clean the resident.

Review of resident #037's care plan indicated that the resident was compliant with care when cared for by their regular PSWs; if the resident was cared for by somebody the resident doesn't know, the resident may exhibit responsive behaviours. In addition, the resident tended to refuse care during the evening and night shifts so staff are to approach resident in a calm and gentle manner. Staff were also to negotiate time for providing care to the resident and return at agreed upon time.

In an interview, ADOC #134 stated that during the investigation, RPN #152 told ADOC #134 that in the morning, PSW #153 changed resident #037 because the resident was covered with an identified substance. PSW #153 also stated that they did not hold the resident's hand although the resident was exhibiting responsive behaviours during care.

In an interview, RPN #152 stated that when the day shift PSW greeted resident #037, the resident told the PSW that they didn't want to be changed, but the night PSW changed them. RPN #152 then went to assess the resident, and observed an altered skin integrity to a specific area of their body. RPN #152 further stated that the resident was exhibited a specific responsive behaviour and staff need to leave the resident and re-approach. RPN #152 further stated that if PSW #153 had reported to them of the resident's refusal for care prior to providing care, RPN #152 would have advised them to leave the resident and re-approach at a later time.

PSW #153 refused to speak with the inspector about this incident.

In an interview, ADOC #134 acknowledged PSW #153 did not provide care to resident #037 as specified in the resident's care plan.

e. A CIS report was submitted to the Director regarding the unexpected death of resident #016.

Review of the medical records for resident #016 indicated that they had an

identified disorder and required a specific treatment.

Review of the physician order indicated that a specific type of blood work was ordered. Record review of the plan of care also directed staff members to administer specific disorder related medication and monitor treatment outcomes.

Review of the records did not indicate if the blood work was completed as ordered.

Interviews with the Clinical consultant #159 and Interim-DOC #160 indicated that the blood work was not completed as ordered by the physician or as indicated in the plan of care. The Clinical consultant contacted the laboratory company and confirmed that the blood work was not completed. They both indicated that the home has a process in place to complete blood work and they were not sure how it was missed at this time. [s. 6. (7)]

3. The licensee has failed to ensure that for resident #024, their plan of care was updated when the care needs changed.

A CIS report was submitted to the Director related to an incident of resident to resident abuse.

In an interview with resident #023, they stated the police advised resident #023 to stay away from resident #024. Record review of resident #024’s care plan with full revision did not indicate that resident #024 should keep their distance away from resident #023.

In an interview with PSW #176, they were not aware of the above mentioned intervention.

In an interview with BSO nurse #115, they indicated that after the incident between resident #023 and #024, both residents were advised to keep their distance from each other. They further indicated that this should have been updated to their care plan. [s. 6. (10) (b)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 003

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 staff and others involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other; and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that for resident #014, safe transferring and positioning techniques were used.

A CIS report was submitted to the Director regarding the unexpected death of resident #014.

Record review of the progress notes indicated that resident #014 fell during care provision. The records indicated that PSW #137 was providing care and the resident fell from their bed when the PSW walked away from the bed to grab a pillow. Record reviews of the plan of care indicated that the resident required specific level of staff assistance to turn and reposition in bed. The resident was sent to the hospital following the fall and was diagnosed with a specific injury.

Record review of the notes also indicated that the home was investigating if an improper/incompetent treatment and neglect, caused the resident to fall.

Interview with PSW #137 indicated that they were providing care when the incident occurred. They indicated that they placed a specific pillow on one side of the resident, walked away from the resident's bedside to grab a pillow to place on the other side of the resident. They walked away without maintaining safety of the resident. The PSW indicated that they left the resident at the edge of the bed and should have positioned the resident with another pillow before moving away.

Interview with DOC #101 indicated that the incident was an improper/incompetent treatment and neglect of a resident. They reiterated that the PSW walked away from the resident's bed without maintaining safety of the resident. The resident fell and sustained an injury as a result. The DOC reiterated that it is the expectation of the home that staff provide appropriate and safe care to the resident at all times. [s. 36.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 resident #031 was protected from financial abuse by anyone.

As per O. Reg. 79/10, s.2 (1), the definition of "financial abuse", subject to subsection (2) (1) of the Act, means any misappropriation or misuse of a resident's money or property.

Two CIS reports were submitted to the Director regarding the misuse/ misappropriation of resident #031's money.

Review of resident #031's health record indicated the identified family member was the power of attorney (POA) for property.

Review of the email communication from the delegate office manager, staff #121 to the DOC, ADOC and the ED at the time indicated resident #031's account received a lot of non sufficient funds (NSF) notices since a specific month. Staff #121 also indicated mail sent to resident #031's above mentioned identified family member were returned and calls were not responded to. The email also indicated during a call to resident #031's identified family member on a specific date, they admitted using resident #031's money for their own personal use.

Review of the first CIS report submitted to the Director indicated the home notified the police and submitted the CIS report on the above mentioned misuse of

resident #031's money.

Review of the home's record indicated resident #031's identified family member made an agreement with the home on an identified date to pay the outstanding balance in the following months.

Review of the second CIS report submitted to the Director indicated that there were a couple of notices of NSFs with resident #031's account. Resident #031's identified family member was not responding to any calls from the home. Police were notified.

Review of the home's record indicated the home sent a letter to resident #031's identified family member, informed them of the account balance and that it was a specific amount of days past due.

An on-site inquiry was conducted by inspector #535 related to the allegation of financial abuse. Following this inquiry, a review of the home's record indicated that the police were notified, the Public Guardian and Trustee (PGT) investigation department was contacted, steps were taken to protect the resident from further abuse.

In interviews, office manager, #122 and ED #100 stated the home was aware of the misuse of resident #031's money between a specific period of time, and the home did not take action to contact the PGT department to protect resident #031 from further financial abuse until August 2019. [s. 19. (1)]

2. The licensee has failed to ensure that resident #023 was protected from abuse by resident #024.

As per O. Reg. 79/10, s.2 (1), the definition of "physical abuse", subject to subsection (2) (1) of the Act, includes the use of physical force by a resident that causes physical injury to another resident.

A CIS report was submitted to the Director related to an incident of resident to resident abuse. Review of the CIS showed that resident #023 and resident #024 were having an argument which lead to a physical altercation.

In an interview with resident #023, they recalled the incident indicating that resident #024 was being abusive to them in an identified area of the home. There

were no staff present. They further indicated that they waited for resident #024 to leave the area and went to the elevator. While the resident was waiting for the elevator, resident #024 approached them and started to yell at resident #023 to move out of the way. Resident #023 was attempting to move when resident #024 poured a liquid on an identified area of their body. Resident #023 stated they had an injury with pain and required a specific treatment after the incident. The police were informed and advised resident #023 to stay away from resident #024. Resident #023 indicated that they had no further altercations with resident #024 after this incident.

Record review of resident #023's skin assessment and progress notes indicated that resident #023 had an injury and pain related to the incident. Resident #023 refused to go to hospital.

Resident #024 could not recall the incident when interviewed by the inspector.

In an interview with PSW #176, they indicated that resident #024 can exhibit a specific responsive behaviour and can demand others to move out of the way and it would have to be done right away. Review of resident #024's care plan indicated that the resident had an identified responsive behaviour and staff were to re-approach the resident when resident has settled down. Further review of the care plan did not indicate the above mentioned behaviour.

In an interview with DOC #101, they stated the home did substantiate that abuse did occur between resident #023 and #024. [s. 19. (1)]

3. The licensee has failed to ensure that resident #025 was protected from abuse by resident #026.

A CIS report was submitted to the Director regarding an altercation between residents #027 and #028. Review of the CIS report indicated that resident #028 was walking past resident #027, and resident #027 reached out and exhibited a responsive behaviour toward resident #028, resulting in an injury.

Record review of resident #026’s care plan identified a specific intervention related to their identified responsive behaviour.

In an interview with PSW #150, they indicated that resident #026 can exhibit a specific responsive behaviour and needed to be seated away from other

residents.

In an interview with RPN #116, they indicated that resident #026 was seated beside resident #025 on the day of the incident. They were preparing medications when they heard screams and observed the altercation. The two residents were separated and assessed. Resident #025 was observed to have specific injuries.

In an interview with ADOC #134, they acknowledged that for this incident, resident #025 was not kept safe from harm as resident #026 should have been seated away from other residents due to their responsive behaviours. [s. 19. (1)]

4. The licensee has failed to ensure resident #029 was protected from abuse by PSW #147.

As per O. Reg. 79/10, s.2 (1), the definition of "physical abuse", subject to subsection (2) (1) of the Act, includes the use of physical force by anyone other than a resident that causes physical injury or pain.

A CIS report was submitted to the Director related to alleged abuse towards resident #029. Review of the CIS report indicated that resident #029 alleged that PSW #147 injured them. Resident #029 was assessed and noted to have an injury. Further review of the CIS indicated that the home substantiated abuse.

In an interview with resident #029, they recalled the incident that occurred with PSW #147. They indicated the staff came to assist them and removed their clothes to change them without explaining to the resident what they were doing. They stated the staff member hit them twice and left the room. Resident #029 stated that the staff member returned to the room to assist them with putting on their clothes however the resident had already dressed them self.

A review of resident #029’s hand written letter dated after the incident, indicated that PSW #147 entered the resident’s room without saying anything, took resident’s sheet off and started to dress the resident. Further review of the letter indicated that the staff hit the resident three times on a specific area of their body. PSW #147 started screaming and left the room and told the administration that they were hurt. Resident #029 indicated that they dressed themselves and went back underneath the covers.

Review of the home’s investigation notes indicated that PSW #147 alleged that

resident #029 hurt them while providing care without provocation. PSW #147 denied hurting resident #029.

The inspector was unable to interview PSW #147.

In an interview with PSW #177 indicated resident #029 did not have any responsive behaviours related to provision of care.

In an interview with ADOC #134, they indicated that the home conducted an investigation into the above mentioned incident. They stated that after the incident, resident #029 was fearful about the incident happening again and was deeply affected by the incident. ADOC #134 stated that resident #029 was not an individual that would embellish things and when they spoke to the resident, their story never changed. Based on the home's investigation, abuse was substantiated. [s. 19. (1)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 005

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #030 was positioned safely for drinking fluids during snack service.

The inspector observed resident #030 in a wheelchair by the elevators in tilted position 45 degrees, coughing profusely, spitting up fluids. A staff member attended to resident, calling for the nurse's attention. Inspector #699 observed a cup in resident's hand with fluids, and the cup was taken away from the resident by the staff. RPN #110 came to the resident and tilted resident #030 up into 90-degree position. Resident #030 continued to cough and spit up fluids. RPN #110 took resident #030 to nursing station and completed an assessment. Resident #030 stopped coughing and was seated back in the main lounge.

Review of the home's policy tilted "Pleasurable Dining", VII-1-10.40, last revised January 2015, shows the following:
-Where a resident cannot be transferred to regular dining chair, the resident's chair is positioned properly at the table and the resident is seated in the upright position.

In an interview with RPN #110, they indicated that resident #030 should not have been in a tilted position when they were served their coffee. The resident should have been seated upright position as being in tilted position could put the resident at risk for choking, fluid in the lungs and pneumonia. [s. 73. (1) 10.]

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 proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any policy and procedure the home had, instituted or otherwise put in place was complied with.

As required by the Regulation (O. Reg. 79/10, s. 48 (1). 1) the licensee was required to ensure that an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury was implemented in the home. As required by the Regulation (O. Reg. 79/10, s. 30 (1). 1) a written description of the program was required that included its goals and objectives and relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

a. Record review of the progress notes indicated that resident #016 had an unwitnessed fall and sustained an injury.

The home's policy titled "Fall-prevention and Management, #VII-G-30.10" last reviewed on April 2019, states that when a resident has fallen, registered staff should complete the following: Fall risk assessment; post fall assessment; complete head injury routine(HIR) if head injury is suspected, conduct a thorough, complete head to toe and skin assessment to examine bleeding, bone protrusions, hematomas and fractures, update the plan of care and implement interventions immediately following a fall.

Record review of the home's policy titled Head Injury Neurological observation tips sheet, VII-G-30.20(b), indicated that HIR should be initiated each time a resident sustains:
-an injury to the head (abrasion, cut, swelling, bump, or sudden onset of vomiting) following a fall or impact with an object; and
-an unwitnessed head injury or fall

Further review of the records did not indicate if the HIR was completed. The records also did not indicate if a post fall assessment was conducted to identify contributing factors. Review of the hospital discharge summary notes directed staff members to complete HIR and monitor for head injury complications such as visual problems, headaches, double visions, balance problems, dizziness and nausea.

Interview with RN #158 indicated that the HIR was not completed following the incident of fall. The RPN indicated that the hospital discharge summery directed them to complete the HIR as well. RN #158 indicated that they only completed a head to toe assessment and vital signs and they forgot to complete the HIR following the fall.

Interview with ADOC #134 confirmed that there was no HIR and a thorough post fall assessment completed immediately following the fall and after the resident returned from the hospital. The ADOC reiterated that it is the expectation of the home that registered staff complete a thorough post fall assessment and HIR when head injury is suspected.

b. The Director received a complaint related to concerns regarding resident #022 sustaining altered skin integrity to a specific area of their body. In a conversation with the complainant, they indicated that they were not provided a cause of injury related to the resident's altered skin integrity. They indicated they took the resident to the hospital after the resident was discharged from the home and the

physician in the hospital indicated the altered skin integrity could have been caused by an impact, like a fall.

Record review of resident #022's progress notes indicated resident #022 was found with an altered skin integrity. Further review of the progress notes does not indicate where the source of altered skin integrity came from.

In an interview with RN #120, they indicated that residents who have altered skin integrity of unknown cause to their head and face, a HIR would be initiated. They further indicated that for resident #022, the HIR should have been initiated.

In an interview with DOC #101, they indicated that for any resident with altered skin integrity of unknown cause anywhere to the head, a HIR should be initiated. They acknowledged that a HIR should have been completed for resident #022. [s. 8. (1) (a),s. 8. (1) (b)]

2. In accordance with O. Reg. 79/10, s. 48 (1) 3., the licensee is required to ensure that a continence care and bowel management interdisciplinary program is implemented in the home, to promote continence and to ensure that residents are clean, dry and comfortable. Under O. Reg. 79/10, s. 30 (1) 1., the licensee is required to ensure that there is a written description of the interdisciplinary program required under s. 48 of the Regulations that includes its goals and objectives and relevant policies, procedures and protocols.

Specifically, staff did not comply with the licensee's Continence Program - Guidelines for Care, Policy #VII-D-10.00, Current Revision: April 2019, which was part of the licensee's continence care and bowel management program, and indicated that upon admission of a resident, and annually, the registered staff were expected to obtain information about the resident's bowel and bladder routine and identify contributing factors to incontinence using the Bladder and Bowel Assessment tool.

A CIS report was submitted to the Director related to an incident of alleged neglect involving resident #043. It was alleged that the resident did not receive incontinence care as per their plan of care.

During the record review, Inspector #722 reviewed the Bladder and Bowel Continence Assessments for resident #043 in the electronic health record. The Bladder and Bowel Continence Assessment was completed for resident #043 on

admission, and on another identified date. The Bowel and Bladder Continence Assessment was initiated in PCC on a specific date, the tool was blank.

Inspector #722 interviewed ADOC #134, who indicated that the expectation was that the Bladder and Bowel Continence Assessment should be completed annually for every resident. The ADOC reviewed the tool in PCC that was initiated on an identified date and agreed that the tool was blank, and was not completed as required.

This finding is additional evidence for an existing order issued under inspection number 2019_808535_0010, on November 10, 2019, with a compliance due date of January 31, 2020. [s. 8. (1) (b)]

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

Specifically failed to comply with the following:

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

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 has failed to ensure that every suspected incident of abuse of residents #014, #032, #033, #034 and #015, by anyone that the licensee knew of, was immediately investigated.

a. A CIS report was submitted to the Director regarding the unexpected death of resident #014.

Review of the progress notes indicated that resident #014 fell from their bed during care provision. The records indicated that PSW #137 was providing care and the resident fell from their bed when the PSW walked away from the bed. Further review of the home's records did not indicate that the incident was investigated.

In an interview, the DOC confirmed that the incident was related to improper and incompetent care. They further indicated they expected an investigation to be conducted, however could not find any documentation related to any investigation related to the incident. The DOC confirmed that the home did not investigate the incident involving resident #014.

b. Three CIS reports related to a suspected incident of abuse of residents #032, #033 and #034 were submitted to the Director.

Review of the CIS report and the progress notes for resident #032 indicated that resident #032 was exhibiting specific responsive behaviours during care and accidentally hit themselves which caused injuries.

Review of the CIS report and progress notes for resident #033 indicated that an altered skin integrity was observed on resident #033.

Review of the CIS report and progress notes of resident #034 indicated that an altered skin integrity was observed.

In interviews, RN #127 stated that on the morning of October 2019, they received report that the above-mentioned skin alterations were observed on resident #032, #033 and #034. NM #129 stated that on a specific date and time, they suspected that resident #032, #033 and #034 were abused by staff during care earlier that day which caused the skin alterations on all three residents when they reviewed the 24 hours report. Charge Nurse (CN) #128 stated that they agreed with NM #129's suspicion during shift change report. NM #129 and CN #128 further stated that they did not initiate the investigation immediately when they suspected an abuse of the residents may have occurred. ADOC #134 stated they were notified by NM #129 and CN #128 the next day of the suspicion of abuse of resident #032, #033 and #034 and initiated the investigation.

In an interview, ADOC #134 acknowledged the above mentioned suspicion of abuse of resident #032, #033, and #034 was not investigated immediately as required.

c. A report via the after-hours INFOLINE was submitted to the Director, regarding an alleged incident of abuse. The report indicated that resident #015 was verbally abused by a staff member.

Review of the progress notes indicated that evening nurse manager (ENM) #135 reported the alleged incident of abuse via the INFOLINE. Further review of the records did not indicate if the alleged incident of abuse was investigated. There was no documentation available regarding the nature of the incident, staff members involved in the incident and the action taken.

During an interview, ADOC #134 verified that the incident occurred and that there were no investigative notes available related to the incident of abuse.

Interview with the DOC confirmed that the home did not investigate the alleged incident of abuse. The DOC reiterated it was the expectation of the home that the alleged incident of abuse was investigated to understand the root cause problem and develop interventions to prevent recurrence.

During the course of the inspection, through record review and staff interviews, it was noted that there was frequent change in management leadership teams and it led to some incidents of alleged abuse or neglect not being investigated, and additionally, some records of investigations were not available. [s. 23. (1) (a)]

2. The licensee has failed to report to the Director the results of the investigation undertaken under clause (1)(a) of the LTCHA, related to the improper or incompetent care of resident #037.

The home reported an incident involving resident #037 to the Director by calling the after hours emergency number. The home submitted a CIS report related to the same improper/incompetent treatment to resident #037 to the Director.

In an interview, ADOC #134 stated the home initiated and completed the investigation when the incident report was submitted by the RPN.

Review of the CIS report and interview with ADOC #134, confirmed that the CIS report was not updated with the outcome of the investigation. [s. 23. (2)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that an alleged incident of abuse and neglect of resident #032, #033, #034, #037, #042, #043, and #045 by the licensee or staff, was immediately reported to the Director.

a. Three CIS reports related to a suspected incident of abuse to residents #032, #033 and #034 was submitted to the Director.

In interviews, NM #129 stated that they suspected that resident #032, #033 and #034 were abused by staff during care earlier that day which caused the skin alterations on all three residents when they reviewed the 24 hours report. CN #128 stated that they agreed with NM #129's suspicion during shift change report. ADOC #134 stated they were notified by NM #129 and CN #128 the next day of the suspicion of abuse of resident #032, #033 and #034 and initiated the investigation.

In an interview, ADOC #134 acknowledged the above mentioned suspicion of abuse was not reported to the Director immediately as required.

b. The home reported an incident involving improper treatment/incompetent treatment resident #037 to the Director by calling the after hours emergency

number. The home submitted a CIS related to the same to the Director.

Review of the CIS and progress notes of resident #037, and interview with RPN #152 indicated that PSW #153 reported to RPN #152 that earlier that specific day, they observed resident #037 was covered by an identified substance, and PSW #153 changed the resident as they were concerned of the resident's skin condition. Resident #037 refused to be changed, PSW #153 continued to clean the resident while the resident was exhibiting a specific responsive behaviour towards PSW #153. PSW #153 told RPN #152 that they had to hold the resident's hand in order to clean the resident. Upon assessment, RPN #152 observed an altered skin integrity.

In an interview, ADOC #134 acknowledged that the above mentioned improper care was not reported to the Director immediately as required.

c. A critical incident report was received related to an allegation of neglect involving residents #033, #042, and #043. The CIS report indicated that the residents were left in a soiled incontinence product by direct care staff during a specific shift.

The InfoLine report was reviewed and indicated that RN #135 notified the Ministry of Long-Term Care (MLTC) of the alleged neglect involving residents #033, #042, and #043 on a later date.

The progress notes and investigation file for each of the specified residents were reviewed and confirmed that the alleged neglect occurred during a specific shift and was identified by PSWs #133 and #146.

RN #135 confirmed during an interview that they were working and notified of the suspected neglect at the beginning of the next shift. They indicated that they were responsible for calling the MLTC Infoline after-hours for suspected neglect and acknowledged that they should have made the call on that shift.

ADOC #134 acknowledged during an interview that the suspected neglect involving residents #033, #042, and #043 should have been reported by RN #135, the nurse manager on duty soon after it was brought to their attention. The ADOC acknowledged that the suspected neglect was not immediately reported.

d. A CIS report was submitted to the Director on which indicated that there was a

suspicion of staff-to-resident physical abuse involving PSW #154 related to several altered skin integrities identified on resident #045 on two specific dates.

ADOC #134 was interviewed and confirmed some members of the management team suspected that the areas of altered skin integrity of unknown origin on resident #045 may have been due to staff-to-resident physical abuse. The ADOC indicated that the investigation was initiated and confirmed that the after-hours InfoLine was not called, and acknowledged that the suspected abuse was not reported to the Director until the next day. [s. 24. (1)]

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

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 104 (1).
5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following description of the incident, type of incident, area or location of the incident, name of staff members involved, date and time of the incident, and events leading up to the incident.

The Director received an after-hours INFOLINE report, regarding an alleged incident of abuse. The report indicated that resident #015 was verbally abused by a staff member. Further review of the intake indicated that there was no mandatory CIS report submitted by the home. The report indicated that the Centralized Intake, Assessment and Triage Team (CIATT), attempted to contact the home to initiate the CIS on two separate dates. The CIATT notes on a specific date, indicated that the home did not initiate the CIS report as required.

On December 02, 2019, the Inspector reviewed the Long-Term Care Homes.net reporting website and was unable to locate a mandatory critical incident report submitted by the home. There was no incident report describing the following:
- A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
- description of the staff involved in the incident including, names of any staff members or other persons who were present at or discovered the incident, and names of staff members who responded to the incident,
- actions taken in response to the incident and
- the immediate and long-term actions taken to prevent recurrence.

Review of the progress notes indicated that ENM #135 reported the alleged incident of abuse via the INFOLINE. There was no further documentation available regarding the staff members involved in the incident, the circumstances leading to the incident and the action taken. The record review also did not indicate if the alleged incident was investigated.

Interview with the ENM #135 confirmed that they contacted the Director via the INFOLINE. They indicated that the incident did not occur during their shift, and they were instructed by the day shift manager to contact the Director to report the incident that happened on previous shift. The ENM further indicated that they don’t know the staff member involved and they don’t know what was said and the circumstances around the alleged incident of abuse. The ENM also indicated that they do not recall which day shift manager instructed them to report to the Director.

Interview with DOC #101 confirmed that the previous DOC received a call from CIATT to initiate the CI but they were not sure what happened. The DOC indicated that it is the responsibility of the DOC to initiate the CIS report

describing the nature of the incident, the name of staff involved, and action taken to prevent recurrence. [s. 104. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #027's BSO-DOS monitoring document was kept.

A CIS report was submitted to the Director regarding an altercation between resident #027 and #028.

The inspector requested resident #027's BSO-DOS document for a specific month review. Inspector reviewed resident #027's chart and could not locate the document.

The BSO nurse #115 confirmed that they could not locate the resident's BSO-DOS monitoring tool. [s. 231. (b)]

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Issued on this 22nd day of April, 2020 (A3)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by PRAVEENA SITTAMPALAM (699) - (A3)
Inspection No. / No de l'inspection :	2019_780699_0025 (A3)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	001618-18, 028400-18, 012635-19, 013723-19, 016672-19, 016673-19, 018409-19, 019349-19, 019506-19, 019508-19, 019818-19, 019819-19, 020570-19, 020750-19, 021421-19, 023109-19 (A3)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 22, 2020(A3)
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 :	Midland Gardens Care Community 130 Midland Avenue, SCARBOROUGH, ON, M1N-4E6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lora Monaco

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 Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Order / Ordre :

The licensee must be compliant with r. 97. (2) of the O.Regulations.

Specifically, the licensee must:
1. Notify the resident and the resident's substitute decision-maker, if any, of the results of any investigations required under subsection 23 (1) of the Act, immediately upon the completion of the investigation and is documented.

Grounds / Motifs :

1. The licensee has failed to ensure that the substitute decision-makers (SDMs) for residents #033, #042, #043, and #045 were notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

a. A CIS report was submitted to the Director related to an allegation of neglect that involved residents #033, #042, and #043. The CIS report indicated that all three residents' SDMs were notified of the incident.

The progress notes were reviewed for residents #033, #042, and #043, which indicated that all three residents' SDMs had been notified of the incident, but there were no notes that indicated that they had been notified of the results of the investigation related to the alleged neglect.

The investigation file was reviewed, and no notes were identified in the investigation file that indicated that any of the residents' SDMs had been notified of the results of

the investigation.

ADOC #134 was interviewed and indicated that they were responsible for the investigation into the allegations of neglect that involved residents #033, #042, and #043. They confirmed that the investigation was completed. The ADOC confirmed that none of the residents' SDMs had been notified of the results of the investigation immediately upon its completion.

b. A CIS report was submitted to the Director which indicated that there was a suspicion of staff-to-resident physical abuse involving PSW #154.

The CIS report indicated that the resident's SDM was notified of the suspected abuse.

ADOC #134 was interviewed and verified that an investigation was initiated. The ADOC also indicated that they conducted the investigation, along with Interim ED #130, and that the investigation was concluded. They confirmed that at the time of this inspection, resident #045's SDM had not been notified of the results of the investigation.

The severity of this issue was determined to be a level 1 as there was no risk to the residents. The scope of the issue was a level 3 as it related to four out of four residents reviewed. The home had a level 3 history as there were 1 or more related non-compliances issued to the same subsection that included:

-Written notification (WN) issued February 13, 2018, 2018_324535_0002 (722)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2020(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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 Act.

The licensee shall prepare, submit and implement a plan to ensure that all staff comply with the home's Prevention of Abuse and Neglect of a Resident policy. This plan must include:

1. a) A description of the training and education that will occur on the home's policy for all staff who provide direct resident care. The description must include who will be responsible for providing the education, and the dates the training will occur.
b) A description of how the home will verify that all staff who have received the training have understood the policy and their ability to implement the home's Prevention of Abuse and Neglect policy.

2. a) The development of a tool outlining the home's investigation and reporting process that is based on the home's Abuse and Neglect Prevention policy, which includes but is not limited to the following:
-who initiates the investigation;
-when and how investigations are initiated; and
-who must report to the Director, how and when to contact the Director.
This tool will be utilized for any alleged or suspected abuse/neglect investigation and should be readily accessible at all nursing stations.
b) A description of training and education that will be provided to all

registered staff and management on the tool and its use. Indicate who will be responsible for providing the education, and the dates this training will occur.

3. The development of on-going monthly auditing process to ensure that any and all alleged incidents of abuse or neglect of a resident is immediately investigated. Conduct an analysis of the audit and provide follow up education to staff as required. Maintain a written record of the audits and analysis. Include who will be responsible for doing the analysis, and outcome of the analysis.

4. The development of on-going monthly analysis of Critical Incident reports to identify if any staff who has reasonable grounds to suspect that abuse and/or neglect to any resident may have occurred has reported to the Director immediately. Include who will be responsible for doing the analysis, and outcome of the analysis.

Please submit the written plan for achieving compliance for 2019_780699_0024 to Praveena Sittampalam, LTC Homes Inspector, MLTC, by email to TorontoSAO.MOH@ontario.ca by February 12, 2020.

Grounds / Motifs :

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

The home's Prevention of Abuse and Neglect of a Resident policy, Policy # VII-G-10.00, Current Revision: April 2019, was reviewed, and indicated the following:
-All team members are required to report immediately any suspected or known incident of abuse or neglect to the provincial health authorities and the Executive Director or designate in charge of the care community;
- the Executive Director or designate, at the time of immediate notification, initiates 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 is also asked to write, sign, and date a statement of the event;
- the written statements are obtained as close to the time of the event as possible; and

- the Executive Director or designate interviews the resident, other residents, and/or persons who may have any knowledge of the situation.

a. A CIS report was submitted to the Director related to an allegation of neglect involving residents #033, #042, and #043 that occurred during a specific shift.

Review of the home's staff schedule for a specific date, indicated the following:
- PSWs #131 and #132 worked the shift on the unit where the three residents resided; PSW #131 was assigned to provide care to residents #033 and #042, and PSW #132 was assigned to provide care to resident #043.
- PSWs #146 and #133 worked a shift on the unit where the three residents resided; PSW #146 was assigned to provide care to residents #033 and #042, and PSW #133 was assigned to provide care to resident #043.
- RPN #162 was the charge nurse during the one shift shift, and RN #120 was the charge nurse during the another shift.
- RN #135 was the nurse manager on duty during a different shift.

RN #120 was interviewed and confirmed that they were the charge nurse working on the unit where residents #033, #042, and #043 resided during a specific shift. They confirmed that PSWs #133 and #146 notified them that the residents' incontinence products were soiled at the beginning of their shift. They acknowledged that the PSWs were concerned that the resident had been neglected during the shift before, and indicated that they notified RN #135, the nurse manager on duty, of the alleged neglect. RN #135 confirmed during an interview that they were notified of the alleged neglect and reported it to the MLTC via the after-hours InfoLine.

The investigation documentation was reviewed and included three separate typed interview notes for interviews with PSWs #131, #132, and #133. Inspector #722 did not identify any written statements in the investigation file by any staff who may have been aware of or involved in the situation, including PSWs #131 and #132. There was also no documentation related to interviews with RPN #162, RN #120, or RN #135.

ADOC #134 confirmed during an interview that they were responsible for conducting the investigation related to the allegation of neglect towards residents #033, #042, and #043. They also confirmed that they did not interview staff who would have had knowledge of the incident, including PSW #146, RPN #162, RN #120, and RN #135.

b. A CIS report was submitted to the Director which indicated that there was a suspicion of staff-to-resident physical abuse involving PSW #154.

Review of the CIS report, progress notes, and the home's incident reports indicated that PSW #154 notified RPN #117 of an altered skin integrity above resident #045's identified part of their body. On another day, PSW #155 notified RN #145 of a larger altered skin integrity on resident #045's identified part of their body. RN #145 completed a head-to-toe assessment, completed an incident report, and notified former DOC #101 who also assessed the resident and identified an additional altered skin integrity on different part of the resident's body.

The investigation file related to this incident was provided by the home, and included the typed notes from four separate staff interviews, where interim ED #130 interviewed PSW #154, RPN #117, RN #145 and PSW #155. ADOC #134 was also present for the meetings with PSW #154 and RPN #117.

The investigation file did not include any written, signed, and dated statements by any staff identified in the CIS report related to this incident, including PSW #154. There were no other interviews identified for any staff on any other shifts between a specific period of time.

The ADOC indicated that they and Interim ED #130 were responsible for the investigation. They confirmed that they did not interview all staff who may have had knowledge of an incident of physical abuse toward resident #045. Specifically, they indicated that the abuse could have occurred over the weekend prior to the identified date and none of the weekend staff were interviewed.

The ADOC acknowledged that there were no written statements from any staff involved in the two incidents of suspected abuse and neglect described above because they thought that management were not permitted to request staff to write and sign statements about such incidents. The ADOC acknowledged that the home's Prevention of Abuse and Neglect of a Resident policy was not complied with.

Please refer to the grounds provided for Written Notification #8 issued pursuant to LTCHA, s. 23. (1).

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Please refer to the grounds provided for Written Notification #9 issued pursuant to LTCHA, s. 24. (1).

The severity of this issue was determined to be a level 2 as there was minimal risk to the residents. The scope of the issue was a level 3 as it related to three out of three residents reviewed. The home had a level 2 history as there were 1 or more unrelated non-compliances issued to the same subsection. (722)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jul 31, 2020(A3)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 003

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 Act.
Specifically, the licensee must ensure:

1. For resident #032, #033, and #037, and all other residents in the home, that the care set out in the plan of care is provided as specified in the plan.
2. All staff involved in the care of residents #032, #033, and #037 must be provided re-education on each of the residents' required needs as outlined in the plan of care. A written record must be kept of all staff who were provided the education.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #032, #033, #034, #037 and #016, as specified in the plan.

a. A CIS report related to a suspected incident of abuse of resident #032 was submitted to the Director.

Review of the CIS report and the home's investigation notes indicated that at the beginning of a specific shift, resident #032 was exhibiting a specific responsive behaviour. PSW #123 tried to provide care to the resident twice without success. When PSW #123 observed resident #032 had a bowel movement, PSWs #123 and #124 changed the resident when the resident continued to exhibit their responsive behaviour. Resident #032 accidentally hit themselves during care which caused injury.

Review of the home's investigation notes showed that both PSW #123 and #124 stated that resident #032 was exhibiting specific responsive behaviours, and the resident hit themselves.

PSWs #123 and #124 were not available for interview as they were no longer working in the home at the time of the inspection.

Review of resident #032's care plan indicated staff to leave and re-approach the resident at a later time if the resident was exhibiting a specific responsive behaviour.

In an interview, ADOC #134 acknowledged staff should have left resident #032 and re-approach when the resident was exhibiting a specific responsive behaviour as indicated in the resident's care plan.

b. A CIS report related to a suspected incident of abuse of resident #033 was submitted to the Director.

Review of the home's investigation notes showed that PSW #123 stated that during the morning care in October 2019, resident #033 was exhibiting responsive behaviour, and the resident hit PSW #125 during care.

PSWs #123 was not available for interview as they were no longer working in the home at the time of the inspection.

In an interview, PSW #125 stated during care on October 2019, resident #033 was exhibiting responsive behaviours, and hit PSW #125 during care. PSW #125 further stated that they continued to provide care to resident #033.

Review of resident #033's care plan completed on August 2019, indicated that when the resident was exhibiting responsive behaviours, staff to leave the resident alone and re-approach at a later time to improve compliance.

In an interview, ADOC #134 acknowledged staff should have left resident #033 and re-approach when the resident was exhibiting responsive behaviours to care as indicated in the resident's care plan.

c. A CIS report related to a suspected incident of abuse of resident #034 was submitted to the Director.

Review of the CIS report indicated that an altered skin integrity was observed on a specific area of resident #034's body.

Review of the home's investigation notes showed PSW #123 stated that resident #034 was exhibiting responsive behaviour during care. RPN #126 stated they assisted PSWs #123 and #125 to change resident #034 as the resident was exhibiting responsive behaviour. Nurse Manger #129 stated RPN #126 told them resident #034 it was difficult to change them.

PSW #123 and RPN #126 were not available for interview as they were no longer working in the home at the time of the inspection.

In an interview, PSW #125 stated that resident #034 was cooperative during care on the identified date. PSW #125 stated they did not hit the resident causing the altered skin integrity on the body during care.

Review of resident #034's care plan indicated that staff are to leave and re-approach the resident at a later time if the resident was exhibiting responsive behaviour.

In an interview, ADOC #134 acknowledged staff should have left resident #034 and re-approached when the resident was exhibiting responsive behaviour as indicated in the resident's care plan.

d. The home reported an incident that involved resident #037 through the after hours emergency number to the Director. The home submitted a CIS report related to the improper/incompetent treatment to resident #037 to the Director.

Review of the CIS report and progress notes for resident #037, and an interview with RPN #152 indicated that PSW #153 reported to RPN #152 that earlier that morning, they observed resident #037 was covered with an identified substance. PSW #153 changed the resident as they were concerned about the resident's skin condition. Resident #037 refused to be changed, and PSW #153 continued to clean the resident while the resident was exhibiting a responsive behaviour towards the PSW. PSW #153 told RPN #152 that they had to hold the resident's hand in order to clean

the resident.

Review of resident #037's care plan indicated that the resident was compliant with care when cared for by their regular PSWs; if the resident was cared for by somebody the resident doesn't know, the resident may exhibit responsive behaviours. In addition, the resident tended to refuse care during the evening and night shifts so staff are to approach resident in a calm and gentle manner. Staff were also to negotiate time for providing care to the resident and return at agreed upon time.

In an interview, ADOC #134 stated that during the investigation, RPN #152 told ADOC #134 that in the morning, PSW #153 changed resident #037 because the resident was covered with an identified substance. PSW #153 also stated that they did not hold the resident's hand although the resident was exhibiting responsive behaviours during care.

In an interview, RPN #152 stated that when the day shift PSW greeted resident #037, the resident told the PSW that they didn't want to be changed, but the night PSW changed them. RPN #152 then went to assess the resident, and observed an altered skin integrity to a specific area of their body. RPN #152 further stated that the resident was exhibited a specific responsive behaviour and staff need to leave the resident and re-approach. RPN #152 further stated that if PSW #153 had reported to them of the resident's refusal for care prior to providing care, RPN #152 would have advised them to leave the resident and re-approach at a later time.

PSW #153 refused to speak with the inspector about this incident.

In an interview, ADOC #134 acknowledged PSW #153 did not provide care to resident #037 as specified in the resident's care plan.

e. A CIS report was submitted to the Director regarding the unexpected death of resident #016.

Review of the medical records for resident #016 indicated that they had an identified disorder and required a specific treatment.

Review of the physician order indicated that a specific type of blood work was

ordered. Record review of the plan of care also directed staff members to administer specific disorder related medication and monitor treatment outcomes.

Review of the records did not indicate if the blood work was completed as ordered.

Interviews with the Clinical consultant #159 and Interim-DOC #160 indicated that the blood work was not completed as ordered by the physician or as indicated in the plan of care. The Clinical consultant contacted the laboratory company and confirmed that the blood work was not completed. They both indicated that the home has a process in place to complete blood work and they were not sure how it was missed at this time.

The severity of this issue was determined to be a level 3 as there was actual harm to the residents. The scope of the issue was a level 2 as it related to five out of eleven residents reviewed. The home had a level 3 history as there were 1 or more related non-compliances issued to the same subsection that included:

-Written Notification (WN), issued April 19, 2017, 2017_420643_0006;
-Compliance Order (CO), issued October 20, 2017, 2017_630589_0015;
-CO, issued February 5, 2018, 2017_324535_0023;
-WN, issued August 9, 2018, 2018_493652_0011;
- Voluntary Plan of Correction (VPC), issued December 21, 2018, 2018_630589_0011; and
-VPC issued June 6, 2019, 2019_650565_0009. (507)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2020(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with r. 36 of the O. Regulations. Specifically, the licensee must:

1. Monitor PSW #137 to ensure they use safe transferring, positioning devices or techniques and educate PSW #137 on strategies to request assistance without leaving the resident's side when providing care and assistance. Monitor PSW #137 for 21 days from receipt of this order and maintain a written record documenting the monitoring.

Grounds / Motifs :

1. The licensee has failed to ensure that for resident #014, safe transferring and positioning techniques were used.

A CIS report was submitted to the Director regarding the unexpected death of resident #014.

Record review of the progress notes indicated that resident #014 fell during care provision. The records indicated that PSW #137 was providing care and the resident fell from their bed when the PSW walked away from the bed to grab a pillow. Record reviews of the plan of care indicated that the resident required specific level of staff assistance to turn and reposition in bed. The resident was sent to the hospital following the fall and was diagnosed with a specific injury.

Record review of the notes also indicated that the home was investigating if an improper/incompetent treatment and neglect, caused the resident to fall.

Interview with PSW #137 indicated that they were providing care when the incident occurred. They indicated that they placed a specific pillow on one side of the resident, walked away from the resident's bedside to grab a pillow to place on the other side of the resident. They walked away without maintaining safety of the resident. The PSW indicated that they left the resident at the edge of the bed and should have positioned the resident with another pillow before moving away.

Interview with DOC #101 indicated that the incident was an improper/incompetent treatment and neglect of a resident. They reiterated that the PSW walked away from the resident's bed without maintaining safety of the resident. The resident fell and sustained an injury as a result. The DOC reiterated that it is the expectation of the home that staff provide appropriate and safe care to the resident at all times.

The severity of this issue was determined to be a level 3 as there was actual harm to resident #014. The scope of the issue was a level 1 as it related to one out of three residents reviewed. The home had a level 3 history as there were 1 or more related non-compliances issued to the same subsection that included:

-Director Referral (DR), issued May 24, 2017, 2017_644507_0003;
-DR, issued October 27, 2017, 2017_324535_0014;
-DR issued February 5, 2017, 2017_324535_0023;
- Compliance order (CO) issued December 21, 2018, 2018_630589_0011;
-Written Notification (WN) issued March 14, 2019, 2019_324535_0003;
-WN issued June 6, 2019, 2019_650565_0010 (699)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 27, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee will be compliant with s. 19 of the LTCH Act.
Specifically, the licensee must:

1.Ensure that resident #031 and any other resident is protected from financial abuse by anyone.

2.Ensure that resident #024's plan of care is reassessed and updated based on an interdisciplinary assessment of the resident's responsive behaviour, specifically related to resident to resident interactions and potential for resident to resident altercations.

3.Ensure that resident #025 and any other resident are kept safe from harm by resident #026.

4.Ensure that PSW #147, if they return to the home as a direct care staff member, does not provide care to resident #029 and is provided re-education on the home's Prevention of Abuse and Neglect policy. In addition, this education must include a description of how the home will verify that PSW #147 has understood the policy and their ability to implement the home's Prevention of Abuse and Neglect policy.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #031 was protected from financial abuse by anyone.

As per O. Reg. 79/10, s.2 (1), the definition of "financial abuse", subject to subsection (2) (1) of the Act, means any misappropriation or misuse of a resident's money or property.

Two CIS reports were submitted to the Director regarding the misuse/ misappropriation of resident #031's money.

Review of resident #031's health record indicated the identified family member was the power of attorney (POA) for property.

Review of the email communication from the delegate office manager, staff #121 to the DOC, ADOC and the ED at the time indicated resident #031's account received a lot of non sufficient funds (NSF) notices since a specific month. Staff #121 also indicated mail sent to resident #031's above mentioned identified family member were returned and calls were not responded to. The email also indicated during a call to resident #031's identified family member on a specific date, they admitted using resident #031's money for their own personal use.

Review of the first CIS report submitted to the Director indicated the home notified the police and submitted the CIS report on the above mentioned misuse of resident #031's money.

Review of the home's record indicated resident #031's identified family member made an agreement with the home on an identified date to pay the outstanding balance in the following months.

Review of the second CIS report submitted to the Director indicated that there were a couple of notices of NSFs with resident #031's account. Resident #031's identified family member was not responding to any calls from the home. Police were notified.

Review of the home's record indicated the home sent a letter to resident #031's identified family member, informed them of the account balance and that it was a specific amount of days past due.

An on-site inquiry was conducted by inspector #535 related to the allegation of financial abuse. Following this inquiry, a review of the home's record indicated that the police were notified, the Public Guardian and Trustee (PGT) investigation

department was contacted, steps were taken to protect the resident from further abuse.

In interviews, office manager, #122 and ED #100 stated the home was aware of the misuse of resident #031's money between a specific period of time, and the home did not take action to contact the PGT department to protect resident #031 from further financial abuse until August 2019. (507)

2. The licensee has failed to ensure that resident #023 was protected from abuse by resident #024.

As per O. Reg. 79/10, s.2 (1), the definition of "physical abuse", subject to subsection (2) (1) of the Act, includes the use of physical force by a resident that causes physical injury to another resident.

A CIS report was submitted to the Director related to an incident of resident to resident abuse. Review of the CIS showed that resident #023 and resident #024 were having an argument which lead to a physical altercation.

In an interview with resident #023, they recalled the incident indicating that resident #024 was being abusive to them in an identified area of the home. There were no staff present. They further indicated that they waited for resident #024 to leave the area and went to the elevator. While the resident was waiting for the elevator, resident #024 approached them and started to yell at resident #023 to move out of the way. Resident #023 was attempting to move when resident #024 poured a liquid on an identified area of their body. Resident #023 stated they had an injury with pain and required a specific treatment after the incident. The police were informed and advised resident #023 to stay away from resident #024. Resident #023 indicated that they had no further altercations with resident #024 after this incident.

Record review of resident #023's skin assessment and progress notes indicated that resident #023 had an injury and pain related to the incident. Resident #023 refused to go to hospital.

Resident #024 could not recall the incident when interviewed by the inspector.

In an interview with PSW #176, they indicated that resident #024 can exhibit a specific responsive behaviour and can demand others to move out of the way and it

would have to be done right away. Review of resident #024's care plan indicated that the resident had an identified responsive behaviour and staff were to re-approach the resident when resident has settled down. Further review of the care plan did not indicate the above mentioned behaviour.

In an interview with DOC #101, they stated the home did substantiate that abuse did occur between resident #023 and #024.
(699)

3. The licensee has failed to ensure that resident #025 was protected from abuse by resident #026.

A CIS report was submitted to the Director regarding an altercation between residents #027 and #028. Review of the CIS report indicated that resident #028 was walking past resident #027, and resident #027 reached out and exhibited a responsive behaviour toward resident #028, resulting in an injury.

Record review of resident #026's care plan identified a specific intervention related to their identified responsive behaviour.

In an interview with PSW #150, they indicated that resident #026 can exhibit a specific responsive behaviour and needed to be seated away from other residents.

In an interview with RPN #116, they indicated that resident #026 was seated beside resident #025 on the day of the incident. They were preparing medications when they heard screams and observed the altercation. The two residents were separated and assessed. Resident #025 was observed to have specific injuries.

In an interview with ADOC #134, they acknowledged that for this incident, resident #025 was not kept safe from harm as resident #026 should have been seated away from other residents due to their responsive behaviours.
(699)

4. The licensee has failed to ensure resident #029 was protected from abuse by PSW #147.

As per O. Reg. 79/10, s.2 (1), the definition of "physical abuse", subject to subsection (2) (1) of the Act, includes the use of physical force by anyone other than a resident

that causes physical injury or pain.

A CIS report was submitted to the Director related to alleged abuse towards resident #029. Review of the CIS report indicated that resident #029 alleged that PSW #147 injured them. Resident #029 was assessed and noted to have an injury. Further review of the CIS indicated that the home substantiated abuse.

In an interview with resident #029, they recalled the incident that occurred with PSW #147. They indicated the staff came to assist them and removed their clothes to change them without explaining to the resident what they were doing. They stated the staff member hit them twice and left the room. Resident #029 stated that the staff member returned to the room to assist them with putting on their clothes however the resident had already dressed them self.

A review of resident #029's hand written letter dated after the incident, indicated that PSW #147 entered the resident's room without saying anything, took resident's sheet off and started to dress the resident. Further review of the letter indicated that the staff hit the resident three times on a specific area of their body. PSW #147 started screaming and left the room and told the administration that they were hurt. Resident #029 indicated that they dressed themselves and went back underneath the covers.

Review of the home's investigation notes indicated that PSW #147 alleged that resident #029 hurt them while providing care without provocation. PSW #147 denied hurting resident #029.

The inspector was unable to interview PSW #147.

In an interview with PSW #177 indicated resident #029 did not have any responsive behaviours related to provision of care.

In an interview with ADOC #134, they indicated that the home conducted an investigation into the above mentioned incident. They stated that after the incident, resident #029 was fearful about the incident happening again and was deeply affected by the incident. ADOC #134 stated that resident #029 was not an individual that would embellish things and when they spoke to the resident, their story never changed. Based on the home's investigation, abuse was substantiated.

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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The severity of this issue was determined to be a level 3 as there was actual harm to the residents. The scope of the issue was a level 2 as it related to two out of three residents reviewed. The home had a level 3 history as there were 1 or more related non-compliances issued to the same subsection that included:

-Voluntary Plan of Correction (VPC) issued May 24, 2017, 2017_644507_0003;
- Compliance order (CO) issued October 20, 2017, 2017_632502_0014;
-CO issued August 9, 2018, 2018_493652_0011;
-CO issued December 21, 2018, 2018_630589_0011;
-WN issued March 14, 2019, 2019_324535_0003;
-WN issued June 6, 2019, 2019_650565_0010; and
-WN issued August 6, 2019, 2019_808535_0010. (699)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2020(A1)

Order(s) of the Inspector

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

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REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 22nd day of April, 2020 (A3)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by PRAVEENA SITTAMPALAM (699) - (A3)

Ontario

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Ministère des Soins de longue durée

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