Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 13, 2019	2019_823653_0026	011460-19, 018309-19, 019001-19, 019873-19	Critical Incident System

Licensee/Titulaire de permis

Royal Canadian Legion District 'D' Care Centres
59 Lawson Rd TORONTO ON M1C 2J1

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

Tony Stacey Centre for Veterans' Care
59 Lawson Road TORONTO ON M1C 2J1

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

ROMELA VILLASPIR (653)

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): October 15, 17, 18, 21, 22, 23, and 24, 2019.

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

CIS intakes related to abuse and responsive behaviours:
Log #(s): 011460-19, 019001-19, 019873-19.

CIS intake related to a fall:
Log #018309-19.

During the course of the inspection, the inspector conducted observations of resident interactions, resident care provision, reviewed the staff schedule, clinical health records, the home's video surveillance and investigation notes, training records, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the residents, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Agency Nurse Manager (ANM), Resident Assessment Instrument (RAI) Coordinator, Behavioural Support Ontario (BSO) Manager, Physiotherapist (PT), Unit Clerk, and the interim Director of Care (DOC).

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **4 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #004, #002, and #008 were protected from abuse by anyone in the home.

The home had submitted a Critical Incident Report (CIR) to the Director related to abuse. The CIR indicated an altercation ensued between residents #004 and #005 which resulted in resident #004's fall. As per the registered staff's assessment following the incident, resident #004 complained of pain, and an alteration in skin integrity was noted on resident #004.

A review of resident #005's assessment, indicated their cognitive skills for daily decision-making were impaired, and a review of progress notes and separate interviews with Personal Support Workers (PSWs) #101, #107, and Registered Practical Nurse (RPN) #110 indicated resident #005 exhibited responsive behaviours towards co-residents.

A review of resident #004's assessment and separate interviews with PSWs #107, #120, RPNs #109, and #119, indicated resident #004 had cognitive impairment and they exhibited responsive behaviours.

An interview with the BSO manager indicated resident #004 was not actively on BSO and had been discharged from the program. However, resident #004 was on BSO on as needed basis. The BSO manager acknowledged resident #004 had disruptive responsive behaviours. They further indicated resident #005 was not under the BSO program and they had not seen nor heard anything related to the resident exhibiting responsive behaviours, and there was no behavioural plan of care for the resident related to responsive behaviours identified by the PSWs and registered staff. The BSO manager acknowledged that resident #005's responsive behaviour should have been addressed and included in their plan of care.

Separate interviews with PSW #107 and RPN #109 indicated they were assigned to resident #004's care at the time of the incident. Shortly before the incident, both staff were with resident #004 in the hallway. PSW #107 and RPN #109 indicated resident #004 was agitated and did not take any medication and declined care. PSW #107 stated resident #004 spilled some beverage on the floor so they cleaned it and headed to the end of the hallway to dispose of the dirty towel. While RPN #109 went to the nursing station to check documentation related to resident #004. PSW #107 indicated by the time they returned, resident #004 was already sitting on the floor. RPN #109 stated the

Agency Nurse Manager (ANM) notified them that there had been a fall in the hallway, and RPN #109 attended to resident #004 who was sitting on the floor.

An interview with PSW #101 indicated at the time of the incident, they were in the hallway helping a resident. PSW #101 stated resident #004 was in the hallway and resident #005 was coming from the elevator. PSW #101 witnessed the altercation between residents #004 and #005 that resulted in resident #004's fall.

A review of resident #004's diagnostic result indicated an identified injury.

An interview with the interim Director of Care (iDOC) acknowledged the above mentioned information and that resident #004 was abused when they sustained an injury as a result of the altercation with resident #005. [s. 19. (1)]

2. The home had submitted a CIR to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIR indicated an altercation ensued between residents #002 and #003, and resident #002 fell and was sent to hospital.

A review of resident #003's assessment, indicated their cognitive skills for daily decision-making were impaired, and their written plan of care did not identify any information on responsive behaviours.

Separate interviews with PSWs #106, #120, RPNs #105, #119, and the BSO manager indicated resident #003 did not have responsive behaviours nor any history of altercation with co-residents.

A review of resident #002's assessment, indicated their cognitive skills for daily decision-making were impaired, and their written plan of care consisted of a focus on responsive behaviours.

Separate interviews with PSWs #106, #120, and RPN #119, indicated resident #002 was known to exhibit identified responsive behaviours towards staff, but not towards co-residents.

An interview with RPN #105 indicated at the time of the incident, they were inside the nursing station and resident #003 was just outside sitting in a chair in the hallway, and the RPN saw resident #002 was tugging on resident #003's arm. Before the RPN could

reach the two residents, an altercation ensued between residents #002 and #003, resulting in resident #002's fall, and they were sent to hospital for further assessment.

A review of resident #002's diagnostic result from the hospital indicated an identified injury.

A review of progress note and an interview with the BSO manager, indicated they had spoken to resident #003 regarding the incident, and resident #003 stated that resident #002 was pulling at them for over half an hour and was in their space. The BSO manager instructed resident #003 that if they were not comfortable and felt like their space was being invaded, that they should go to the nurse to seek out help.

An interview with the iDOC acknowledged the above mentioned information and that resident #002 was abused when they sustained an identified injury due to a fall, following the altercation with resident #003. [s. 19. (1)]

3. On an identified date and time, the home had notified the Ministry of Long-Term Care (MLTC) of an incident of altercation between residents #008 and #009. Subsequently, the home had submitted a CIR for the aforementioned incident.

A review of the home's internal report indicated as RN #122 was coming out of the main dining room, they had found residents #008 and #009 in an altercation and the RN immediately separated them.

A review of resident #008's assessment indicated their cognitive skills for daily decision-making were impaired.

A review of resident #008's written plan of care consisted of a focus on responsive behaviours, and a review of the BSO white board in the nursing station indicated identified interventions for resident #008.

An interview with PSW #121 indicated resident #008 had a history of exhibiting responsive behaviours towards staff and co-residents. An interview with the BSO manager indicated resident #008 was known to exhibit responsive behaviours towards staff and co-residents as well.

A review of resident #009's assessment and separate interviews with RPN #105 and the BSO manager, indicated their cognitive skills for daily decision-making were impaired,

and they exhibited responsive behaviours. A review of the BSO white board in the nursing station indicated identified interventions for resident #009.

During the course of the inspection, Inspector #653 was provided access to video footages from the home's video surveillance of the identified incident. The iDOC confirmed that RN #122, residents #008 and #009 were identified in the video. A review of the home's video surveillance revealed an altercation ensued between residents #008 and #009.

A review of progress note and an interview with RPN #123 indicated resident #008 was assessed for injury post altercation with resident #009. The RPN indicated resident #008 complained of pain and an alteration in skin integrity was noted on the resident.

An interview with the BSO manager indicated residents #008 and #009 were both high risk residents due to their responsive behaviours, and further indicated that they should be taken out of the identified area at different times, or closely monitored as they get out of the area to prevent incidents such as the one that had happened.

An interview with the iDOC indicated based on the home's investigation including a review of the home's video surveillance, resident #008 was abused as they had sustained an injury as a result of the altercation with resident #009. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for resident #001 that sets out the planned care for the resident.

The home had submitted a CIR to the Director for an incident that caused an injury to resident #001 for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIR indicated that resident #001 was found on the floor in an identified area. A head to assessment was done and the resident was sent to hospital for further assessment.

A review of the home's internal report and progress notes, identified that prior to the above mentioned incident, resident #001 sustained a fall on four different dates.

An interview with the Physiotherapist (PT) and a review of their progress notes indicated resident #001 was at high risk for falls, and the PT recommended fall prevention strategies to be implemented by nursing.

A review of resident #001's written plan of care and an interview with the RAI Coordinator, indicated the section for falls including the focus, goal, and interventions were initially added following the fifth fall. Further review of resident #001's written plan of

care effective at the time of the incident, did not reflect the PT's recommendations or any other falls prevention strategies in place prior to the incident.

Separate interviews with PSWs #116 and #117 indicated resident #001 was already using an identified falls intervention prior to the incident. An interview with PSW #102 indicated they do not recall applying the identified falls intervention on the resident prior to the incident, when they were assigned to their care.

Separate interviews with the RAI Coordinator, PT, RPN #103, and the iDOC, acknowledged that resident #001's written plan of care did not set out the planned care for the resident as it related to the falls prevention strategies in place prior to the incident. [s. 6. (1) (a)]

2. As a result of non-compliance identified related to resident #001's written plan of care not setting out the planned care for the resident, the sample size was expanded to two additional residents including resident #007.

A review of the home's internal report records indicated resident #007 sustained six falls since admission. A review of resident #007's written plan of care did not reflect any falls prevention strategies in place prior to the sixth fall.

During separate interviews, the RAI Coordinator and the iDOC acknowledged the above mentioned information and that resident #007's written plan of care did not set out the planned care for the resident as it related to falls prevention strategies in place prior to their sixth fall. [s. 6. (1) (a)]

3. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

The home had submitted a CIR to the Director for an incident that caused an injury to resident #001 for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIR indicated that resident #001 was found on the floor in an identified area. A head to assessment was done and the resident was sent to hospital for further assessment.

A review of the home's internal report records and progress notes on PCC, identified that

prior to the above-mentioned incident, resident #001 sustained four falls.

An interview with the PT and a review of their progress notes indicated resident #001 was at high risk for falls, and the PT recommended fall prevention strategies to be implemented by nursing. The PT stated they followed up with the registered staff regarding one of their recommendations, but not the rest of the strategies.

A review of resident #001's written plan of care and an interview with the RAI Coordinator, indicated the section for falls including the focus, goal, and interventions were initially added following the fifth fall. Further review of resident #001's current written plan of care did not reflect the PT's recommendations, with the exception of one.

Separate interviews with the RAI Coordinator, PT, RPN#103, and the DOC, acknowledged that the staff and others involved in the different aspects of care of resident #001 did not collaborate with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other. [s. 6. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out the planned care for the resident and that the staff and others involved in the different aspects of care of the resident 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, to be implemented voluntarily.

WN #3: 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 written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home had submitted a CIR to the Director related to abuse. The CIR indicated an altercation ensued between residents #004 and #005 which resulted in resident #004's fall. As per the registered staff's assessment following the incident, resident #004 complained of pain, and an alteration in skin integrity was noted on resident #004.

A review of the home's policy titled "Abuse and Negligence – Document No. 02-06" dated October 2015, indicated the following under procedure: "The Nurse Manager once they have determined the resident is safe will inform the Director of Care and the Executive Director".

An interview with PSW #101 indicated at the time of the incident, they were in the hallway helping a resident. PSW #101 stated resident #004 was in the hallway and resident #005 was coming from the elevator. PSW #101 witnessed the altercation between resident #004 and resident #005 that resulted in resident #004's fall.

A review of resident #004's diagnostic result indicated an identified injury.

An interview with the ANM confirmed they were the most responsible person in the building at the time of the incident and indicated they did not inform the Director of Care, the Executive Director, nor the on-call manager regarding the abuse incident, as required by the home's policy.

An interview with the iDOC acknowledged the above mentioned information and that the home's policy on "Abuse and Negligence" was not complied with when the ANM did not inform the Director of Care and the Executive Director of the incident of abuse. [s. 20. (1)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours where possible.

The home had submitted a CIR to the Director related to abuse. The CIR indicated an altercation ensued between resident #004 and resident #005 which resulted in resident #004's fall. As per the registered staff's assessment following the incident, resident #004 complained of pain, and an alteration in skin integrity was noted on resident #004.

A review of resident #005's assessment, indicated their cognitive skills for daily decision-making were impaired.

A review of resident #005's PCC progress notes and separate interviews with PSWs #101, #107, and RPN #110 indicated resident #005 exhibited responsive behaviours towards co-residents.

An interview with the BSO manager indicated resident #005 was not under the BSO program and they had not seen nor heard anything related to the resident exhibiting responsive behaviours, and there was no behavioural plan of care for the resident related to responsive behaviours identified by the PSWs and registered staff. The BSO manager further acknowledged that strategies had not been developed and implemented to respond to the resident demonstrating responsive behaviours. [s. 53. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff received training on the home's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities.

According to Long-Term Care Homes Act (LTCHA),2007, s. 74 (2) "Agency staff" means staff who work at the long-term care home pursuant to a contract between the licensee and an employment agency or other third party.

The home had submitted a CIR to the Director related to abuse. The CIR indicated an altercation ensued between resident #004 and resident #005 which resulted in resident #004's fall. As per the registered staff's assessment following the incident, resident #004 complained of pain, and an alteration in skin integrity was noted on resident #004.

An interview with the ANM confirmed they were the most responsible person in the building at the time of the incident. They further indicated they worked under an agency

as an RN, and picked up about four shifts at Tony Stacey since they started. When asked by the inspector if they had received training on the home's policy on "Abuse and Negligence" prior to performing their responsibilities at Tony Stacey, the ANM confirmed they did not receive any training from the home.

An interview with the iDOC acknowledged the above mentioned information and that the home utilizes agency to replace PSWs, RPNs, and RNs, if needed. The iDOC indicated agency staff receive a general orientation from the home, which is more specific to the floor. They further indicated it had been an old practice in the home that the agency provides a more in-depth training to the agency staff and not the home. The iDOC acknowledged that the licensee has failed to ensure that agency staff received training on the home's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities. [s. 76. (2) 3.]

2. The licensee has failed to ensure that staff received training in the area of mandatory reporting under section 24 of the Act of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident, prior to performing their responsibilities.

An interview with the ANM confirmed they were the most responsible person in the building at the time of the incident. They further indicated they worked under an agency as an RN, and picked up about four shifts at Tony Stacey since they started. When asked by the inspector if they had received training in the area of mandatory reporting under section 24 of the Act of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident, prior to performing their responsibilities at Tony Stacey, the ANM confirmed they did not receive any training from the home.

An interview with the iDOC acknowledged the above mentioned information and that the licensee has failed to ensure that agency staff received training in the area of mandatory reporting under section 24 of the Act of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident, prior to performing their responsibilities. [s. 76. (2) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: The long-term care home's policy to promote zero tolerance of abuse and neglect of residents and the duty under section 24 to make mandatory reports, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home had submitted a CIR to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIR indicated an altercation ensued between residents #002 and #003, and resident #002 fell and was sent to hospital.

A review of progress notes and an interview with RPN #105 indicated at the time incident, they were inside the nursing station and resident #003 was just outside sitting in a chair in the hallway, and the RPN saw resident #002 was tugging on resident #003's arm. Before the RPN could reach the two residents, an altercation ensued between residents #002 and #003, resulting in resident #002's fall, and were sent to hospital for further assessment. Resident #002 was later diagnosed with an injury.

An interview with the iDOC indicated at the time of the incident, they were present in the home in the capacity of an Assistant Director of Care (ADOC) and attended to the residents with the former DOC. The iDOC acknowledged that the incident of physical abuse was not immediately reported to the Director as required. [s. 24. (1)]

WN #7: 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. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

According to the LTCHA, 2007, s. 23 (2) and (3), 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). A licensee who reports under subsection (2) shall do so as is provided for in the regulations, and include all material that is provided for in the regulations.

According to O. Reg. 79/10, s. 104 (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

On an identified date and time, the home had notified the MLTC of an incident of altercation between residents #008 and #009. Subsequently, the home had submitted a CIR for the aforementioned incident.

A review of the home's internal report indicated as RN #122 was coming out of an identified area, they had found residents #008 and #009 in an altercation, and the RN immediately separated them.

A review of the home's video surveillance revealed an altercation ensued between residents #008 and #009, and separate interviews with RN #122 and RPN #123 indicated resident #008 sustained an alteration in skin integrity due to the altercation with resident #009. RN #122 called the MLTC's afterhours pager and reported the incident as they constituted it as suspected abuse due to the altercation that ensued between the two residents.

A review of Critical Incident System (CIS) log #019873-19 intake, indicated the Centralized Intake Assessment and Triage Team (CIATT) Triage Inspector directed the iDOC to submit reportable CI by end of day after reviewing the incident, and to call if incident was non reportable. The home did not respond to the CIATT Triage Inspector's direction regarding the submission of CI.

On two different dates during the course of the on-site inspection, the iDOC indicated to Inspector #653 that they were still gathering information to include in the CI report. Subsequently, the home had first submitted the CIR to the Director 15 days following the incident of abuse and after becoming aware of the abuse. The licensee has failed to ensure that the report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. [s. 104. (2)]

Issued on this 22nd day of November, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 Homes Division
Long-Term Care Inspections Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	ROMELA VILLASPIR (653)
Inspection No. / No de l’inspection :	2019_823653_0026
Log No. / No de registre :	011460-19, 018309-19, 019001-19, 019873-19
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 13, 2019
Licensee / Titulaire de permis :	Royal Canadian Legion District 'D' Care Centres 59 Lawson Rd, TORONTO, ON, M1C-2J1
LTC Home / Foyer de SLD :	Tony Stacey Centre for Veterans' Care 59 Lawson Road, TORONTO, ON, M1C-2J1
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Catherine Hilge

To Royal Canadian Legion District 'D' Care Centres, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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 must be compliant with s. 19 (1) of the Long-Term Care Homes Act (LTCHA).

Upon receipt of this order the licensee shall: prepare, submit, and implement a plan to ensure the following:

1) Residents #005, #003, and #009 do not abuse and harm any residents in the home.

2) The plan must include, but is not limited to a written description of the interventions that will be implemented to ensure item #1 is complied with.

The plan is to be submitted by e-mail referencing report #2019_823653_0026 to the MLTC Homes Inspector by December 2, 2019, and implemented by February 10, 2020.

Grounds / Motifs :

1. The licensee has failed to ensure that residents #004, #002, and #008 were protected from abuse by anyone in the home.

The home had submitted a Critical Incident Report (CIR) to the Director related to abuse. The CIR indicated an altercation ensued between residents #004 and #005 which resulted in resident #004's fall. As per the registered staff's assessment following the incident, resident #004 complained of pain, and an alteration in skin integrity was noted on resident #004.

A review of resident #005's assessment, indicated their cognitive skills for daily

decision-making were impaired, and a review of progress notes and separate interviews with Personal Support Workers (PSWs) #101, #107, and Registered Practical Nurse (RPN) #110 indicated resident #005 exhibited responsive behaviours towards co-residents.

A review of resident #004's assessment and separate interviews with PSWs #107, #120, RPNs #109, and #119, indicated resident #004 had cognitive impairment and they exhibited responsive behaviours.

An interview with the BSO manager indicated resident #004 was not actively on BSO and had been discharged from the program. However, resident #004 was on BSO on as needed basis. The BSO manager acknowledged resident #004 had disruptive responsive behaviours. They further indicated resident #005 was not under the BSO program and they had not seen nor heard anything related to the resident exhibiting responsive behaviours, and there was no behavioural plan of care for the resident related to responsive behaviours identified by the PSWs and registered staff. The BSO manager acknowledged that resident #005's responsive behaviour should have been addressed and included in their plan of care.

Separate interviews with PSW #107 and RPN #109 indicated they were assigned to resident #004's care at the time of the incident. Shortly before the incident, both staff were with resident #004 in the hallway. PSW #107 and RPN #109 indicated resident #004 was agitated and did not take any medication and declined care. PSW #107 stated resident #004 spilled some beverage on the floor so they cleaned it and headed to the end of the hallway to dispose of the dirty towel. While RPN #109 went to the nursing station to check documentation related to resident #004. PSW #107 indicated by the time they returned, resident #004 was already sitting on the floor. RPN #109 stated the Agency Nurse Manager (ANM) notified them that there had been a fall in the hallway, and RPN #109 attended to resident #004 who was sitting on the floor.

An interview with PSW #101 indicated at the time of the incident, they were in the hallway helping a resident. PSW #101 stated resident #004 was in the hallway and resident #005 was coming from the elevator. PSW #101 witnessed the altercation between residents #004 and #005 that resulted in resident #004's fall.

A review of resident #004's diagnostic result indicated an identified injury.

An interview with the interim Director of Care (iDOC) acknowledged the above mentioned information and that resident #004 was abused when they sustained an injury as a result of the altercation with resident #005. (653)

2. The home had submitted a CIR to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIR indicated an altercation ensued between residents #002 and #003, and resident #002 fell and was sent to hospital.

A review of resident #003's assessment, indicated their cognitive skills for daily decision-making were impaired, and their written plan of care did not identify any information on responsive behaviours.

Separate interviews with PSWs #106, #120, RPNs #105, #119, and the BSO manager indicated resident #003 did not have responsive behaviours nor any history of altercation with co-residents.

A review of resident #002's assessment, indicated their cognitive skills for daily decision-making were impaired, and their written plan of care consisted of a focus on responsive behaviours.

Separate interviews with PSWs #106, #120, and RPN #119, indicated resident #002 was known to exhibit identified responsive behaviours towards staff, but not towards co-residents.

An interview with RPN #105 indicated at the time of the incident, they were inside the nursing station and resident #003 was just outside sitting in a chair in the hallway, and the RPN saw resident #002 was tugging on resident #003's arm. Before the RPN could reach the two residents, an altercation ensued between residents #002 and #003, resulting in resident #002's fall, and they were sent to hospital for further assessment.

A review of resident #002's diagnostic result from the hospital indicated an

identified injury.

A review of progress note and an interview with the BSO manager, indicated they had spoken to resident #003 regarding the incident, and resident #003 stated that resident #002 was pulling at them for over half an hour and was in their space. The BSO manager instructed resident #003 that if they were not comfortable and felt like their space was being invaded, that they should go to the nurse to seek out help.

An interview with the iDOC acknowledged the above mentioned information and that resident #002 was abused when they sustained an identified injury due to a fall, following the altercation with resident #003. (653)

3. On an identified date and time, the home had notified the Ministry of Long-Term Care (MLTC) of an incident of altercation between residents#008 and #009. Subsequently, the home had submitted a CIR for the aforementioned incident.

A review of the home's internal report indicated as RN #122 was coming out of the main dining room, they had found residents #008 and #009 in an altercation and the RN immediately separated them.

A review of resident #008's assessment indicated their cognitive skills for daily decision-making were impaired.

A review of resident #008's written plan of care consisted of a focus on responsive behaviours, and a review of the BSO white board in the nursing station indicated identified interventions for resident #008.

An interview with PSW #121 indicated resident #008 had a history of exhibiting responsive behaviours towards staff and co-residents. An interview with the BSO manager indicated resident #008 was known to exhibit responsive behaviours towards staff and co-residents as well.

A review of resident #009's assessment and separate interviews with RPN #105 and the BSO manager, indicated their cognitive skills for daily decision-making were impaired, and they exhibited responsive behaviours. A review of the BSO

white board in the nursing station indicated identified interventions for resident #009.

During the course of the inspection, Inspector #653 was provided access to video footages from the home's video surveillance of the identified incident. The iDOC confirmed that RN #122, residents #008 and #009 were identified in the video. A review of the home's video surveillance revealed an altercation ensued between residents #008 and #009.

A review of progress note and an interview with RPN #123 indicated resident #008 was assessed for injury post altercation with resident #009. The RPN indicated resident #008 complained of pain and an alteration in skin integrity was noted on the resident.

An interview with the BSO manager indicated residents #008 and #009 were both high risk residents due to their responsive behaviours, and further indicated that they should be taken out of the identified area at different times, or closely monitored as they get out of the area to prevent incidents such as the one that had happened.

An interview with the iDOC indicated based on the home's investigation including a review of the home's video surveillance, resident #008 was abused as they had sustained an injury as a result of the altercation with resident #009.

The severity of this issue was determined to be a level 3 as there was actual harm to residents #004, #002, and #008. The scope of the issue was a level 3 as it related to three of three residents reviewed. The home had a level 2 compliance history as they had one or more unrelated non-compliance in the last 36 months. (653)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 10, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 13th day of November, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Romela Villaspir

Service Area Office /
Bureau régional de services : Central East Service Area Office