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
Oct 15, 2020	2019_725522_0018 (A3)	019111-19, 019112-19, 019142-19, 023143-19, 023663-19	Critical Incident System

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Secord Trails Care Community
263 Wonham Street South INGERSOLL ON N5C 3P6

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

Amended by JULIE LAMPMAN (522) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee has requested an extension to the compliance due dates for orders #002 and #009.

Issued on this 15th day of October, 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 JULIE LAMPMAN (522) - (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): December 18, 20, 30, 2019, January 6, 7, 8, 9, 10, 13, 22, 23, 24, 31 and February 3 and 5, 2020.

The following intakes were inspected during this inspection:

Log #019142-19 Follow up to CO #001 from inspection #2019_725522_0014/015971-19 related to sufficient staffing.

Log #019112-19 Follow-up to CO #002 from inspection #2019_725522_0013/016180-19 related to documentation of care as per the plan of care.

Log #019111-19 Follow up to CO #001 from inspection #2019_725522_0013/016180-19 related to plan of care reviewed and revised when the resident's care needs changed.

Critical Incident System (CIS) report #2628-000036-19/Log #023143-19 related to resident to resident abuse.

CIS report #2628-000037-19/Log #023663-19 related to an unexpected resident death.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Assistant Director of Care, Office Manager, Scheduling Coordinator, Registered Nurses, Registered Practical Nurses, Behavioural Supports Ontario Registered Practical Nurse, an agency Registered Practical Nurse, Personal Support Workers, Behavioural Supports Ontario Personal Support Worker, a Physiotherapist, Physiotherapist Aide, Physicians, a Housekeeper, Security Guards and residents.

The inspectors also observed staff to resident interactions, resident to resident interactions, the provision of resident care, observed home areas, reviewed resident clinical records, bathing schedules, daily rosters, the written staffing plan of the home, the home's program evaluations and policies and procedures related to this inspection.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

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

12 WN(s)
4 VPC(s)
9 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 31. (3)	CO #001	2019_725522_0014	569
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2019_725522_0013	522

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

On October 2, 2019, during Complaint inspection #2019_725522_0014 Compliance Order (CO) #001 was issued related to LTCHA s. 31 (3) which stated the licensee must ensure that residents #001 and #002 and all other residents who require assistance with a specific care task, have the care completed at specific time frames and that the care is documented. The compliance due date was November 29, 2019.

The order was issued as resident #001 did not receive assistance with care as required.

Review of resident #007's (referred to as resident #001 in CO #001) most recent care plan on Point Click Care (PCC) noted resident #007 required specific assistance with daily care.

Resident #007's care plan noted that resident #007 required specific assistance with care.

Review of resident #007’s electronic kardex on PCC noted the resident did not require the specific assistance with care.

Review of resident #007’s care plan history for the specific assistance with care in resident #007’s electronic kardex noted the following:

For over a year, resident #007 required specific assistance with care. This was entered by registered staff.

Shortly after CO #001 was issued, resident #007's care plan was changed and indicated the resident did not require the specific assistance with care. This was revised by Assistant Director of Care (ADOC) #109.

Review of resident #007's most recent Minimum Data Set (MDS) Assessment due to a "Significant Change in Status" indicated noted there was no change in resident #007’s Activities of Daily Living (ADL) functioning compared to resident #007's previous two MDS Assessments.

During observations of resident #007 over a specific five day period, inspector did not observe resident #007 to be independent with the specific area of care. Resident #007 stated they needed assistance with the specific care area.

In an interview, Personal Support Worker (PSW) #118 stated resident #007 required assistance with the specific care area.

In an Interview, Registered Nurse (RN) #119 reviewed resident #007’s plan of care with inspector and stated that resident #007 required assistance with the specific care area. RN #119 stated that the changes made to resident #007’s plan of care did not reflect the care resident #007 required.

In an interview, with Director of Care (DOC) #100 and ADOC #109, DOC #100 stated they had revised resident #007’s care plan to reflect that the resident did not require the specific assistance with care. When inspector asked what the change was based on as resident #007’s ADL functioning on their MDS Assessment had not changed, DOC #100 stated they had witnessed resident #007 complete the specific care task on their own and they had based the change

on information from PSWs. DOC #100 stated registered staff would not know if resident #007 needed the required assistance with the specific care task.

Reviewed resident #007's care plan history with DOC #100 and ADOC #109. ADOC #109 acknowledged their name was noted as making the changes to resident #007's care plan to reflect the resident did not require the specific assistance with care. ADOC #109 stated they did not know why they made the change to resident #007's care plan.

In an interview, PSW #127 stated they worked full time and resident #007 was on their regular assignment. PSW #127 stated that resident #007 required specific assistance with care. PSW #127 stated they were not aware resident #007's care plan had been changed and no one had spoken to them regarding resident #007. PSW #127 stated resident #007 was not capable of completing the specific care task on their own.

The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #007 collaborated with each other when resident #007's plan of care related to assistance with a specific care task was changed by DOC #100 to reflect the resident did not require the specific assistance with care. Resident #007's plan of care was changed prior to the compliance due date for CO #002, which stated resident #007 who required assistance with a specific care task was to have the care completed at specific time frames.

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 assessment of the resident so that their assessments were integrated and were consistent with and complemented each other. [s. 6. (4) (a)]

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

Review of resident #007's most recent electronic care plan in Point Click Care (PCC) noted resident #007 required assistance with daily care.

The care plan noted the resident was a high risk for falls due to falling asleep in their chair. The support action noted team members were to monitor resident #007 and if they fell asleep in their chair they were to put resident #007 back into bed.

Resident #007's electronic kardex in PCC noted a support action for transfers which stated resident #007 required specific assistance for transfers as they often fell asleep in their chair.

During a continuous observation of resident #007 on a specific date the following was noted:

At a specific time, resident #007 was observed seated in a chair outside of the nurses' station. Resident #007 was slumped forward.

Twenty minutes later, resident #007 was still seated in their chair in the same spot outside the nurses' station. Resident #007 was still slumped forward.

Twenty minutes later, a Personal Support Worker took resident #007 to the dining room and positioned resident #007 at a table.

Twenty minutes later, resident #007 was observed seated in their chair at the dining room table. Resident #007 was slumped forward.

In an interview, Director of Care (DOC) #100 stated that resident #007 should be repositioned right away if they were slumped over sleeping in their chair.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan of care. [s. 6. (7)]

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

On October 2, 2019, during Critical Incident inspection #2019_725522_0013 Compliance Order (CO) #002 was issued which stated the licensee must ensure the provision of care set out in the plan of care for resident #001, #002 and #005 and all other residents was documented. The compliance due date was November 29, 2019.

A) Review of documentation of care provided for resident #013 (resident #005 in CO #002) in Point of Care (POC) for a specified time period, noted incomplete documentation on 16 identified care tasks.

A seven day observation for the Minimum Data Set (MDS) Assessment observation period took place during a specific time period for Activities of Daily Living (ADL) – Bed Mobility/ Dressing/Eating/Personal Hygiene/Toileting/Transferring/Walk in corridor/Walk in room. The absence of documentation was noted during the observation period for one night and one day.

In an interview, Director of Care (DOC) #100 confirmed the missing documentation. DOC #100 stated they did not focus on daily, evening and night care needs as part of the home's audit of documentation. DOC #100 stated the documentation audit only focused on resident care such as bathing, turning and repositioning and continence care. DOC #100 stated staff had been given the charting policy for POC and were to read and sign it and staff had also been offered overtime to document but they have refused it.

B) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care related to an incident of resident to resident abuse.

Review of the CIS noted resident #003 received abuse from resident #002 (resident #001 in CO #002). The CIS indicated resident #002 would have identified safety interventions in place until the specific intervention was implemented.

In an interview, RPN #107 stated that resident #002 had one ongoing intervention in place related to the incident and another specific intervention was in place over a 14 day period.

Review of documentation of resident #002's ongoing intervention with RPN #107 noted the absence of documentation over specific time frames. RPN #107 confirmed that documentation should have been completed.

Review of resident #002's electronic kardex in Point Click Care (PCC) noted that the specific intervention for resident #002 had to be documented at specific timeframes.
Review of resident #002's charting for the 14 day intervention in POC noted partial documentation on five out of 14 days.

Review of resident #002's POC documentation for BEHAVIOURS / EXPRESSIONS- noted the absence of documentation on two out of 31 days and

one out of 31 evenings.

Review of resident #002's electronic Treatment Administration Record noted an order for specific documentation every shift.

Review of resident #002's electronic progress notes in Point Click Care (PCC) noted the absence of the specific documentation on nine shifts over a two week period.

In an interview, Director of Care (DOC) #100 acknowledged the absence of documentation for resident #002. DOC #100 stated staff should be completing documentation at specific time frames and every shift for resident #002.

C) Review of resident #005's documentation in POC for a specific time frame, noted incomplete documentation on 6 identified care tasks.

In an interview, ADOC #109 confirmed the missing documentation. ADOC #109 stated for the daily, evening and night care needs, resident #005 was on a seven day observation period for their Minimum Data Set (MDS) Assessment and this information was captured under bed mobility, dressing, eating, locomotion, personal hygiene, toileting, transferring, walk in corridor and room.

Review of resident #005's seven day observation period, noted documentation missing under the above categories for one evening and one night.

D) Resident #016 was to have time specific documentation completed over a five day period related to a specific intervention.

Review of resident #016's specific documentation noted the absence of documentation during specific time frames on three of five days.

In an interview, Director of Care #100 stated they had reviewed the documentation and were aware staff had not been completing the documentation in full. DOC #100 stated they expected that the specific documentation was completed in full for residents that required the specific intervention.

E) Resident #004 was to have time specific documentation completed over a five day period related to a specific intervention.

Review of resident #004's specific documentation noted the absence of documentation during specific time frames on five of five days.

Further review of resident #004's chart noted resident #004 had time specific documentation completed on three more occasions over a five day period.

i) On the first occasion, documentation was noted as absent on three of five days.

ii) On the second occasion, documentation was noted as absent on four of five days.

iii) On the third occasion, documentation was noted as absent on two of five days.

In an interview, Director of Care #100 stated they had reviewed the documentation and were aware staff had not been completing the documentation in full. DOC #100 stated they expected that the specific documentation was completed in full for residents that required the specific intervention.

The licensee has failed to ensure that the provision of care set out in the plan of care was documented. [s. 6. (9) 1.]

Additional Required Actions:

CO # - 001, 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 #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

A) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care related to an incident of resident to resident abuse.

Review of the CIS noted resident #003 received abuse from resident #002. The CIS indicated resident #002 would have specific identified interventions in place.

Review of risk management in Point Click Care (PCC) noted resident #003 had a previous incident of abuse from resident #002.

Review of resident #002's clinical record in PCC noted under "Special Instructions" that resident #002 was a high risk and required frequent monitoring.

Review of resident #002's hard copy chart noted a physician's order from Physician #133 dated prior to the incident of abuse, which stated resident #002 was to have a specific intervention in place due to their behaviours.

Review of resident #002's electronic care plan in PCC dated noted resident #002 would have the specific intervention in place until the resident's behaviour was under control.

A review of resident #002's electronic progress notes in PCC noted documentation three days after the physician's order, from Director of Care (DOC) #100 that resident #002's family had been made aware that resident #002's specific intervention would be removed.

There was no documentation related to an assessment of resident #002 or discussion with direct care staff or the resident's physician regarding removing the specific intervention for resident #002.

Review of resident #002's physician's orders noted no order from Physician #133 to discontinue the specific intervention that they had ordered.

Review of a specialized Assessment for resident #002 completed a day before the incident of abuse, noted that it was unfortunate resident #002 no longer had the specific intervention in place.

Review of resident #002's hard copy chart noted no evidence that resident #002 was monitored after the specific intervention was removed.

In an interview, Personal Support Worker (PSW) #120 stated that resident #002 had the specific intervention which had been helpful for resident #002.

In an interview, PSW #110 stated they had witnessed the incident of abuse between resident #002 and resident #003. PSW #110 stated resident #002 had a tendency to seek out resident #003 and that there had been a previous incident of abuse toward resident #003. PSW #110 stated staff tried to keep an eye on residents but at the time of the incident it was almost supper time and staff were on break. PSW #110 stated the specific intervention helped manage resident #002 and once the intervention was removed it was only a matter of less than a week before there was an incident.

In an interview, Registered Practical Nurse (RPN) #116 and PSW #115 stated they worked with resident #002 due to their behaviours. RPN #116 and PSW 115 stated they had been told by DOC #100 that they would be removing resident #002's specific intervention. RPN #116 and PSW #115 stated they were not involved in the decision and did not agree with the decision to remove resident #002's specific intervention. PSW #115 stated there was no physician's order to remove the specific intervention and that it had been a management decision.

In a telephone interview, Physician #133 stated they had ordered the specific intervention for resident #002. Physician #133 stated DOC #100 had mentioned in passing that resident #002 had been improving and the possibility of stopping the specific intervention. Physician #133 stated they were not called to discontinue their order for the specific intervention, and they were not made aware that the specific intervention had ceased. Physician #133 stated as resident #002's doctor they would have expected to be called about the decision to remove resident #002's specific intervention.

In a telephone interview, DOC #100 confirmed that they had made the decision to remove resident #002's specific intervention. DOC #100 stated the decision to remove the specific intervention was based on a change to resident #002's medication and the decision with the doctor. DOC #100 stated there was nothing reported that resident #002 was abusive to other residents and resident #002 had a medication change six weeks ago. DOC #100 stated they had based their decision on review of resident #002's progress notes and PSW dashboard alerts, they had not discussed the decision with resident #002's direct care staff. DOC #100 stated they had not documented the conversation with Physician #133 or confirmed that there was an order from Physician #133 prior to removing the specific intervention.

DOC #100 stated usually after a specific intervention was removed from a resident, the resident would be monitored, and this would be documented. DOC #100 stated they reviewed resident #002's hard copy chart and were unable to locate documented monitoring of resident #002 after their specific intervention was removed.

The licensee failed to protect resident #003 from resident #002 who had history of behaviours and a previous incident of abuse toward resident #003. Management removed a specific intervention for resident #002 without an assessment or documented consultation with resident #002's direct care staff, resident #002's physician who had ordered the specific intervention for resident #002. After the removal of the specific intervention, monitoring was not implemented to monitor resident #002's behaviours and several days later, resident #002 had an incident of abuse towards resident #003.

The licensee has failed to ensure that resident #003 was protected from abuse by resident #002.

B) Review of resident #016's electronic progress notes in PCC noted on a specific date, that a resident reported an incident of abuse from resident #016. The progress note had been documented by an Agency RPN.

In an interview, Agency RPN #129 stated a PSW had reported to them that resident #018 had reported to the PSW an incident of abuse from resident #016. Agency RPN #129 stated they had documented the incident in resident #018's electronic progress notes.

Review of resident #018's electronic progress notes in PCC noted documentation of the incident of abuse.

In an interview, Director of Care (DOC) #100 stated they recalled the incident between resident #016 and resident #018. DOC #100 acknowledged that the incident was considered abuse.

The licensee has failed to ensure that resident #018 was protected from abuse by resident #016.

C) A review of resident #004's electronic progress notes in PCC noted on a specific date, an incident of abuse toward another resident. The progress note indicated the PSW had observed the incident and put in an alert but did not verbally report the incident to the RPN. There was no information to determine the name of the resident who received the abuse.

In a telephone interview. PSW #128 stated they were aware of the incident, but they had not actually witnessed the incident. PSW #128 stated they had been informed by PSW #110 and then had entered an alert of the incident for resident #004. PSW #128 stated they could not recall the name of the other resident involved.

In an interview, DOC #100 stated they were not aware of the incident with resident #004. DOC #100 stated the incident would appear on the 24 hour nursing report. DOC #100 stated the ADOC reviewed the 24 hour report and the incident would be reported to the DOC during daily registered staff huddle. DOC #100 stated sometimes the way staff typed the incident, it made it look like something happened and then when you followed up you found out they meant something else. Inspector informed DOC #100 that a PSW had stated that the incident involving resident #004 had been reported to them. DOC #100 acknowledged that the incident was abuse.

In a telephone interview, PSW #110 stated that another PSW had reported to them that while PSW #110 was on break they had witnessed an incident of abuse from resident #004 towards resident #019. PSW #110 stated resident #019 was their assigned resident and they went and checked resident #019 for injuries and documented for resident #019. PSW #110 stated they had informed the PSW assigned to resident #004 what had happened and that PSW had entered the

alert for resident #004. PSW #110 stated they should have informed the registered staff about what had happened, but they had thought the PSW who had witnessed the incident had informed the RPN.

In a telephone interview, RPN #132 stated they had documented the progress note for resident #004 and resident #019 after they saw a dashboard alert related to the incident of abuse. RPN #132 stated they had assessed resident #019 for injury and at the time could not find any injuries. RPN #132 stated since the PSW who witnessed the incident and the PSWs who had entered the alert for resident #019 and resident #004 had already finished their shift, they did not have enough information to fully document what happened.

In a telephone interview, DOC #100 reviewed resident #019's electronic progress notes in PCC and acknowledged there was no documented follow up with resident #019 to determine if resident #019 had sustained any injuries after the incident of abuse.

The licensee has failed to ensure that resident #019 was protected from abuse by resident #004.

D) Review of resident #004's electronic progress notes in Point Click Care (PCC) noted on a specific date, two incidents of abuse towards two separate residents.

i) Review of a risk management report in PCC dated on the specific date, noted an incident of abuse from resident #004 towards resident #014. The report noted resident #014 had no injuries at that time and a Pain Assessment noted resident #014's pain level to be a six. The risk management report was documented by Assistant Director of Care (ADOC) #109 and noted that the ADOC had sat with resident #014 for 10 minutes to provide reassurance.

In an interview, Personal Support Worker (PSW) #115 stated they witnessed the incident of abuse from resident #004 towards resident #014. PSW #115 stated ADOC #109 was covering for the DOC at that time and had come to check on the residents after the incident.

In an interview, resident #014 indicated that they recalled the incident of abuse from resident #004. Resident #014 indicated they experienced pain after the incident. Resident #014 indicated that management did not speak with them after the incident. Resident #014 indicated that no one followed up with them or

checked to see how they were doing after the incident of abuse.

ii) Review of a risk management report in PCC on the specific date, noted an incident of abuse from resident #004 towards resident #016. No injury was noted at the time of the incident and resident #016's pain level was noted as a four. The risk management report was documented by ADOC #109.

In an interview, resident #017 stated they had observed the incident between resident #004 and resident #016 and reported the incident to the nurse.

Review of resident #004's electronic progress notes in PCC noted a specific intervention was initiated for resident #004 due to their behaviours, approximately one month prior to the two incidents of abuse.

Further review of resident #004's progress notes noted behavioural issues with resident #004 towards staff and residents leading up to the incidents of abuse. The day prior to the two incidents of abuse, the progress notes indicated resident #004 no longer had the specific intervention in place.

Review of the home's Daily Roster noted the home was short a PSW for four hours the morning the incidents occurred, the day after the specific intervention was removed and was short two PSWs for four hours the next day, with no management onsite.

In an interview, PSW #115 stated right after the incident between resident #004 and resident #014 they went straight to the Executive Director's (ED) office to report the incident and ask what was going to be put in place prior to management being away the next day. PSW #115 stated that resident #004 previously had a specific intervention in place due to their behaviours. PSW #115 stated that the specific intervention had been removed by the DOC and there had been no consultation with direct care staff.

In an interview, Registered Practical Nurse (RPN) #116 stated they worked with resident #004 due to their behaviours. RPN #116 stated they had no input regarding resident #004's specific intervention being removed.

In an interview, PSW #105 stated resident #004 was part of their full time assignment. PSW #105 stated resident #004 displayed behaviours. PSW #105 stated resident #004's specific intervention had been removed prior to the incident

with resident #014. PSW #105 stated they had been informed by the DOC of the decision to remove the specific intervention, and they had not been involved in any discussion prior to the removal of the specific intervention.

In a telephone interview, Physician #130 stated they were resident #004's doctor. Physician #130 stated they were not involved in the decisions regarding the specific intervention for resident #004. Physician #130 stated if a resident was having behaviors and the home wanted to implement a specific intervention, it would be helpful to involve the physician in that decision. Physician #130 stated they trusted the staff's judgement to make the decision to remove the specific intervention as they were with the resident daily.

In an interview, ADOC #109 stated that resident #004 previously had a specific intervention in place. ADOC #109 stated the decision was made by the DOC in collaboration with the ADOC. ADOC #109 stated they thought the specific intervention was removed as there was documentation to support the removal of the specific intervention and resident #004 only had a few single episodes of behaviours. ADOC #109 stated there was an incident of abuse from resident #004 towards resident #014, the day after the specific intervention was removed. ADOC #109 acknowledged that there was no documentation in resident #004's progress notes about the decision to remove resident #004's specific intervention.

In a telephone interview, DOC #100 stated a decision to remove a specific support for a resident was based on progress notes and PSW dashboard alerts. DOC #100 stated the resident's doctor had to be in agreement and the team following the resident had to be involved in the decision. DOC #100 stated they had made the decision to remove resident #004's specific intervention. DOC #100 stated for more than a month there was no indication that resident #004 was having behaviours, no progress notes, or dash board alerts. DOC #100 stated there was nothing in the documentation that told them resident #004 needed the specific intervention.

DOC #100 was unable to provide documented evidence to support that the resident's physician, the team following the resident and staff were involved in the decision to remove resident #004's specific intervention.

Resident #004 had a specific intervention in place related to behaviours. Review of resident #004's progress notes noted several incidents of behaviours toward staff and residents and incidents where resident #004 had refused their

medications, prior to the removal of the specific intervention. Review of the home's Daily Roster for staffing noted the home was working short staffed after the specific intervention was removed. There was no documented evidence to support collaboration with direct care staff, the team following the resident and the resident's physician prior to the removal of resident #004's specific intervention.

The licensee has failed to protect resident #014 and resident #016 abuse by resident #004. [s. 19. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knew of, or that was reported was immediately investigated.

A) Review of resident #016's electronic progress notes in PCC noted on a specific date, that a resident reported an incident of abuse from resident #016. The progress note had been documented by an Agency RPN.

In an interview, Agency RPN #129 stated a PSW had reported to them that resident #018 had reported to the PSW an incident of abuse from resident #016. Agency RPN #129 stated they had documented the incident in resident #018's electronic progress notes.

Agency RPN #129 stated they did not find any injuries on resident #018. Agency RPN #129 stated when there was an incident of alleged or suspected abuse, they were required to report the incident to the Charge Nurse who would notify the Director of Care or the Oncall Manager depending on the time of day. Agency RPN #129 stated they could not recall if they had reported the incident between resident #016 and resident #018.

Review of resident #018's electronic progress notes in PCC noted that resident #018 was assessed after the incident and noted the resident did not have any injuries at that time. The progress note indicated resident #018 would be monitored.

Review of the home's ""Prevention of Abuse and Neglect of a Resident" policy VII-G-10.00 with a revision date of April 2019, noted in part,

"The Executive Director or designate 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 written statements are obtained as close to the time of the event as possible.
All investigative information is kept in a separate report from the resident's record.
The Executive Director or designate interviews the resident, other residents, and/or persons who may have any knowledge of the situation. If possible, include a management witness during interviews with all residents. The witness takes detailed notes of the conversation.
The Executive Director or designate interviews the alleged abuser."

In an interview, Director of Care (DOC) #100 stated they recalled the incident of abuse from resident #016 towards resident #018. DOC #100 stated for specific incidents of resident to resident abuse, they would complete the investigation into the abuse and for other incidents of resident to resident abuse the nursing staff would complete the investigation and they would assist if needed. DOC #100 stated they would document the investigation of abuse in the Critical Incident System (CIS) report which would be submitted to the Ministry of Long-Term Care and registered staff were required to document the incident of abuse in risk management.

DOC #100 stated they became aware of the incident of abuse between resident #016 and resident #018 during morning huddle. DOC #100 stated that they had reviewed the progress notes and decided what needed to be done and the Registered Nurse that cared for resident #016 was to follow up on the process for resident #016.

DOC #100 stated they did not recall if an investigation had been completed into the alleged abuse. DOC #100 acknowledged that they did not have any documentation related to an investigation and a CIS report had not been submitted related to the incident of alleged abuse.

B) A review of resident #004's electronic progress notes in PCC noted on a specific date, an incident of abuse toward another resident. The progress note indicated a PSW had observed the incident and put in an alert but did not verbally report the incident to the RPN. There was no information to determine the name of the resident who received the abuse.

In a telephone interview, PSW #128 stated they were aware of the incident, but they had not actually witnessed the incident. PSW #128 stated they had been informed by PSW #110 and then had entered an alert of the incident for resident #004. PSW #128 stated they could not recall the name of the other resident involved.

In an interview, DOC #100 stated they were not aware of the incident with resident #004. DOC #100 stated the incident would appear on the 24 hour nursing report. DOC #100 stated the ADOC reviewed the 24 hour report and the incident would be reported to the DOC during daily registered staff huddle. DOC #100 stated sometimes the way staff typed the incident, it made it look like something

happened and then when you followed up you found out they meant something else. Inspector informed DOC #100 that a PSW had stated that the incident involving resident #004 had been reported to them. DOC #100 acknowledged that the incident was abuse.

In a telephone interview, PSW #110 stated that another PSW had reported to them that while PSW #110 was on break they had witnessed an incident of abuse from resident #004 towards resident #019. PSW #110 stated resident #019 was their assigned resident and they went and checked resident #019 for injuries and documented for resident #019. PSW #110 stated they had informed the PSW assigned to resident #004 what had happened and that PSW had entered the alert for resident #004. PSW #110 stated they should have informed the registered staff about what had happened, but they had thought the PSW who had witnessed the incident had informed the RPN.

In a telephone interview, RPN #132 stated when an incident of abuse was reported to them they would check the resident, do a head to toe examine, treat any injuries, and report the incident to the DOC if they were working. RPN #132 stated they go through a checklist of suspected or actual abuse, they would call the doctor and both residents' families. RPN #132 stated it would depend upon the severity of the incident if they would inform the Ministry and nonemergency police. RPN #132 stated they would complete documentation in risk management, progress notes, assessment and follow up.

RPN #132 stated they had documented the progress note for resident #004 and resident #019 after they saw a dashboard alert related to the incident of abuse. RPN #132 stated they had assessed resident #019 for injury and at the time could not find any injuries. RPN #132 stated since the PSW who witnessed the incident and the PSWs who had entered the alert for resident #019 and resident #004 had already finished their shift, they did not have enough information to fully document what happened.

RPN #132 stated they reported the incident to DOC #100 as the DOC was working a night shift that night. RPN #132 stated DOC #100 agreed that they did not have all the information to complete the appropriate documentation and RPN #132 was to pass the information to the oncoming shift to have registered staff follow up with the PSWs for more information and complete the documentation.

In a telephone interview, inspector informed DOC #100 that resident #019 had

been the resident who had received abuse from resident #004. DOC #100 stated they still did not recall the incident. DOC #100 reviewed resident #019's electronic progress notes in PCC and acknowledged that the progress note related to the incident was the same as resident #004's progress note. DOC #100 stated there had been no investigation into the incident of abuse.

C) Review of resident #004's electronic progress notes in Point Click Care (PCC) noted on a specific date, two incidents of abuse towards two separate residents.

i) Review of risk management report in PCC dated on the specific date, noted an incident of abuse from resident #004 towards resident #014. The risk management report was documented by Assistant Director of Care (ADOC) #109 and noted that the ADOC had sat with resident #014 for 10 minutes to provide reassurance.

In an interview, ADOC #109 stated they had been covering for DOC #100 when the incident occured. ADOC #109 stated they were told by a PSW what had happened to resident #014 and they had spent some time with resident #014 as they had been quite shaken by the incident and resident #014 did not have an injury at that time. ADOC #109 they had been made aware of the incident as well as Executive Director (ED) #135.

ADOC #100 stated they had not completed an investigation into the incident of abuse of resident #014.

In an interview, ED #135 stated there was no documentation related to an investigation into the incident of abuse of resident #014.

ii) Review of risk management report in PCC on the specific date, noted an incident of abuse from resident #004 towards resident #016. The risk management report was documented by ADOC #109.

In an interview, ADOC #109 stated resident #017 had reported the incident that occurred between resident #004 and resident #016. ADOC #109 they had been made aware of the incident as well as ED #135. ADOC #109 stated they had assessed resident #016 after the incident and completed the risk management report on the incident.

ADOC #100 stated they had not completed an investigation into the incident of

abuse of resident #016.

In an interview, ED #135 stated there was no documentation related to an investigation into the incident of abuse of resident #016.

The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knew of, or that was reported was immediately investigated. [s. 23. (1) (a)]

2. The licensee has failed to ensure that that appropriate action was taken in response to every alleged, suspected or witnessed incident of abuse of a resident by anyone.

A) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care related to an incident of resident to resident abuse.

Review of the CIS noted resident #003 received abuse from resident #002. The CIS indicated resident #002 would have specific interventions in place.

A review of the home's Prevention of Abuse and Neglect of a Resident – Actual or Suspected – Nursing Checklist for the Investigation of Alleged Abuse of a Resident by Another Resident VII-G-10.00(b) dated April 2019, noted the checklist was to be used with any issues of suspected or actual abuse of a resident. The Checklist noted in part, "Within 24 hours of assault or neglect, at a minimum documentation and assessment of resident status each shift…, and within the next 48 hours, offer to arrange additional emotional counselling and support to the resident…"

A review of resident #003's electronic progress notes in PCC noted a PSW had witnessed the incident of abuse from resident #002 towards resident #003 and reported it to the RPN. The RPN documented that a head to toe assessment was completed of resident #003 and no injuries were noted. The RPN noted they had entered a specific intervention in Point of Care for PSWs to complete on resident #002.

Review of resident #003's progress notes noted no documented monitoring or assessment of resident #003 after the incident of abuse involving resident #002.

In an interview, RPN #132 stated the incident between resident #002 and resident

#003 was reported to them. RPN #132 stated they told the PSW to monitor resident #003 for any abnormal behaviours. RPN #132 stated they did not receive a report from the PSW of any abnormal behaviours and they had passed on to the next shift to monitor resident #003. RPN #132 stated they would only document in a resident's progress notes if the resident displayed abnormal behaviour after an incident of abuse.

In an interview, Director of Care #100 stated if there was an incident of resident to resident abuse, they would expect the resident who received the abuse to be monitored to ensure the resident was safe. DOC #100 stated a reminder should be added to a resident's Treatment Administration Record to remind registered staff to monitor the resident and there should be a documented progress note of the monitoring.

B) In an interview, Agency RPN #129 stated a PSW had reported to them that resident #018 had reported to the PSW an incident of abuse from resident #016. Agency RPN #129 stated they had documented the incident in resident #018's electronic progress notes. Agency RPN #129 stated at the time they did not find any injuries on resident #018.

Review of resident #018's electronic progress notes in PCC noted documentation of the incident of abuse. The progress note indicated that resident #018 did not have any injuries at that time and that staff would continue to monitor the resident.

There was a documented progress note for the next shift that the resident was monitored and then no further documentation in resident #018's progress notes related to monitoring resident #018 after the alleged incident of abuse.

Review of resident #018's assessment tab in PCC noted the absence of a documented physical assessment of resident #018 after the incident of alleged abuse.

In an interview, DOC #100 stated they recalled the incident between resident #016 and resident #018. DOC #100 acknowledged that the incident was considered abuse. DOC #100 stated when there was an incident of resident to resident abuse a head to toe assessment should be completed for the resident who received the abuse. DOC #100 reviewed resident #018's assessments in PCC and acknowledged the absence of a documented head to toe assessment for resident #018 after the alleged incident of abuse by resident #016. DOC #100

stated that registered staff probably did not see any injury and that was why an assessment was not completed. DOC #100 stated resident #018 should also have been monitored the following day after the incident of alleged abuse.

C) A review of resident #004's electronic progress notes in PCC noted on a specific date, an incident of abuse toward another resident. The progress note indicated the PSW had observed the incident and put in an alert but did not verbally report the incident to the RPN. There was no information to determine the name of the resident who received the abuse.

In a telephone interview, PSW #110 stated that another PSW had reported to them that while PSW #110 was on break they had witnessed an incident of abuse from resident #004 towards #019. PSW #110 stated resident #019 was their assigned resident and they went and checked resident #019 for any injuries and documented for resident #019. PSW #110 stated they had informed the PSW assigned to resident #004 what had happened and that PSW had entered the alert for resident #004. PSW #110 stated they should have informed the registered staff about what happened, but they had thought the PSW who had witnessed the incident had informed the RPN.

In a telephone interview, RPN #132 stated when an incident of abuse was reported to them, they would check the resident, do a head to toe examine, treat any injuries, and report the incident to the DOC if they were working. RPN #132 stated they go through a checklist of suspected or actual abuse, they would call the doctor and both residents' families. RPN #132 stated it would depend upon the severity of the incident if they would inform the Ministry and nonemergency police. RPN #132 stated they would complete documentation in risk management, progress notes, assessment and follow up.

RPN #132 stated they had documented the progress note for resident #004 and resident #019 after they saw a dashboard alert related to the incident of abuse. RPN #132 stated they had assessed resident #019 for injury and at the time could not find any injuries. RPN #132 stated since the PSW who witnessed the incident and the PSWs who had entered the alert for resident #019 and resident #004 had already finished their shift, they did not have enough information to fully document what happened.

RPN #132 stated they reported the incident to DOC #100 as the DOC was working a night shift that night. RPN #132 stated DOC #100 agreed that they did

not have all the information to complete the appropriate documentation and RPN #132 was to pass the information to the oncoming shift to have registered staff follow up with the PSWs for more information and complete the documentation.

In a telephone interview, DOC #100 reviewed resident #019's electronic progress notes and assessments in PCC. DOC #100 acknowledged that there was no documented assessment of resident #019 for any injuries. DOC #100 stated usually staff would check a resident if there was an incident of abuse and if there were no signs of bruises, they may not complete an assessment. DOC #100 stated if there were issues like a skin tear or bruising, staff should complete a head to toe assessment. DOC #100 stated there were no vital signs taken for resident #019 after the incident. DOC #100 stated staff should have entered a progress note to say resident #019 was assessed and there were no injuries and indicate that an assessment was not done. DOC #100 stated there was no documented monitoring of resident #019's status after the incident of abuse.

D) Review of resident #004's electronic progress notes in Point Click Care (PCC) noted on a specific date, two incidents of abuse towards two separate residents.

i) Review of a risk management report in PCC dated on the specific date, noted an incident of abuse from resident #004 towards resident #014. The report noted resident #014 had no injuries at that time and a Pain Assessment noted resident #014's pain level to be a six. The risk management report was documented by Assistant Director of Care (ADOC) #109 and noted that the ADOC had sat with resident #014 for 10 minutes to provide reassurance.

Review of resident #014's progress notes indicated a Head to Toe Skin Assessment was completed after the incident of abuse. The following day a progress note entry noted resident #004's family had called to check on the resident and resident seemed their usual self.

There were no other progress notes related to monitoring resident #014 after the incident of abuse.

In an interview, resident #014 indicated that they recalled the incident of abuse from resident #004. Resident #014 indicated they experienced pain after the incident. Resident #014 indicated that management did not speak with them after the incident. Resident #014 indicated that no one followed up with them or checked to see how they were doing after the incident of abuse.

In an interview, ADOC #109 stated they had been covering for DOC #100 at the time of the incident. ADOC #109 stated they were told by a PSW what had happened to resident #014 and they had spent some time with resident #014 as they had been quite shaken by the incident and resident #014 did not have an injury at that time. ADOC #100 acknowledged that they had sat with resident #014 immediately after the incident with resident #004 but had not completed any other follow up with resident #014. ADOC #109 stated there was no documentation to support that resident #014 had been monitored after the incident of abuse.

In an interview, Executive Director (ED) #135 stated they would expect resident #014 to be checked for injury, and there be follow up and monitoring of the resident after the incident.

ii) Review of risk management report in PCC noted an incident of abuse from resident #004 towards resident #016. No injury was noted at the time of the incident and resident #016's pain level was noted as a four. The risk management report was documented by ADOC #109.

Further review of resident #016's electronic progress notes noted documentation related to the incident of abuse. There were no other progress notes related to monitoring resident #016 after the incident of abuse.

In an interview, ADOC #109 stated resident #017 had reported the incident that occurred between resident #004 and resident #016. ADOC #109 they had been made aware of the incident as well as ED #135. ADOC #109 stated they had assessed resident #016 after the incident and completed the risk management report on the incident. ADOC #109 acknowledged that there was no documentation to support that resident #016 had been monitored after the incident of abuse. ADOC #109 stated after an incident of abuse they would expect the resident to be monitored to ensure they were okay.

In an interview, ED #135 stated they would expect resident #016 to be consoled if they were upset and to be monitored to make sure they were well, as fear could set in.

The licensee has failed to ensure that that appropriate action was taken in response to every alleged, suspected or witnessed incident of abuse of a resident

by anyone. [s. 23. (1) (b)]

Additional Required Actions:

CO # - 004, 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

WN #4: 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 comply with s. 24 (1) 2, in that a person who had

reasonable grounds to suspect abuse of a resident, failed to report the alleged abuse immediately to the Director in accordance with s. 24 (1) 2 of the LTCHA.

Pursuant to LTCHA 2007, s. 152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

A) Review of resident #016's electronic progress notes in PCC noted on a specific date, that a resident reported an incident of abuse from resident #016. The progress note had been documented by an Agency Registered Practical Nurse (RPN) and indicated that it was to show on the 24 hour nursing report.

In an interview, Agency RPN #129 stated a PSW had reported to them that resident #018 had reported to the PSW an incident of abuse from resident #016. Agency RPN #129 stated they had documented the incident in resident #018's electronic progress notes.

Agency RPN #129 stated resident #018 did not have any injuries at the time. Agency RPN #129 stated when there was an incident of alleged or suspected abuse, they were required to report the incident to the Charge Nurse who would notify the Director of Care or the Oncall Manager depending on the time of day. Agency RPN #129 stated they could not recall if they had reported the incident between resident #016 and resident #018.

Review of resident #018's electronic progress notes in PCC noted documentation of the incident of abuse.

In an interview, Director of Care (DOC) #100 stated they recalled the incident between resident #016 and resident #018. DOC #100 acknowledged that the incident was considered abuse. DOC #100 acknowledged that the incident had not been reported to the Ministry of Long-Term Care (MLTC).

B) A review of resident #004's electronic progress notes in PCC noted on a specific date, an incident of abuse toward another resident. The progress note indicated a PSW had observed the incident and put in an alert but did not verbally report the incident to the RPN. There was no information to determine the name of the resident who received the abuse. The progress note indicated that it was to show on the 24 hour nursing report.

In a telephone interview. PSW #128 stated they were aware of the incident, but

they had not actually witnessed the incident. PSW #128 stated they had been informed by PSW #110 and then had entered an alert of the incident for resident #004. PSW #128 stated they could not recall the name of the other resident involved.

In an interview, DOC #100 stated they were not aware of the incident with resident #004. DOC #100 stated the incident would appear on the 24 hour nursing report. DOC #100 stated the ADOC reviewed the 24 hour report and the incident would be reported to the DOC during daily registered staff huddle. DOC #100 stated sometimes the way staff typed the incident, it made it look like something happened and then when you followed up you found out they meant something else. Inspector informed DOC #100 that a PSW had stated that the incident involving resident #004 had been reported to them. DOC #100 acknowledged that the incident was abuse.

DOC #100 stated when there was an incident of specific resident to resident abuse, they would complete the investigation into the abuse and for any other incidents of resident to resident abuse the nursing staff would complete the investigation and they would assist if needed. DOC #100 stated they would document the investigation of abuse in the Critical Incident System (CIS) report which would be submitted to the MLTC and registered staff were required to document the incident of abuse in risk management.

In a telephone interview, PSW #110 stated that another PSW had reported to them that while PSW #110 was on break they had witnessed an incident of abuse from resident #004 towards resident #019. PSW #110 stated resident #019 was their assigned resident and they went and checked resident #019 for injuries and documented for resident #019. PSW #110 stated they had informed the PSW assigned to resident #004 what had happened and that PSW had entered the alert for resident #004. PSW #110 stated they should have informed the registered staff about what had happened, but they had thought the PSW who had witnessed the incident had informed the RPN.

In a telephone interview, RPN #132 stated they had documented the progress note for resident #004 and resident #019 after they saw a dashboard alert related to the incident of abuse. RPN #132 stated they had assessed resident #019 for injury and at the time could not find any injuries. RPN #132 stated since the PSW who witnessed the incident and the PSWs who had entered the alert for resident #019 and resident #004 had already finished their shift, they did not have enough

information to fully document what happened. RPN #132 stated when an incident of abuse of a resident occurred it would depend on the severity of the incident whether they would report it to the MLTC.

RPN #132 stated they reported the incident to DOC #100 as the DOC was working a night shift that night. RPN #132 stated DOC #100 agreed that they did not have all the information to complete the appropriate documentation and RPN #132 was to pass the information to the oncoming shift to have registered staff follow up with the PSWs for more information and complete the documentation.

In a telephone interview, Inspector #522 informed DOC #100 that resident #019 had been the resident who had received abuse from resident #004. DOC #100 stated they still did not recall the incident. DOC #100 stated that the MLTC had not been notified of the incident of abuse and a CIS report had not been submitted.

C) Review of resident #004's electronic progress notes in Point Click Care (PCC) noted on a specific date, two incidents of abuse towards two separate residents.

Review of a risk management report in PCC dated on the specific date, noted an incident of abuse from resident #004 towards resident #014. The report noted resident #014 had no injuries at that time and a Pain Assessment noted resident #014's pain level to be a six. The risk management report was documented by ADOC #109 and noted that the ADOC had sat with resident #014 for 10 minutes to provide reassurance.

In an interview, PSW #115 stated they witnessed the incident of abuse from resident #004 towards resident #014. PSW #115 stated ADOC #109 was covering for DOC at that time and had come to check on the residents after the incident. PSW #115 stated right after the incident they went straight to the Executive Director's (ED) office to report the incident and ask what was going to be put in place prior to management being away the following day.

In an interview, resident #014 indicated that they recalled the incident of abuse from resident #004. Resident #014 indicated they experienced pain after the incident. Resident #014 indicated that management did not speak with them after the incident. Resident #014 indicated that no one followed up with them or checked to see how they were doing after the incident of abuse.

In an interview, ADOC #109 stated they had been covering for DOC #100 at the time of the incident. ADOC #109 stated they were told by a PSW what had happened to resident #014 and they had spent some time with resident #014 as they had been quite shaken by the incident and resident #014 did not have an injury at that time. ADOC #109 they had been made aware of the incident as well as ED #135. ADOC #109 stated the incident was not reported to the MLTC as there was no injury to resident #014 and their level of care did not change.

In an interview, ED #135 stated they were working from home on the specific date, and they would have been made aware of the incident the next day by the Office Manager who was oncall. ED #135 stated the MLTC had not been informed of the incident of resident to resident abuse as there was no injury to resident #014. Inspector #522 asked ED #135 if they were aware of the reporting requirements for abuse and ED #135 stated they were aware of the reporting requirements and that staff needed to follow the abuse decision tree when reporting abuse.

Inspector #522 reviewed the MLTC Reporting Requirements Tip Sheet for Section 24 (1) Mandatory Reports with ED #135 which indicated that the home was required to immediately report abuse of a resident by anyone that resulted in harm or risk of harm and then investigate. ED #135 stated they were not aware of the requirement and the decision not to report was based on the abuse decision tree.

D) Review of resident #004’s electronic progress notes in Point Click Care (PCC) noted on a specific date, two incidents of abuse towards two separate residents.

Review of a risk management report in PCC on the specific date, noted the incident involved resident #016. No injury was noted at the time of the incident and resident #016’s pain level was noted as a four. The risk management report was documented by ADOC #109.

In an interview, PSW #115 stated they when they started their shift on the specific date, they were made aware of an incident of abuse from resident #004 towards resident #016. PSW #115 stated they then witnessed an incident of abuse from resident #004 towards resident #014. PSW #115 stated right after the incident they went straight to the ED's office to report the incident and ask what was going to be put in place prior to management being away the following day.

In an interview, ADOC #109 stated resident #017 had reported the incident that occurred between resident #004 and resident #016. ADOC #109 they had been made aware of the incident as well as ED #135. ADOC #109 stated the incident was not reported to the MLTC as there was no injury to resident #016 and their level of care did not change.

In an interview, ED #135 stated they were working from home on the specific date, and they would have been made aware of the incident the next day by the Office Manager who was oncall. ED #135 stated the MLTC had not been informed of the incident of resident to resident abuse as there was no injury to resident #016.

The licensee has failed to comply with s. 24 (1) 2, in that a person who had reasonable grounds to suspect abuse of a resident, that resulted in harm or risk of harm, failed to report the alleged abuse immediately to the Director in accordance with s. 24 (1) 2 of the LTCHA. [s. 24. (1)]

Additional Required Actions:

CO # - 006 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# 006

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In an interview, Registered Practical Nurse (RPN) #107 stated that resident #004 currently had a specific intervention in place due to recent behaviours.

Review of resident #004's electronic progress notes in Point Click Care (PCC) noted on a specific date an incident occurred where resident #004 had access to an item that caused risk to staff and residents.

The progress note indicated the manager on call had been informed of the incident.

In an interview, Personal Support Worker (PSW) #115 stated they were working on the specific date when the incident occurred.

PSW #115 stated when they walked in for their shift on the specific date, they were told resident #004 was having behaviours. PSW #115 stated resident #004 then gained access to an item from the physio area which put staff and other residents at risk.

In an interview, PSW #117 stated they were working on resident #004's home area when the incident occurred. PSW #117 stated they observed resident #004 with the item from the physio area. PSW #117 stated they had witnessed resident #004 with this item before. PSW #117 stated staff kept telling management it was not safe in the lounge as physio left all the equipment out and a curtain was not

secure like walls and a door.

In an interview, Registered Practical Nurse (RPN) #106 stated they were assigned to resident #004 on the date of the incident. RPN #106 confirmed that resident #004 had gained access to an item from the physio area which put other residents at risk.

In an interview PSW #105 stated resident #004 was their assigned resident. PSW #105 stated that when resident #004 displayed behaviours to ensure the safety of resident #004 and other residents they removed everyone from the area. PSW #105 stated they would try to herd resident #004 away from any items that put others at risk.

Inspectors #522 and #569 observed a specific lounge. Inspectors observed two wheelchairs in the resident sitting area, one was folded and against the wall along with a folding table. A privacy curtain was pulled across to divide the physiotherapy area from the lounge.

In resident #004’s home area, inspectors observed an unlocked closet. Inside the closet on the bottom shelf was an identified item.

In an interview, Physiotherapy Aide (PTA)#123 stated that resident #004 had gotten a hold of an item from the physio area. PTA#123 stated the item was now stored downstairs. PTA#123 stated they ensured all items they used for residents were now locked in the closet and other items were now stored downstairs.

Inspector #522 showed PTA#123 the closet on resident #004's home area. Inspector asked if the identified item should be stored in their since it was not locked. PTA#123 looked in the closet and stated they did not know where the identified item was from and that the door to the closet should be locked and locked the closet.

Inspector #522 showed RPN #106 the closet on resident #004's home area. The closet was unlocked. RPN #106 stated the closet should be locked and that it should not be open with the identified item in it. RPN #106 looked through the closet, found the lock and put the lock on the door.

Observation of the same closet three days later noted the door was closed, with the lock hanging on the latch but the lock was not engaged. PSW #105 who was

seated in the lounge at the end of hall by the closet stated that the closet should be locked, but they had just removed their tablet from the closet and they were sitting in the lounge completing their documentation. PSW #105 stated they could see the closet from where they were. PSW #105 stated there was a key to the lock that was hanging around the corner from the closet in the lounge. Inspector #105 observed the key which was hanging within reach on the wall in the lounge.

Observation of the closet sevral days later, noted the door was unlocked with the lock inside on the shelf. On the floor of the closet was the item from physiotherapy that resident #004 had previously gained access to. A resident was observed seated in a wheelchair in the lounge beside the closet door.

Inspector spoke with PTA #123 who was entering the hallway. PTA#123 stated they had stored the item in the closet as the closet was locked. PTA #123 confirmed the closet was left unlocked. PTA #123 took the lock from the shelf in the closet and locked the closet door. PTA#123 stated the closet should have been locked and they would find another spot to store the item.

In an interview, Assistant Director of Care (ADOC) #109 stated they were covering for the DOC at the time of the incident. ADOC #109 stated after the incident the physio item was removed from the area and put downstairs. ADOC #109 stated they were aware that the physio item had been put back in the specific home area closet. ADOC #109 stated the physio item was to be kept out of the area so it could not be picked up again. ADOC #109 stated all storage closets at the end of the hallway in each home area should be locked at all times.

The licensee has failed to ensure all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors were kept closed and locked when they were not being supervised by staff. [s. 9. (1) 2.]

Additional Required Actions:

CO # - 007 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# 007

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure the resident's responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included:
• any identified responsive behaviours;
• any potential behavioural triggers and variations in resident functioning at different times of the day.

A) In an interview, Registered Practical Nurse (RPN) #107 stated that resident #004 currently had a specific intervention in place due to recent behaviours.

Review of resident #004's electronic progress notes in Point Click Care (PCC) noted on a specific date an incident occurred where resident #004 had access to an item that caused risk to staff and residents.

Further review of resident #004's electronic progress notes noted an entry which indicated specific interventions for the resident at meal time.

There were numerous entries in resident #004's progress notes related to behaviours.

Review of resident #004's most recent electronic care plan on Pont Click Care (PCC) noted that resident #004 had behaviours.

Review of resident #004's electronic care plan, kardex and posted interventions noted no interventions related to certain behaviours and the specific interventions for resident #004 related to meal time.

In an interview, Personal Support Worker (PSW) #115 stated they worked with resident #004. PSW #115 stated resident #004 had displayed behaviours since their admission.

Inspectors #522 and #569 observed resident #004's room and noted several items accessible to the resident that could put other residents at risk.

Inspector #522 showed RPN #106 the items in resident #004's room. RPN #106 stated the items should not be in resident #004's room. RPN #106 removed the items and stated they would lock the items in the closet in the hallway.

In an interview, Assistant Director of Care (ADOC) #109 reviewed resident #004's plan of care with inspector #522. ADOC #109 acknowledged that resident #004's plan of care did not include specific interventions for meal time. ADOC #109 stated those interventions should be included in resident #004's plan of care. ADOC #109 acknowledged that there was no documentation in resident #004's plan of care related to specific behaviours.

B) Review of resident #016's electronic progress notes in PCC noted three separate incidents of specific behaviours.

Review of resident #016's most recent electronic care plan and posted interventions noted no documentation in resident #016's plan of care related to the specific behaviours.

In a telephone interview, PSW #115 stated that they worked with resident #016 and that resident #016 did display the specific behaviours.

In an interview, Registered Nurse (RN) #108 confirmed resident #016 displayed the specific behaviours. RN #108 reviewed resident #016's care plan, kardex and supportive actions in PCC and posted interventions and confirmed there were no interventions related to resident #016's specific behaviour.

In an interview, Director of Care (DOC) #100 stated resident #016's specific

behaviour would be considered a responsive behaviour. DOC #100 stated this behaviour and interventions should be identified in resident #016's plan of care.

In a telephone interview, DOC #100 stated they had thought about the incidents and felt the incidents were isolated and therefore would not expect them to be included in resident #016's plan of care.

The licensee failed to ensure resident #004's responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included:
• any identified responsive behaviours;
• any potential behavioural triggers and variations in resident functioning at different times of the day. [s. 26. (3) 5.]

Additional Required Actions:

CO # - 008 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# 008

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Findings/Faits saillants :

1. The licensee has failed to comply with the following requirement of the LTCHA: it is a condition of every licence that the licensee shall comply with every order made under the LTCHA.

On October 2, 2019, during Complaint inspection #2019_725522_0014 Compliance Order (CO) #001 was issued with a compliance due date of November 29, 2019.

Compliance Order (CO) #001 ordered the licensee to be compliant with s. 31. (3) of the LTCHA related to the home's staffing plan.

Specifically, the licensee was to:
a) Ensure that residents #002, #003, and #004, and all other residents, are bathed at a minimum twice a week by the method of their choice and bathing is documented.
b) Ensure that residents #001 and #002, and all other residents who require assistance with a specific care task, have the care completed at specific time frames and that the care is documented.
c) Ensure that residents #001 and #002, and all other residents receive specific care before and after meals and the specific care is documented.
d) Ensure resident #003 and all other residents that have specific interventions related to continence, have those interventions provided and documented.
e) Ensure resident #007 and all other residents receive the required assistance with personal care, and personal care is documented.
f) Ensure that resident #002 and all other residents are dressed appropriately, suitable to the time of day and dressing care is documented.
g) Ensure that resident #002 and all other residents that require assistance to get to the dining room for meals are brought down to meals prior to the start of the meal service.
h) Ensure resident care, as per the resident's individualized plan of care, is documented in Point of Care.
i) Develop and implement an auditing process to ensure that all residents receive two baths per week by the method of their choice, receive continence care and assistance with turning and repositioning as per their individualized plan of care and that resident care is documented in Point of Care. A documented record of these audits must be kept in the home and must include the dates conducted, the names and signatures of the participants, the results of the review and what changes were implemented as a result of the review.

j) Evaluate and revise the home's staffing plan and "Contingency Plan" document to ensure the staffing compliment meets the assessed care and safety needs of the residents of the home, until such a time that the home is fully staffed, according to the staffing plan. The evaluation and revision must be documented including the date it was conducted, the names and signatures of the participants, the results of the evaluation and what was done with the results of the evaluation."

The licensee completed steps a) to g) in CO #001.
The licensee failed to complete steps h), i) and j).

A) On October 2, 2019, during Complaint inspection #2019_725522_0014 Compliance Order (CO) #001 was issued. Part h) of the order stated that the licensee must ensure that resident care, as per the resident's individualized plan of care, was documented in Point of Care. The compliance due date was November 29, 2019.

i) Review of documentation of care provided for resident #008 (resident #002 in CO #001) and resident #009 (resident #003 in CO #001) in Point of Care (POC) for a specific time period noted the absence of required documentation during full or partial shifts for nine identified care tasks.

The prevalence for missing documentation trended towards night shifts for resident #008. For resident #009, missing documentation trended towards day shifts for during one month, and night shifts for another month.

In an interview, Director of Care (DOC) #100 was asked what the home's process was to ensure that resident care documentation was completed. DOC #100 said they ran a POC documentation compliance report in the mornings which included the tasks of turning and repositioning, bladder continence and baths provided. When asked DOC #100 stated they did not focus on daily, evening and night care needs as part of the home's audit of documentation. The documentation audit only focused on resident care such as bathing, turning and repositioning and continence care. DOC #100 stated staff had been given the charting policy for POC and were to read and sign it and staff had also been offered overtime to document but they had refused it.

A document was provided to the inspection team named "EDUCATION IN-SERVICE ATTENDANCE SHEET" with the in-service topic being "Documentation

– Electronic Resident Record". The document showed names/signatures of 15 Personal Support Workers (PSWs) out of the home's assignment list of 33 PSW's. The document was dated December 24, 2019, which was after CO #001's compliance due date of November 29, 2019. No other policy in-service attendance document was provided to the inspection team during this inspection.

Attached to the attendance document was the policy titled "Documentation – Electronic Resident Record", Policy #VII-J-10.00 with a current revision date of April 2019.

Review of the policy showed under the category Procedure:
"The Personal Support Worker / Resident Care Aide will: 1) Complete all Point of Care Documentation for the resident."

Additionally "The PSW / RCA will:
1) Document on POC all pertinent resident care delivery information prior to the end of their shift on the resident's individual record, which includes:
• MDS Observational Record for ADLs
• Nursing Rehab (if applicable)
• Food & Fluid intake following each meal and snack time
• Restraint and or repositioning tool as identified on POC if applicable
• Other assigned areas as identified on the POC system"

ii) Review of resident #007's (resident #001 in CO #001) electronic documentation in POC from for a specific time from noted the absence of documentation for full or partial shifts for 10 identified care tasks.

In a telephone interview, DOC #100 reviewed resident #007's documentation from POC. DOC #100 acknowledged the missing documentation for resident #007. DOC #100 stated if there was missing documentation for resident #007 it must have been because the PSW had something happen during the shift that affected them from completing their documentation.

DOC #100 reviewed the staffing schedule for a specific date, one of the days where documentation was noted as missing for resident #007. DOC #100 stated that the home area was short a PSW and an agency staff member had filled in. DOC #100 stated that it was the expectation that agency staff completed documentation in POC for resident care that was provided.

The licensee failed to comply with section h) of CO #001 to ensure resident care, as per the resident's individualized plan of care, is documented in Point of Care.

B) During the course of this follow-up inspection, various members of the home management team were asked how the home came into compliance with CO #001 part i) which stated “Develop and implement an auditing process to ensure that all residents receive two baths per week by the method of their choice, receive continence care and assistance with turning and repositioning as per their individualized plan of care and that resident care is documented in Point of Care. A documented record of these audits must be kept in the home and must include the dates conducted, the names and signatures of the participants, the results of the review and what changes were implemented as a result of the review.” The due date for this compliance order was November 29, 2019.

In an interview, Assistant Director of Care (ADOC) #109 was asked by Inspector #569 what audits were being completed to ensure that care was provided and that all residents received two baths per week, received continence care and assistance with turning and repositioning as per their individualized plan of care. ADOC #109 said they had completed three observational audits. When asked by Inspector #522 if there were any additional audits of care provided, ADOC #109 stated that registered staff were completing audits of care Personal Support Workers provided to residents.

Assistant Director of Care (ADOC) #109 provided a WORD document to Inspector #522. The document showed three visual audits completed by the ADOC. On December 9, 2019, an audit of catheter assistance for resident #009 was documented and an audit of turning and repositioning assistance was documented for resident #008. On December 10, 2019, an audit of turning and repositioning assistance was documented for resident #007. There were no names of the auditors and no associated signatures on the document. Also, there were no audit review results provided that identified what changes were implemented as a result of the review.

On January 24, 2020, in an interview, Registered Nurse (RN) #119 informed Inspector #522 that registered staff had not been recently asked to complete audits or observations of care provided to residents and that there had not been a formal meeting with all registered staff about completing audits of resident care.

RN #119 proved Inspector #522 with the registered staff meeting minutes binder.

Inspector #522 reviewed the meeting minutes for November 15, 2019, and noted no discussion related to audits of resident care related to repositioning and turning and continence care. There were no registered staff meeting minutes found for December 2019 in the same binder.

In an interview, Registered Practical Nurse #121 told Inspector #522 that registered staff were never asked to complete resident care audits and that they were unaware of a meeting that directed registered staff to do so. They also shared that they were recently directed to complete a visual audit of care for resident #009 which was done. Inspector #522 asked how the audit was documented and RPN #121 said they sent the observation in an email to ADOC #109.

A review of an email provided by RPN #121 to Inspector #522 and addressed to ADOC #109 documented that RPN #121 went over the catheter care and observed PSW #114. RPN #121 identified the resident referred to in the email to be #009. The email did not indicate the results of the observation and what changes were implemented as a result.

In a telephone interview, RPN #132 informed Inspector #522 that they had received no direction from management for registered staff to complete audits on the care provided to residents by PSWs.

Registered staff had indicated there had been a brief meeting with the Executive Director (ED) and two other registered staff members on January 13, 2020.

Review of the home's "Risk Management Plan – Nursing" policy #XXIII-G-10.00 with a revision date of June 2019, stated "As part of the risk management framework, the risk management plan is developed to monitor process and identify risks and outcomes of care. A series of resident care audits will be completed on a regularly scheduled basis."

During this inspection there were no other resident care audits provided to the inspection team for catheter assistance or turning and repositioning. Also, no auditing schedule was provided for these care tasks.

DOC #100 acknowledged there was no auditing process developed or implemented to ensure that all residents received continence care and assistance with turning and repositioning with the required documentation as identified in CO

#001 part i).

C) ED #135 had provided Inspector #569 a document "Secord Trails Care Community Staffing Plan Review, Review Date – November November 2018 from November 2019".. ED #135 said they had typed up the review document and said it was in error and should read 'November 2018 to November 2019. ED #135 said the review date occurred on November 28, 2019, which was identified in the body of the document as well as the document "Contingency Plan Meeting - November 28, 2019"

In an interview DOC #100 and ADOC #109, ADOC #109 stated the evaluation of the home's Staffing Contingency Plan was completed in March 2019. When asked by Inspector #522 if an evaluation of the Staffing Contingency Plan was completed as part of CO #001, DOC #100 stated an evaluation had not been completed as part of CO #001 as the evaluation was not due to be completed again until March 2020. ADOC #109 stated they did not complete an evaluation, but they did have a meeting in November 2019, regarding the Staffing Contingency Plan.

In an interview, ADOC #109 informed Inspector #522 that they had emailed ED #135 to clarify if there had been an evaluation of the staffing plan and contingency plan in relation to the order. ADOC #109 stated the ED had let them know that the evaluation of the Staffing Plan had taken place in March 2019 and had been reviewed at the Staffing Plan review meeting they held on November 28, 2019.

ED #135 was asked to provide the inspection team the staffing plan evaluation document that was to include the date it was conducted, the names and signatures of the participants, the results of the evaluation and what was done with the results as directed in Order #001, part j). ED #135 said that the home used their "Quality Management – LTC Program/Committee Evaluation Tool' to evaluate their programs including their staffing plan.

The home's "Quality Management – LTC Program/Committee Evaluation Tool' related to their staffing plan evaluation was provided to the inspection team by ED #135. Upon review of the evaluation tool it was documented "Period Reviewed: January – December 2019" and "Date of Report: March 2019". There was no specified date of the evaluation found that correlated with CO #001's due date of November 29, 2019, and although there was a list of those who participated in the evaluation, there were no associated signatures included.

ED #135 explained that the evaluation tool was a living document and that ongoing additions were made to it throughout the year. ED #135 acknowledged that there were no dates added when changes had been made to it as well as no signatures included with the list of the participants.

The licensee did not comply with Compliance Order #001 part h), i) and j) issued October 2, 2019, in inspection #2019_725522_0014 with a compliance due date of November 29, 2019. They failed to ensure that the provision of care for residents #007, #008 and #009, as per their individualized plan of care, was documented. They did not develop and implement an auditing process to ensure all residents received continence care and assistance with turning and repositioning as per their individualized plan of care with associated documentation. There were no documented records of these audits that included the dates conducted, the names and signatures of the participants, the results of the review and what changes were implemented as a result of the review. The licensee also did not include the date of the evaluation of the staffing plan and contingency plan, as well as the signatures of the participants.

The licensee has failed to comply with the following requirement of the LTCHA: it is a condition of every licence that the licensee shall comply with every order made under the LTCHA. [s. 101. (3)]

Additional Required Actions:

CO # - 009 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# 009

WN #8: 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 where the Act or Regulations required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

A) Ontario Regulation 79/10 s. 55 (a) states, “Every licensee of a long-term care home shall ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident’s behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.”

Review of the home’s “Residents with Behavioural & Psychological Symptoms of Dementia (BPSD)” policy VII-F_10.20 with a revision date of April 2019, noted in part:

In all specific incidents the Director of Care or designate will:
“1) Following the incident, meet with all team members involved to debrief regarding the situation and provide follow up support as required.
2) Complete required incident reporting.”

In an interview, Registered Practical Nurse (RPN) #107 stated that resident #004 currently had a specific intervention in place due to recent behaviours.

Review of resident #004’s electronic progress notes in Point Click Care (PCC)

noted on a specific date an incident occurred where resident #004 had access to an item that caused risk to staff and residents.

The progress note indicated the manager on call had been informed of the incident.

In an interview, Personal Support Worker (PSW) #115 stated they were working on the specific date when the incident occurred. PSW #115 stated when they walked in for their shift on the specific date, they were told resident #004 was having behaviours. PSW #115 stated resident #004 then gained access to an item from the physio area which put staff and other residents at risk.

PSW #115 stated the staff had debriefed together after the incident but there had been no formal debrief or discussion as a team with management after the incident.

In an interview, PSW #117 stated they were working on resident #004's home area when the incident occurred. PSW #117 stated they observed resident #004 with the item from the physio area.

In an interview, Registered Practical Nurse (RPN) #106 stated they were assigned to resident #004 on the date of the incident. RPN #106 confirmed that resident #004 had gained access to an item from physio which put other residents at risk. RPN #106 stated the Charge Nurse called the Oncall Manager and the Executive Director (ED) had called to check in.

RPN #106 stated they did a debrief with the staff working to tell them what a good job they had done. RPN #106 stated there was no debrief as a team with management after the incident with resident #004. RPN #106 stated they were in the thick of everything and no one spoke with them about what had happened.

In an interview, Assistant Director of Care (ADOC) #109 stated they were covering for the DOC at the time of the incident. ADOC #109 stated they believed they were made aware of the incident with resident #004 the following day after they read report. ADOC #109 stated they did not do anything in regards to the incident that occurred with resident #004. ADOC #109 stated there was no follow up with staff after the incident. When asked by inspector #522, ADOC #109 acknowledged that there was risk to residents during the incident.

In an interview, ED #135 stated the Oncall Manager had called them the day of the incident to inform them of the incident with resident #004. ED #135 stated they had called the Charge Nurse to see if everyone was okay. ED #135 stated other than the phone call to the Charge Nurse they did not meet with staff after the incident to have a formal debrief regarding the incident with resident #004. ED #135 acknowledged they had not completed a debrief with staff as per the home's policy. [s. 8. (1) (b)]

2. Ontario Regulation 79/10 s.228 (1) states, "Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements: There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review."

Review of the home's "Resident Incident Reporting" policy XXII-D-10.00 with a revision date of June 2019, located in the home's LTC Quality and Risk Management manual noted in part:

"All incidents involving residents will be reported through the Risk management module in the electronic documentation platform for the following incidents:

Verbal aggression initiated
Verbal aggression received
Physical aggression initiated
Physical aggression initiated

The nurse will:
• Initiate and complete documentation of the incident in Risk Management module and complete the User Defined Assessment as part of the incident.

The Director of Care of designate will:
• Review the Risk Management dashboard for new instructions and conduct an investigation and document investigation findings as required,
• Follow up resolution of risk areas identified,
• Sign off the Director of Care section Risk management upon completion of the investigation,
• If an incident meets regulatory reporting criteria for critical incidents or mandatory reports, submit the critical incidents as per regulatory requirements,

• Report themes and trends to appropriate committees, including Daily Morning Leadership and Leadership & Quality Committee.

The Executive Director will:
• Review the Risk Management dashboard for new incidents and conduct an investigation as required,
• Sign off the Executive Director section of the incident upon completion of the investigation,
• Follow up on resolution of risk areas identified,
• Report incidents and status on Weekly Operations Report,
• Trend resident incident reports and review them at appropriate committees, including Daily Risk, Leadership & Quality Mgt. team meetings."

In an interview, RPN #132 noted when an incident of resident to resident abuse occurred, they were required to document the incident in risk management.

A) Review of resident #016's electronic progress notes in PCC noted two incidents of abuse initiated by resident #016 toward other residents:

i) Review of risk management noted no documented report related to aggression initiated by resident #016. There was no report for the specific date for aggression received, therefore making it difficult to identify who the resident was that reported being abused by resident #016.

ii) Review of risk management noted no documented report related to the second incident of aggression initiated by resident #016. There was no report for the second date identified in resident #016's progress notes of aggression received, therefore making it difficult to identify who the residents were that received the aggression.

In an interview, ADOC #109 stated when there was an incident of resident to resident abuse registered staff were to document the incident in risk management in PCC.

In an interview, DOC #100 stated every incident of physical or verbal abuse of a resident should be documented in risk management. DOC #100 stated the incident should be documented by the registered staff who address the incident of abuse.

DOC #100 reviewed risk management for both dates and acknowledged there was no risk management documented for the incidents of aggression initiated by resident #016. DOC #100 also acknowledged there was no risk management documentation for the incidents of aggression received by residents and they would have no way of knowing who the residents were that were involved in the incidents.

B) Review of resident #004's electronic progress notes in PCC noted an incident of abuse initiated by resident #004 toward another resident.

Review of risk management noted no documented report related to aggression initiated by resident #004. There was no report for the specific date for aggression received, therefore making it difficult to identify who the resident was who was involved in the incident.

In an interview, DOC #100 reviewed risk management in PCC for the specific date. DOC #100 acknowledged there was no risk management documented for the incident of aggression initiated by resident #004. DOC #100 stated they did not recall the incident and did not know the name of the resident who received the aggression.

The licensee has failed to ensure where the Act or Regulations required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with. [s. 8. (1) (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 where the Act or Regulations requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was kept relating to the evaluation of the responsive behaviour program that included the summary of the changes made, and the date that those changes were implemented.

The home's Quality Management -LTC Program/Committee Evaluation Tool for Responsive Behaviours provided by Director of Care (DOC) #100 on January 31, 2020 was reviewed. The period review date was noted as January to December 2019, with the date of report noted as March 22, 2019.

Goals and objectives for the period under review were noted as complete an annual antipsychotic medication review, develop and implement training for new hires, and annual retraining with front line staff.

The Summary of Changes Made/Accomplishments were blank. The Outstanding Issues/Goals for Coming Period were blank and the Communication Plan – Discuss Residents' Council, Family Council and Staff dates were blank.

In a telephone interview, DOC #100 stated there were no changes implemented to the Responsive Behaviour program as part of the 2019 evaluation. DOC #100 stated antipsychotic medication reviews were taking place but training had not been developed and implemented and training had not taken place.

Inspector #522 asked DOC #100 why there was no summary of changes made or accomplishments and the dates the changes were implemented and why the training was not listed as an outstanding issue or goal for the coming period. DOC #100 stated the evaluation had not been done prior to 2019, and now in 2020, they would review the evaluation to make adjustments for 2020.

The licensee failed to ensure that a written record was kept relating to the evaluation of the responsive behaviour program that included the summary of the changes made, and the date that those changes were implemented. [s. 53. (3) (c)]

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 a written record is kept relating to the evaluation of the responsive behaviour program that includes the summary of the changes made, and the date that those changes were implemented, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse of the resident.

A) In an interview, Agency Registered Practical Nurse (RPN) #129 stated a Personal Support Worker (PSW) had reported to them that resident #018 had told the PSW that they had been abused by resident #016. Agency RPN #129 stated they had documented the alleged incident in resident #018’s electronic progress notes. Agency RPN #129 stated they did not find any injury on resident #018.

Review of resident #018's electronic progress notes in Point Click Care (PCC) noted the alleged incident of abuse.

There was no documented evidence that resident #018's Substitute Decision-Maker (SDM) was notified of the incident of alleged abuse.

Agency RPN #129 acknowledged that they had not notified resident #018's SDM regarding the incident of alleged abuse. Agency RPN #129 stated that resident #018's SDM should have been notified and that it was possible the may not have notified resident #018's SDM as there was no harm to resident #018.

In an interview, Director of Care (DOC) #100 reviewed resident #018's electronic progress notes and acknowledged resident #018's SDM had not been notified of the alleged abuse. DOC #100 stated resident #018's SDM should have been notified of the alleged abuse.

B) A review of resident #004's electronic progress notes in PCC noted on a specific date, an incident of abuse toward another resident. The progress note indicated the PSW had observed the incident and put in an alert but did not verbally report the incident to the RPN. There was no information to determine the name of the resident who received the abuse.

In a telephone interview, RPN #132 stated when an incident of abuse was reported to them, they would call both residents' families. RPN #132 stated they would complete documentation in risk management, progress notes, assessment and follow up.

RPN #132 stated they had documented the progress note for resident #004 and resident #019 after they saw a dashboard alert related to the incident of abuse. RPN #132 stated they had assessed resident #019 for injury and at the time could not find any injuries. RPN #132 stated since the PSW who witnessed the incident and the PSWs who had entered the alert for resident #019 and resident #004 had already finished their shift, they did not have enough information to fully document what happened.

RPN #132 stated they reported the incident to DOC #100 as the DOC was working a night shift that night. RPN #132 stated DOC #100 agreed that they did not have all the information to complete the appropriate documentation and RPN #132 was to pass the information to the oncoming shift to have registered staff

follow up with the PSWs for more information and complete the documentation. RPN #132 stated they had not notified resident #019's family as they did not have all the information about the incident and when they gave report to the oncoming shift, they let them know when they had all the information, they need to call resident #019's family.

In an interview, DOC #100 stated they reviewed resident #019's electronic progress notes and acknowledged resident #019's SDM had not been notified of the alleged abuse. DOC #100 stated resident #019's SDM should have been notified of the alleged abuse.

The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse of the resident. [s. 97. (1) (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 the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse of the resident, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that:
i) The results of the analysis undertaken of every incident of abuse or neglect of a resident at the home were considered in the evaluation of the home's policy to promote zero tolerance of abuse and neglect of residents.
ii) That the changes and improvements resulting from the annual evaluation to determine the effectiveness of the policy to promote zero tolerance of abuse and neglect of residents, were promptly implemented
iii) A written record of everything provided for in the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents, including the date, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented, was promptly prepared.

The home's Quality Management - LTC Program/Committee Evaluation Tool of the Prevention of Abuse and Neglect was provided by Assistant Director of Care (ADOC) #109 on February 5, 2020.

Review of the home's Quality Management - LTC Program/Committee Evaluation

Tool did not indicate which program was reviewed. The period review date was noted as January to December 2019, with the date of report noted as March 22, 2019.

The evaluation noted the Prevention of Abuse and Neglect Inspection Protocol was used during the evaluation.

There was no documentation to support that results of the analysis of every incident of abuse or neglect of a resident at the home were considered in the evaluation.

Goals and objectives for the period under review were noted as:

1) Annual staff review of Sienna Abuse and Neglect policies;
2) Review with Residents' Council and Family Council the policies related to Abuse and Neglect;
3) Training for new registered hires and an annual review for the registered team of the Duty to Report decision tree.

The Summary of Changes Made/Accomplishments were blank. The Outstanding Issues/Goals for Coming Period were blank and the Communication Plan – Discuss Residents' Council, Family Council and Staff dates were blank.

In a telephone interview, Inspector #522 reviewed the evaluation with Executive Director (ED) #135. ED #135 stated the evaluation was a fluid tool and that all managers used evaluation tools differently. ED #135 stated the managers met on December 13, 2019, to review everything and that December was a busy month to get things done.

ED #135 stated that managers were to complete the remainder of the evaluations for 2019 after the meeting in December and include what needed to be carried forward to 2020. ED #135 stated management would then meet with Residents' and Family Councils in March to review the evaluations.

The licensee has failed to ensure that:
i) The results of the analysis undertaken of every incident of abuse or neglect of a resident at the home were considered in the evaluation of the home's policy to promote zero tolerance of abuse and neglect of residents.
ii) That the changes and improvements resulting from the annual evaluation to

determine the effectiveness of the policy to promote zero tolerance of abuse and neglect of residents, were promptly implemented
iii) A written record of everything provided for in the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents, including the date, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented, was promptly prepared. [s. 99.]

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:
i) The results of the analysis undertaken of every incident of abuse or neglect of a resident at the home were considered in the evaluation of the home's policy to promote zero tolerance of abuse and neglect of residents.
ii) That the changes and improvements resulting from the annual evaluation to determine the effectiveness of the policy to promote zero tolerance of abuse and neglect of residents, were promptly implemented
iii) A written record of everything provided for in the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents, including the date, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented, was promptly prepared, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #007 received individualized personal care, including hygiene care and grooming on a daily basis.

On a specific date, resident #007 was observed seated in their room. Resident #007 had not been provided an identified personal care need.

Observations two and three days after the initial observation noted resident #007 still had not been provided an identified personal care need.

Review of resident #007's most recent care plan on Point Click Care (PCC) noted resident #007 required assistance with daily care.

Review of resident #007's bath days noted resident #007 had received two baths during the time inspector had observed the resident without an identified personal care need completed.

Review of the home's policy "Hygiene, Personal Care and Grooming" VII-G-10.60 with a revision date of April 2019, noted in part:

"Each resident will receive individualized personal care, including hygiene care and grooming, on a daily basis and more often as necessary using an abilities focused care approach. Personal hygiene and care needs include: bathing, hair care, shaving, oral, fingernail, toenail, and perineal care.

The policy continued to state in part that the identified care need observed for resident #007, was to be completed at a specific time.

In an interview, Personal Support Worker (PSW) #112 stated residents would be provided their identified personal care during their bath day or if required their assigned PSW would complete the identified personal care for the resident. PSW #112 acknowledged that they had recently given resident #007 two baths. PSW #112 stated they recalled resident #007 needed the identified personal care but had forgotten to complete the identified personal care for the resident during both baths.

In an interview, Director of Care (DOC) #100 stated that a resident who required assistance with the identified personal care should have the identified care completed during their bath or by their assigned PSW. DOC #100 stated that resident #007 should have had the identified personal care provided.

The licensee has failed to ensure that resident #007 received individualized personal care, including hygiene care and grooming on a daily basis. [s. 32.]

Issued on this 15th day of October, 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

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JULIE LAMPMAN (522) - (A3)
Inspection No. / No de l'inspection :	2019_725522_0018 (A3)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	019111-19, 019112-19, 019142-19, 023143-19, 023663-19 (A3)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 15, 2020(A3)
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Secord Trails Care Community 263 Wonham Street South, INGERSOLL, ON, N5C-3P6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tammy Smith

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

To Vigour Limited Partnership on behalf of Vigour General Partner Inc., 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 :

LTCHA, 2007 S.O. 2007, c.8, 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
(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).

Order / Ordre :

The licensee must comply with s. 6 (4) (a) of LTCHA 2007.

Specifically, the licensee must ensure:

a) That the staff and others involved in the different aspects of care of resident #007 and all other residents, collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.
b) Resident #007's plan of care related to assistance with a specific care task is reassessed in collaboration with direct care staff involved in resident #007's care. The reassessment is documented and changes documented in resident #007's plan of care.

Grounds / Motifs :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

On October 2, 2019, during Complaint inspection #2019_725522_0014 Compliance

Order (CO) #001 was issued related to LTCHA s. 31 (3) which stated the licensee must ensure that residents #001 and #002 and all other residents who require assistance with a specific care task, have the care completed at specific time frames and that the care is documented. The compliance due date was November 29, 2019.

The order was issued as resident #001 did not receive assistance with care as required.

Review of resident #007's (referred to as resident #001 in CO #001) most recent care plan on Point Click Care (PCC) noted resident #007 required specific assistance with daily care.

Resident #007's care plan noted that resident #007 required specific assistance with care.

Review of resident #007's electronic kardex on PCC noted the resident did not require the specific assistance with care.

Review of resident #007's care plan history for the specific assistance with care in resident #007's electronic kardex noted the following:

For over a year, resident #007 required specific assistance with care. This was entered by registered staff.

Shortly after CO #001 was issued, resident #007's care plan was changed and indicated the resident did not require the specific assistance with care. This was revised by Assistant Director of Care (ADOC) #109.

Review of resident #007's most recent Minimum Data Set (MDS) Assessment due to a "Significant Change in Status" indicated noted there was no change in resident #007's Activities of Daily Living (ADL) functioning compared to resident #007's previous two MDS Assessments.

During observations of resident #007 over a specific five day period, inspector did not observe resident #007 to be independent with the specific area of care. Resident #007 stated they needed assistance with the specific care area.

In an interview, Personal Support Worker (PSW) #118 stated resident #007 required assistance with the specific care area.

In an Interview, Registered Nurse (RN) #119 reviewed resident #007's plan of care with inspector and stated that resident #007 required assistance with the specific care area. RN #119 stated that the changes made to resident #007's plan of care did not reflect the care resident #007 required.

In an interview, with Director of Care (DOC) #100 and ADOC #109, DOC #100 stated they had revised resident #007's care plan to reflect that the resident did not require the specific assistance with care. When inspector asked what the change was based on as resident #007's ADL functioning on their MDS Assessment had not changed, DOC #100 stated they had witnessed resident #007 complete the specific care task on their own and they had based the change on information from PSWs. DOC #100 stated registered staff would not know if resident #007 needed the required assistance with the specific care task.

Reviewed resident #007's care plan history with DOC #100 and ADOC #109. ADOC #109 acknowledged their name was noted as making the changes to resident #007's care plan to reflect the resident did not require the specific assistance with care. ADOC #109 stated they did not know why they made the change to resident #007's care plan.

In an interview, PSW #127 stated they worked full time and resident #007 was on their regular assignment. PSW #127 stated that resident #007 required specific assistance with care. PSW #127 stated they were not aware resident #007's care plan had been changed and no one had spoken to them regarding resident #007. PSW #127 stated resident #007 was not capable of completing the specific care task on their own.

The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #007 collaborated with each other when resident #007's plan of care related to assistance with a specific care task was changed by DOC #100 to reflect the resident did not require the specific assistance with care. Resident #007's plan of care was changed prior to the compliance due date for CO #002, which stated resident #007 who required assistance with a specific care task was to have the care completed at specific time frames.

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

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 assessment of the resident so that their assessments were integrated and were consistent with and complemented each other. [s. 6. (4) (a)]

The severity of this issue was determined to be a level 3 as there was actual risk to the resident. The scope of the issue was level 1 as it was isolated. The home had a level 2 compliance history with a different subsection of the LTCHA. (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 30, 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: 002

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

Linked to Existing Order / Lien vers ordre existant: 2019_725522_0013, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Order / Ordre :

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

The licensee must comply with s. 6 (9) 1 of LTCHA 2007.

The licensee shall prepare, submit and implement a plan to ensure the provision of care set out in the plan of care for residents #002, #004, #005, #013, and #016 and all other residents is documented.

The plan must include, but is not limited, to the following:
a) An ongoing auditing process to ensure the provision of care for all residents is documented in electronic and hard copy form, including specific charting. Include who will be responsible for completing the audits and evaluating the results.
b) Training and education with all PSWs related to electronic and hard copy documentation, including a description of the education that will occur, who will be responsible for providing the education and education material, and the dates this education will occur. A written record of attendees must be kept.

Please submit the written plan for achieving compliance for inspection 2019_725522_0018 to Julie Lampman, LTC Homes Inspector, MLTC, by email to LondonSAO.MOH@ontario.ca by March 13, 2020.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

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

On October 2, 2019, during Critical Incident inspection #2019_725522_0013 Compliance Order (CO) #002 was issued which stated the licensee must ensure the provision of care set out in the plan of care for resident #001, #002 and #005 and all other residents was documented. The compliance due date was November 29, 2019.

A) Review of documentation of care provided for resident #013 (resident #005 in CO #002) in Point of Care (POC) for a specified time period, noted incomplete documentation on 16 identified care tasks.

A seven day observation for the Minimum Data Set (MDS) Assessment observation

period took place during a specific time period for Activities of Daily Living (ADL) – Bed Mobility/ Dressing/Eating/Personal Hygiene/Toileting/Transferring/Walk in corridor/Walk in room. The absence of documentation was noted during the observation period for one night and one day.

In an interview, Director of Care (DOC) #100 confirmed the missing documentation. DOC #100 stated they did not focus on daily, evening and night care needs as part of the home's audit of documentation. DOC #100 stated the documentation audit only focused on resident care such as bathing, turning and repositioning and continence care. DOC #100 stated staff had been given the charting policy for POC and were to read and sign it and staff had also been offered overtime to document but they have refused it.

B) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care related to an incident of resident to resident abuse.

Review of the CIS noted resident #003 received abuse from resident #002 (resident #001 in CO #002). The CIS indicated resident #002 would have identified safety interventions in place until the specific intervention was implemented.

In an interview, RPN #107 stated that resident #002 had one ongoing intervention in place related to the incident and another specific intervention was in place over a 14 day period.

Review of documentation of resident #002's ongoing intervention with RPN #107 noted the absence of documentation over specific time frames. RPN #107 confirmed that documentation should have been completed.

Review of resident #002's electronic kardex in Point Click Care (PCC) noted that the specific intervention for resident #002 had to be documented at specific timeframes. Review of resident #002's charting for the 14 day intervention in POC noted partial documentation on five out of 14 days.

Review of resident #002's POC documentation for BEHAVIOURS / EXPRESSIONS- noted the absence of documentation on two out of 31 days and one out of 31 evenings.

Review of resident #002's electronic Treatment Administration Record noted an order for specific documentation every shift.

Review of resident #002's electronic progress notes in Point Click Care (PCC) noted the absence of the specific documentation on nine shifts over a two week period.

In an interview, Director of Care (DOC) #100 acknowledged the absence of documentation for resident #002. DOC #100 stated staff should be completing documentation at specific time frames and every shift for resident #002.

C) Review of resident #005's documentation in POC for a specific time frame, noted incomplete documentation on 6 identified care tasks.

In an interview, ADOC #109 confirmed the missing documentation. ADOC #109 stated for the daily, evening and night care needs, resident #005 was on a seven day observation period for their Minimum Data Set (MDS) Assessment and this information was captured under bed mobility, dressing, eating, locomotion, personal hygiene, toileting, transferring, walk in corridor and room.

Review of resident #005's seven day observation period, noted documentation missing under the above categories for one evening and one night.

D) Resident #016 was to have time specific documentation completed over a five day period related to a specific intervention.

Review of resident #016's specific documentation noted the absence of documentation during specific time frames on three of five days.

In an interview, Director of Care #100 stated they had reviewed the documentation and were aware staff had not been completing the documentation in full. DOC #100 stated they expected that the specific documentation was completed in full for residents that required the specific intervention.

E) Resident #004 was to have time specific documentation completed over a five day period related to a specific intervention.

Review of resident #004's specific documentation noted the absence of

documentation during specific time frames on five of five days.

Further review of resident #004's chart noted resident #004 had time specific documentation completed on three more occasions over a five day period.

i) On the first occasion, documentation was noted as absent on three of five days.

ii) On the second occasion, documentation was noted as absent on four of five days.

iii) On the third occasion, documentation was noted as absent on two of five days.

In an interview, Director of Care #100 stated they had reviewed the documentation and were aware staff had not been completing the documentation in full. DOC #100 stated they expected that the specific documentation was completed in full for residents that required the specific intervention.

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

The severity of this issue was determined to be a level 2 as there was minimal risk to the resident. The scope of the issue was level 2 as it was a pattern, involving six out of eight residents. The home had a level 5 compliance history as there was previous non-compliance with the same subsection that included:
• Voluntary Plan of Correction (VPC) issued November 22, 2018 (2018_722630_0024);
• Compliance Order (CO) made under s. 6 (9) 1 of the LTCHA 2007, issued October 2, 2019 (#2019_725522_0013) with a compliance due date of November 29, 2019.

Additionally, the LTCH has a history of 15 Written Notifications (WN), 21 VPCs, 14 COs and 1 Director Referral to other subsections in the last 36 months. (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 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. 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 comply with s. 19 (1) of LTCHA 2007.

Specifically, the licensee must ensure all residents are protected from abuse by anyone, including resident #002 and #004.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents were protected from abuse by anyone.

A) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care related to an incident of resident to resident abuse.

Review of the CIS noted resident #003 received abuse from resident #002. The CIS indicated resident #002 would have specific identified interventions in place.

Review of risk management in Point Click Care (PCC) noted resident #003 had a previous incident of abuse from resident #002.

Review of resident #002's clinical record in PCC noted under "Special Instructions" that resident #002 was a high risk and required frequent monitoring.

Review of resident #002's hard copy chart noted a physician's order from Physician #133 dated prior to the incident of abuse, which stated resident #002 was to have a specific intervention in place due to their behaviours.

Review of resident #002's electronic care plan in PCC dated noted resident #002 would have the specific intervention in place until the resident's behaviour was under control.

A review of resident #002's electronic progress notes in PCC noted documentation three days after the physician's order, from Director of Care (DOC) #100 that resident #002's family had been made aware that resident #002's specific intervention would be removed.

There was no documentation related to an assessment of resident #002 or discussion with direct care staff or the resident's physician regarding removing the specific intervention for resident #002.

Review of resident #002's physician's orders noted no order from Physician #133 to discontinue the specific intervention that they had ordered.

Review of a specialized Assessment for resident #002 completed a day before the incident of abuse, noted that it was unfortunate resident #002 no longer had the specific intervention in place.

Review of resident #002's hard copy chart noted no evidence that resident #002 was monitored after the specific intervention was removed.

In an interview, Personal Support Worker (PSW) #120 stated that resident #002 had the specific intervention which had been helpful for resident #002.

In an interview, PSW #110 stated they had witnessed the incident of abuse between resident #002 and resident #003. PSW #110 stated resident #002 had a tendency to seek out resident #003 and that there had been a previous incident of abuse toward resident #003. PSW #110 stated staff tried to keep an eye on residents but at the time of the incident it was almost supper time and staff were on break. PSW #110 stated the specific intervention helped manage resident #002 and once the intervention was removed it was only a matter of less than a week before there was an incident.

In an interview, Registered Practical Nurse (RPN) #116 and PSW #115 stated they worked with resident #002 due to their behaviours. RPN #116 and PSW 115 stated

they had been told by DOC #100 that they would be removing resident #002's specific intervention. RPN #116 and PSW #115 stated they were not involved in the decision and did not agree with the decision to remove resident #002's specific intervention. PSW #115 stated there was no physician's order to remove the specific intervention and that it had been a management decision.

In a telephone interview, Physician #133 stated they had ordered the specific intervention for resident #002. Physician #133 stated DOC #100 had mentioned in passing that resident #002 had been improving and the possibility of stopping the specific intervention. Physician #133 stated they were not called to discontinue their order for the specific intervention, and they were not made aware that the specific intervention had ceased. Physician #133 stated as resident #002's doctor they would have expected to be called about the decision to remove resident #002's specific intervention.

In a telephone interview, DOC #100 confirmed that they had made the decision to remove resident #002's specific intervention. DOC #100 stated the decision to remove the specific intervention was based on a change to resident #002's medication and the decision with the doctor. DOC #100 stated there was nothing reported that resident #002 was abusive to other residents and resident #002 had a medication change six weeks ago. DOC #100 stated they had based their decision on review of resident #002's progress notes and PSW dashboard alerts, they had not discussed the decision with resident #002's direct care staff. DOC #100 stated they had not documented the conversation with Physician #133 or confirmed that there was an order from Physician #133 prior to removing the specific intervention.

DOC #100 stated usually after a specific intervention was removed from a resident, the resident would be monitored, and this would be documented. DOC #100 stated they reviewed resident #002's hard copy chart and were unable to locate documented monitoring of resident #002 after their specific intervention was removed.

The licensee failed to protect resident #003 from resident #002 who had history of behaviours and a previous incident of abuse toward resident #003. Management removed a specific intervention for resident #002 without an assessment or documented consultation with resident #002's direct care staff, resident #002's physician who had ordered the specific intervention for resident #002. After the

removal of the specific intervention, monitoring was not implemented to monitor resident #002's behaviours and several days later, resident #002 had an incident of abuse towards resident #003.

The licensee has failed to ensure that resident #003 was protected from abuse by resident #002.

B) Review of resident #016's electronic progress notes in PCC noted on a specific date, that a resident reported an incident of abuse from resident #016. The progress note had been documented by an Agency RPN.

In an interview, Agency RPN #129 stated a PSW had reported to them that resident #018 had reported to the PSW an incident of abuse from resident #016. Agency RPN #129 stated they had documented the incident in resident #018's electronic progress notes.

Review of resident #018's electronic progress notes in PCC noted documentation of the incident of abuse.

In an interview, Director of Care (DOC) #100 stated they recalled the incident between resident #016 and resident #018. DOC #100 acknowledged that the incident was considered abuse.

The licensee has failed to ensure that resident #018 was protected from abuse by resident #016.

C) A review of resident #004's electronic progress notes in PCC noted on a specific date, an incident of abuse toward another resident. The progress note indicated the PSW had observed the incident and put in an alert but did not verbally report the incident to the RPN. There was no information to determine the name of the resident who received the abuse.

In a telephone interview. PSW #128 stated they were aware of the incident, but they had not actually witnessed the incident. PSW #128 stated they had been informed by PSW #110 and then had entered an alert of the incident for resident #004. PSW #128 stated they could not recall the name of the other resident involved.

In an interview, DOC #100 stated they were not aware of the incident with resident #004. DOC #100 stated the incident would appear on the 24 hour nursing report. DOC #100 stated the ADOC reviewed the 24 hour report and the incident would be reported to the DOC during daily registered staff huddle. DOC #100 stated sometimes the way staff typed the incident, it made it look like something happened and then when you followed up you found out they meant something else. Inspector informed DOC #100 that a PSW had stated that the incident involving resident #004 had been reported to them. DOC #100 acknowledged that the incident was abuse.

In a telephone interview, PSW #110 stated that another PSW had reported to them that while PSW #110 was on break they had witnessed an incident of abuse from resident #004 towards resident #019. PSW #110 stated resident #019 was their assigned resident and they went and checked resident #019 for injuries and documented for resident #019. PSW #110 stated they had informed the PSW assigned to resident #004 what had happened and that PSW had entered the alert for resident #004. PSW #110 stated they should have informed the registered staff about what had happened, but they had thought the PSW who had witnessed the incident had informed the RPN.

In a telephone interview, RPN #132 stated they had documented the progress note for resident #004 and resident #019 after they saw a dashboard alert related to the incident of abuse. RPN #132 stated they had assessed resident #019 for injury and at the time could not find any injuries. RPN #132 stated since the PSW who witnessed the incident and the PSWs who had entered the alert for resident #019 and resident #004 had already finished their shift, they did not have enough information to fully document what happened.

In a telephone interview, DOC #100 reviewed resident #019's electronic progress notes in PCC and acknowledged there was no documented follow up with resident #019 to determine if resident #019 had sustained any injuries after the incident of abuse.

The licensee has failed to ensure that resident #019 was protected from abuse by resident #004.

D) Review of resident #004's electronic progress notes in Point Click Care (PCC) noted on a specific date, two incidents of abuse towards two separate residents.

i) Review of a risk management report in PCC dated on the specific date, noted an incident of abuse from resident #004 towards resident #014. The report noted resident #014 had no injuries at that time and a Pain Assessment noted resident #014's pain level to be a six. The risk management report was documented by Assistant Director of Care (ADOC) #109 and noted that the ADOC had sat with resident #014 for 10 minutes to provide reassurance.

In an interview, Personal Support Worker (PSW) #115 stated they witnessed the incident of abuse from resident #004 towards resident #014. PSW #115 stated ADOC #109 was covering for the DOC at that time and had come to check on the residents after the incident.

In an interview, resident #014 indicated that they recalled the incident of abuse from resident #004. Resident #014 indicated they experienced pain after the incident. Resident #014 indicated that management did not speak with them after the incident. Resident #014 indicated that no one followed up with them or checked to see how they were doing after the incident of abuse.

ii) Review of a risk management report in PCC on the specific date, noted an incident of abuse from resident #004 towards resident #016. No injury was noted at the time of the incident and resident #016's pain level was noted as a four. The risk management report was documented by ADOC #109.

In an interview, resident #017 stated they had observed the incident between resident #004 and resident #016 and reported the incident to the nurse.

Review of resident #004's electronic progress notes in PCC noted a specific intervention was initiated for resident #004 due to their behaviours, approximately one month prior to the two incidents of abuse.

Further review of resident #004's progress notes noted behavioural issues with resident #004 towards staff and residents leading up to the incidents of abuse. The day prior to the two incidents of abuse, the progress notes indicated resident #004 no longer had the specific intervention in place.

Review of the home's Daily Roster noted the home was short a PSW for four hours

the morning the incidents occurred, the day after the specific intervention was removed and was short two PSWs for four hours the next day, with no management onsite.

In an interview, PSW #115 stated right after the incident between resident #004 and resident #014 they went straight to the Executive Director's (ED) office to report the incident and ask what was going to be put in place prior to management being away the next day. PSW #115 stated that resident #004 previously had a specific intervention in place due to their behaviours. PSW #115 stated that the specific intervention had been removed by the DOC and there had been no consultation with direct care staff.

In an interview, Registered Practical Nurse (RPN) #116 stated they worked with resident #004 due to their behaviours. RPN #116 stated they had no input regarding resident #004's specific intervention being removed.

In an interview, PSW #105 stated resident #004 was part of their full time assignment. PSW #105 stated resident #004 displayed behaviours. PSW #105 stated resident #004's specific intervention had been removed prior to the incident with resident #014. PSW #105 stated they had been informed by the DOC of the decision to remove the specific intervention, and they had not been involved in any discussion prior to the removal of the specific intervention.

In a telephone interview, Physician #130 stated they were resident #004's doctor. Physician #130 stated they were not involved in the decisions regarding the specific intervention for resident #004. Physician #130 stated if a resident was having behaviors and the home wanted to implement a specific intervention, it would be helpful to involve the physician in that decision. Physician #130 stated they trusted the staff's judgement to make the decision to remove the specific intervention as they were with the resident daily.

In an interview, ADOC #109 stated that resident #004 previously had a specific intervention in place. ADOC #109 stated the decision was made by the DOC in collaboration with the ADOC. ADOC #109 stated they thought the specific intervention was removed as there was documentation to support the removal of the specific intervention and resident #004 only had a few single episodes of behaviours. ADOC #109 stated there was an incident of abuse from resident #004 towards

resident #014, the day after the specific intervention was removed. ADOC #109 acknowledged that there was no documentation in resident #004's progress notes about the decision to remove resident #004's specific intervention.

In a telephone interview, DOC #100 stated a decision to remove a specific support for a resident was based on progress notes and PSW dashboard alerts. DOC #100 stated the resident's doctor had to be in agreement and the team following the resident had to be involved in the decision. DOC #100 stated they had made the decision to remove resident #004's specific intervention. DOC #100 stated for more than a month there was no indication that resident #004 was having behaviours, no progress notes, or dash board alerts. DOC #100 stated there was nothing in the documentation that told them resident #004 needed the specific intervention.

DOC #100 was unable to provide documented evidence to support that the resident's physician, the team following the resident and staff were involved in the decision to remove resident #004's specific intervention.

Resident #004 had a specific intervention in place related to behaviours. Review of resident #004's progress notes noted several incidents of behaviours toward staff and residents and incidents where resident #004 had refused their medications, prior to the removal of the specific intervention. Review of the home's Daily Roster for staffing noted the home was working short staffed after the specific intervention was removed. There was no documented evidence to support collaboration with direct care staff, the team following the resident and the resident's physician prior to the removal of resident #004's specific intervention.

The licensee has failed to protect resident #014 and resident #016 abuse by resident #004. [s. 19. (1)]

The severity of this issue was determined to be a level 3 as there was actual harm to residents. The scope of the issue was level 3 as it was widespread, involving five out of five residents. The home has a level 3 compliance history as there was previous non-compliance with the same subsection of the LTCHA that included:
• Compliance Order (CO) issued March 26, 2018, (#2018_605213_0004) with a compliance due date of April 6, 2018. (522)

Apr 06, 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

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

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: 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) appropriate action is taken in response to every such incident; and
(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).

Order / Ordre :

The licensee must comply with s. 23 (1) (a) of LTCHA 2007.

Specifically, the licensee must ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported is immediately investigated.

Grounds / Motifs :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knew of, or that was reported was immediately investigated.

A) Review of resident #016's electronic progress notes in PCC noted on a specific date, that a resident reported an incident of abuse from resident #016. The progress note had been documented by an Agency RPN.

In an interview, Agency RPN #129 stated a PSW had reported to them that resident #018 had reported to the PSW an incident of abuse from resident #016. Agency RPN #129 stated they had documented the incident in resident #018's electronic progress notes.

Agency RPN #129 stated they did not find any injuries on resident #018. Agency RPN #129 stated when there was an incident of alleged or suspected abuse, they were required to report the incident to the Charge Nurse who would notify the Director of Care or the Oncall Manager depending on the time of day. Agency RPN #129 stated they could not recall if they had reported the incident between resident #016 and resident #018.

Review of resident #018's electronic progress notes in PCC noted that resident #018 was assessed after the incident and noted the resident did not have any injuries at that time. The progress note indicated resident #018 would be monitored.

Review of the home's ""Prevention of Abuse and Neglect of a Resident" policy VII-G-10.00 with a revision date of April 2019, noted in part,

"The Executive Director or designate 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 written statements are obtained as close to the time of the event as possible.
All investigative information is kept in a separate report from the resident's record.
The Executive Director or designate interviews the resident, other residents, and/or persons who may have any knowledge of the situation. If possible, include a management witness during interviews with all residents. The witness takes detailed notes of the conversation.
The Executive Director or designate interviews the alleged abuser."

In an interview, Director of Care (DOC) #100 stated they recalled the incident of abuse from resident #016 towards resident #018. DOC #100 stated for specific incidents of resident to resident abuse, they would complete the investigation into the abuse and for other incidents of resident to resident abuse the nursing staff would complete the investigation and they would assist if needed. DOC #100 stated they would document the investigation of abuse in the Critical Incident System (CIS)

report which would be submitted to the Ministry of Long-Term Care and registered staff were required to document the incident of abuse in risk management.

DOC #100 stated they became aware of the incident of abuse between resident #016 and resident #018 during morning huddle. DOC #100 stated that they had reviewed the progress notes and decided what needed to be done and the Registered Nurse that cared for resident #016 was to follow up on the process for resident #016.

DOC #100 stated they did not recall if an investigation had been completed into the alleged abuse. DOC #100 acknowledged that they did not have any documentation related to an investigation and a CIS report had not been submitted related to the incident of alleged abuse.

B) A review of resident #004's electronic progress notes in PCC noted on a specific date, an incident of abuse toward another resident. The progress note indicated a PSW had observed the incident and put in an alert but did not verbally report the incident to the RPN. There was no information to determine the name of the resident who received the abuse.

In a telephone interview, PSW #128 stated they were aware of the incident, but they had not actually witnessed the incident. PSW #128 stated they had been informed by PSW #110 and then had entered an alert of the incident for resident #004. PSW #128 stated they could not recall the name of the other resident involved.

In an interview, DOC #100 stated they were not aware of the incident with resident #004. DOC #100 stated the incident would appear on the 24 hour nursing report. DOC #100 stated the ADOC reviewed the 24 hour report and the incident would be reported to the DOC during daily registered staff huddle. DOC #100 stated sometimes the way staff typed the incident, it made it look like something happened and then when you followed up you found out they meant something else. Inspector informed DOC #100 that a PSW had stated that the incident involving resident #004 had been reported to them. DOC #100 acknowledged that the incident was abuse.

In a telephone interview, PSW #110 stated that another PSW had reported to them that while PSW #110 was on break they had witnessed an incident of abuse from resident #004 towards resident #019. PSW #110 stated resident #019 was their

assigned resident and they went and checked resident #019 for injuries and documented for resident #019. PSW #110 stated they had informed the PSW assigned to resident #004 what had happened and that PSW had entered the alert for resident #004. PSW #110 stated they should have informed the registered staff about what had happened, but they had thought the PSW who had witnessed the incident had informed the RPN.

In a telephone interview, RPN #132 stated when an incident of abuse was reported to them they would check the resident, do a head to toe examine, treat any injuries, and report the incident to the DOC if they were working. RPN #132 stated they go through a checklist of suspected or actual abuse, they would call the doctor and both residents' families. RPN #132 stated it would depend upon the severity of the incident if they would inform the Ministry and nonemergency police. RPN #132 stated they would complete documentation in risk management, progress notes, assessment and follow up.

RPN #132 stated they had documented the progress note for resident #004 and resident #019 after they saw a dashboard alert related to the incident of abuse. RPN #132 stated they had assessed resident #019 for injury and at the time could not find any injuries. RPN #132 stated since the PSW who witnessed the incident and the PSWs who had entered the alert for resident #019 and resident #004 had already finished their shift, they did not have enough information to fully document what happened.

RPN #132 stated they reported the incident to DOC #100 as the DOC was working a night shift that night. RPN #132 stated DOC #100 agreed that they did not have all the information to complete the appropriate documentation and RPN #132 was to pass the information to the oncoming shift to have registered staff follow up with the PSWs for more information and complete the documentation.

In a telephone interview, inspector informed DOC #100 that resident #019 had been the resident who had received abuse from resident #004. DOC #100 stated they still did not recall the incident. DOC #100 reviewed resident #019's electronic progress notes in PCC and acknowledged that the progress note related to the incident was the same as resident #004's progress note. DOC #100 stated there had been no investigation into the incident of abuse.

C) Review of resident #004's electronic progress notes in Point Click Care (PCC) noted on a specific date, two incidents of abuse towards two separate residents.

i) Review of risk management report in PCC dated on the specific date, noted an incident of abuse from resident #004 towards resident #014. The risk management report was documented by Assistant Director of Care (ADOC) #109 and noted that the ADOC had sat with resident #014 for 10 minutes to provide reassurance.

In an interview, ADOC #109 stated they had been covering for DOC #100 when the incident occured. ADOC #109 stated they were told by a PSW what had happened to resident #014 and they had spent some time with resident #014 as they had been quite shaken by the incident and resident #014 did not have an injury at that time. ADOC #109 they had been made aware of the incident as well as Executive Director (ED) #135.

ADOC #100 stated they had not completed an investigation into the incident of abuse of resident #014.

In an interview, ED #135 stated there was no documentation related to an investigation into the incident of abuse of resident #014.

ii) Review of risk management report in PCC on the specific date, noted an incident of abuse from resident #004 towards resident #016. The risk management report was documented by ADOC #109.

In an interview, ADOC #109 stated resident #017 had reported the incident that occurred between resident #004 and resident #016. ADOC #109 they had been made aware of the incident as well as ED #135. ADOC #109 stated they had assessed resident #016 after the incident and completed the risk management report on the incident.

ADOC #100 stated they had not completed an investigation into the incident of abuse of resident #016.

In an interview, ED #135 stated there was no documentation related to an investigation into the incident of abuse of resident #016.

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

The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knew of, or that was reported was immediately investigated. [s. 23. (1) (a)]

The severity of this issue was determined to be a level 3 as there was actual risk to residents. The scope of the issue was level 3 as it was widespread, involving four out of five residents. The home has a level 3 compliance history as there was previous non-compliance with the same subsection of the LTCHA that included:
• Compliance Order (CO) issued October 20, 2017, (#2017_607523_0017) with a compliance due date of November 15, 2017. (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 06, 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. 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;
(b) appropriate action is taken in response to every such incident; and
(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).

Order / Ordre :

The licensee must comply with s. 23 (1) (b) of LTCHA 2007.

Specifically, the licensee must ensure that appropriate action is taken in response to every alleged, suspected or witnessed incident of abuse of a resident by anyone.
Which includes, but is not limited to:
a) Documentation and assessment of the resident for distress after an incident of abuse for a minimum of 24 hours, as per the home's Prevention of Abuse and Neglect policy;
b) Complete a documented assessment of the resident for injuries after an incident of abuse;
c) All registered staff receive training and education on the home's Prevention of Abuse and Neglect policy. A written record of attendees must be kept.

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

Grounds / Motifs :

1. The licensee has failed to ensure that that appropriate action was taken in response to every alleged, suspected or witnessed incident of abuse of a resident by anyone.

A) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care related to an incident of resident to resident abuse.

Review of the CIS noted resident #003 received abuse from resident #002. The CIS indicated resident #002 would have specific interventions in place.

A review of the home's Prevention of Abuse and Neglect of a Resident – Actual or Suspected – Nursing Checklist for the Investigation of Alleged Abuse of a Resident by Another Resident VII-G-10.00(b) dated April 2019, noted the checklist was to be used with any issues of suspected or actual abuse of a resident. The Checklist noted in part, "Within 24 hours of assault or neglect, at a minimum documentation and assessment of resident status each shift…, and within the next 48 hours, offer to arrange additional emotional counselling and support to the resident…"

A review of resident #003's electronic progress notes in PCC noted a PSW had witnessed the incident of abuse from resident #002 towards resident #003 and reported it to the RPN. The RPN documented that a head to toe assessment was completed of resident #003 and no injuries were noted. The RPN noted they had entered a specific intervention in Point of Care for PSWs to complete on resident #002.

Review of resident #003's progress notes noted no documented monitoring or assessment of resident #003 after the incident of abuse involving resident #002.

In an interview, RPN #132 stated the incident between resident #002 and resident #003 was reported to them. RPN #132 stated they told the PSW to monitor resident #003 for any abnormal behaviours. RPN #132 stated they did not receive a report from the PSW of any abnormal behaviours and they had passed on to the next shift to monitor resident #003. RPN #132 stated they would only document in a resident's progress notes if the resident displayed abnormal behaviour after an incident of abuse.

In an interview, Director of Care #100 stated if there was an incident of resident to resident abuse, they would expect the resident who received the abuse to be monitored to ensure the resident was safe. DOC #100 stated a reminder should be added to a resident's Treatment Administration Record to remind registered staff to monitor the resident and there should be a documented progress note of the monitoring.

B) In an interview, Agency RPN #129 stated a PSW had reported to them that resident #018 had reported to the PSW an incident of abuse from resident #016. Agency RPN #129 stated they had documented the incident in resident #018's electronic progress notes. Agency RPN #129 stated at the time they did not find any injuries on resident #018.

Review of resident #018's electronic progress notes in PCC noted documentation of the incident of abuse. The progress note indicated that resident #018 did not have any injuries at that time and that staff would continue to monitor the resident.

There was a documented progress note for the next shift that the resident was monitored and then no further documentation in resident #018's progress notes related to monitoring resident #018 after the alleged incident of abuse.

Review of resident #018's assessment tab in PCC noted the absence of a documented physical assessment of resident #018 after the incident of alleged abuse.

In an interview, DOC #100 stated they recalled the incident between resident #016 and resident #018. DOC #100 acknowledged that the incident was considered abuse. DOC #100 stated when there was an incident of resident to resident abuse a head to toe assessment should be completed for the resident who received the abuse. DOC #100 reviewed resident #018's assessments in PCC and acknowledged the absence of a documented head to toe assessment for resident #018 after the alleged incident of abuse by resident #016. DOC #100 stated that registered staff probably did not see any injury and that was why an assessment was not completed. DOC #100 stated resident #018 should also have been monitored the following day after the incident of alleged abuse.

C) A review of resident #004's electronic progress notes in PCC noted on a specific

date, an incident of abuse toward another resident. The progress note indicated the PSW had observed the incident and put in an alert but did not verbally report the incident to the RPN. There was no information to determine the name of the resident who received the abuse.

In a telephone interview, PSW #110 stated that another PSW had reported to them that while PSW #110 was on break they had witnessed an incident of abuse from resident #004 towards #019. PSW #110 stated resident #019 was their assigned resident and they went and checked resident #019 for any injuries and documented for resident #019. PSW #110 stated they had informed the PSW assigned to resident #004 what had happened and that PSW had entered the alert for resident #004. PSW #110 stated they should have informed the registered staff about what happened, but they had thought the PSW who had witnessed the incident had informed the RPN.

In a telephone interview, RPN #132 stated when an incident of abuse was reported to them, they would check the resident, do a head to toe examine, treat any injuries, and report the incident to the DOC if they were working. RPN #132 stated they go through a checklist of suspected or actual abuse, they would call the doctor and both residents' families. RPN #132 stated it would depend upon the severity of the incident if they would inform the Ministry and nonemergency police. RPN #132 stated they would complete documentation in risk management, progress notes, assessment and follow up.

RPN #132 stated they had documented the progress note for resident #004 and resident #019 after they saw a dashboard alert related to the incident of abuse. RPN #132 stated they had assessed resident #019 for injury and at the time could not find any injuries. RPN #132 stated since the PSW who witnessed the incident and the PSWs who had entered the alert for resident #019 and resident #004 had already finished their shift, they did not have enough information to fully document what happened.

RPN #132 stated they reported the incident to DOC #100 as the DOC was working a night shift that night. RPN #132 stated DOC #100 agreed that they did not have all the information to complete the appropriate documentation and RPN #132 was to pass the information to the oncoming shift to have registered staff follow up with the PSWs for more information and complete the documentation.

In a telephone interview, DOC #100 reviewed resident #019's electronic progress notes and assessments in PCC. DOC #100 acknowledged that there was no documented assessment of resident #019 for any injuries. DOC #100 stated usually staff would check a resident if there was an incident of abuse and if there were no signs of bruises, they may not complete an assessment. DOC #100 stated if there were issues like a skin tear or bruising, staff should complete a head to toe assessment. DOC #100 stated there were no vital signs taken for resident #019 after the incident. DOC #100 stated staff should have entered a progress note to say resident #019 was assessed and there were no injuries and indicate that an assessment was not done. DOC #100 stated there was no documented monitoring of resident #019's status after the incident of abuse.

D) Review of resident #004's electronic progress notes in Point Click Care (PCC) noted on a specific date, two incidents of abuse towards two separate residents.

i) Review of a risk management report in PCC dated on the specific date, noted an incident of abuse from resident #004 towards resident #014. The report noted resident #014 had no injuries at that time and a Pain Assessment noted resident #014's pain level to be a six. The risk management report was documented by Assistant Director of Care (ADOC) #109 and noted that the ADOC had sat with resident #014 for 10 minutes to provide reassurance.

Review of resident #014's progress notes indicated a Head to Toe Skin Assessment was completed after the incident of abuse. The following day a progress note entry noted resident #004's family had called to check on the resident and resident seemed their usual self.

There were no other progress notes related to monitoring resident #014 after the incident of abuse.

In an interview, resident #014 indicated that they recalled the incident of abuse from resident #004. Resident #014 indicated they experienced pain after the incident. Resident #014 indicated that management did not speak with them after the incident. Resident #014 indicated that no one followed up with them or checked to see how they were doing after the incident of abuse.

In an interview, ADOC #109 stated they had been covering for DOC #100 at the time of the incident. ADOC #109 stated they were told by a PSW what had happened to resident #014 and they had spent some time with resident #014 as they had been quite shaken by the incident and resident #014 did not have an injury at that time. ADOC #100 acknowledged that they had sat with resident #014 immediately after the incident with resident #004 but had not completed any other follow up with resident #014. ADOC #109 stated there was no documentation to support that resident #014 had been monitored after the incident of abuse.

In an interview, Executive Director (ED) #135 stated they would expect resident #014 to be checked for injury, and there be follow up and monitoring of the resident after the incident.

ii) Review of risk management report in PCC noted an incident of abuse from resident #004 towards resident #016. No injury was noted at the time of the incident and resident #016's pain level was noted as a four. The risk management report was documented by ADOC #109.

Further review of resident #016's electronic progress notes noted documentation related to the incident of abuse. There were no other progress notes related to monitoring resident #016 after the incident of abuse.

In an interview, ADOC #109 stated resident #017 had reported the incident that occurred between resident #004 and resident #016. ADOC #109 they had been made aware of the incident as well as ED #135. ADOC #109 stated they had assessed resident #016 after the incident and completed the risk management report on the incident. ADOC #109 acknowledged that there was no documentation to support that resident #016 had been monitored after the incident of abuse. ADOC #109 stated after an incident of abuse they would expect the resident to be monitored to ensure they were okay.

In an interview, ED #135 stated they would expect resident #016 to be consoled if they were upset and to be monitored to make sure they were well, as fear could set in.

The licensee has failed to ensure that that appropriate action was taken in response to every alleged, suspected or witnessed incident of abuse of a resident by anyone.

[s. 23. (1) (b)]

The severity of this issue was determined to be a level 3 as there was actual risk to residents. The scope of the issue was level 3 as it was widespread, involving four out of five residents. The home has a level 3 compliance history as there was previous non-compliance with the same subsection of the LTCHA that included:
• Compliance Order (CO) issued October 20, 2017, (#2017_607523_0017) with a compliance due date of November 15, 2017. (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 15, 2020(A1)

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: 006

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The licensee must comply with s. 24 (1) of LTCHA 2007.

Specifically, the licensee must ensure:
a) A person who has reasonable grounds to suspect abuse of a resident, immediately report the suspicion and the information upon which it is based to the Director;
b) All staff receive training and education on mandatory reporting of abuse. A description of the education and training must be documented, along with the signatures off all staff who attended the training.

Grounds / Motifs :

1. 1. The licensee has failed to comply with s. 24 (1) 2, in that a person who had reasonable grounds to suspect abuse of a resident, failed to report the alleged abuse immediately to the Director in accordance with s. 24 (1) 2 of the LTCHA.

Pursuant to LTCHA 2007, s. 152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

A) Review of resident #016's electronic progress notes in PCC noted on a specific date, that a resident reported an incident of abuse from resident #016. The progress note had been documented by an Agency Registered Practical Nurse (RPN) and indicated that it was to show on the 24 hour nursing report.

In an interview, Agency RPN #129 stated a PSW had reported to them that resident #018 had reported to the PSW an incident of abuse from resident #016. Agency RPN #129 stated they had documented the incident in resident #018's electronic progress notes.

Agency RPN #129 stated resident #018 did not have any injuries at the time. Agency RPN #129 stated when there was an incident of alleged or suspected abuse, they were required to report the incident to the Charge Nurse who would notify the Director of Care or the Oncall Manager depending on the time of day. Agency RPN #129 stated they could not recall if they had reported the incident between resident #016 and resident #018.

Review of resident #018's electronic progress notes in PCC noted documentation of the incident of abuse.

In an interview, Director of Care (DOC) #100 stated they recalled the incident between resident #016 and resident #018. DOC #100 acknowledged that the incident was considered abuse. DOC #100 acknowledged that the incident had not been reported to the Ministry of Long-Term Care (MLTC).

B) A review of resident #004's electronic progress notes in PCC noted on a specific date, an incident of abuse toward another resident. The progress note indicated a PSW had observed the incident and put in an alert but did not verbally report the incident to the RPN. There was no information to determine the name of the resident who received the abuse. The progress note indicated that it was to show on the 24 hour nursing report.

In a telephone interview. PSW #128 stated they were aware of the incident, but they had not actually witnessed the incident. PSW #128 stated they had been informed by PSW #110 and then had entered an alert of the incident for resident #004. PSW #128 stated they could not recall the name of the other resident involved.

In an interview, DOC #100 stated they were not aware of the incident with resident #004. DOC #100 stated the incident would appear on the 24 hour nursing report. DOC #100 stated the ADOC reviewed the 24 hour report and the incident would be reported to the DOC during daily registered staff huddle. DOC #100 stated sometimes the way staff typed the incident, it made it look like something happened and then when you followed up you found out they meant something else. Inspector informed DOC #100 that a PSW had stated that the incident involving resident #004 had been reported to them. DOC #100 acknowledged that the incident was abuse.

DOC #100 stated when there was an incident of specific resident to resident abuse, they would complete the investigation into the abuse and for any other incidents of resident to resident abuse the nursing staff would complete the investigation and they would assist if needed. DOC #100 stated they would document the investigation of abuse in the Critical Incident System (CIS) report which would be submitted to the MLTC and registered staff were required to document the incident of abuse in risk management.

In a telephone interview, PSW #110 stated that another PSW had reported to them that while PSW #110 was on break they had witnessed an incident of abuse from resident #004 towards resident #019. PSW #110 stated resident #019 was their assigned resident and they went and checked resident #019 for injuries and documented for resident #019. PSW #110 stated they had informed the PSW assigned to resident #004 what had happened and that PSW had entered the alert for resident #004. PSW #110 stated they should have informed the registered staff about what had happened, but they had thought the PSW who had witnessed the incident had informed the RPN.

In a telephone interview, RPN #132 stated they had documented the progress note for resident #004 and resident #019 after they saw a dashboard alert related to the incident of abuse. RPN #132 stated they had assessed resident #019 for injury and at the time could not find any injuries. RPN #132 stated since the PSW who witnessed the incident and the PSWs who had entered the alert for resident #019 and resident #004 had already finished their shift, they did not have enough information to fully document what happened. RPN #132 stated when an incident of abuse of a resident occurred it would depend on the severity of the incident whether they would report it to the MLTC.

RPN #132 stated they reported the incident to DOC #100 as the DOC was working a night shift that night. RPN #132 stated DOC #100 agreed that they did not have all the information to complete the appropriate documentation and RPN #132 was to pass the information to the oncoming shift to have registered staff follow up with the PSWs for more information and complete the documentation.

In a telephone interview, Inspector #522 informed DOC #100 that resident #019 had been the resident who had received abuse from resident #004. DOC #100 stated they still did not recall the incident. DOC #100 stated that the MLTC had not been notified of the incident of abuse and a CIS report had not been submitted.

C) Review of resident #004's electronic progress notes in Point Click Care (PCC) noted on a specific date, two incidents of abuse towards two separate residents.

Review of a risk management report in PCC dated on the specific date, noted an incident of abuse from resident #004 towards resident #014. The report noted resident #014 had no injuries at that time and a Pain Assessment noted resident #014's pain level to be a six. The risk management report was documented by ADOC #109 and noted that the ADOC had sat with resident #014 for 10 minutes to provide reassurance.

In an interview, PSW #115 stated they witnessed the incident of abuse from resident #004 towards resident #014. PSW #115 stated ADOC #109 was covering for DOC at that time and had come to check on the residents after the incident. PSW #115 stated right after the incident they went straight to the Executive Director's (ED) office to report the incident and ask what was going to be put in place prior to management being away the following day.

In an interview, resident #014 indicated that they recalled the incident of abuse from resident #004. Resident #014 indicated they experienced pain after the incident. Resident #014 indicated that management did not speak with them after the incident. Resident #014 indicated that no one followed up with them or checked to see how they were doing after the incident of abuse.

In an interview, ADOC #109 stated they had been covering for DOC #100 at the time of the incident. ADOC #109 stated they were told by a PSW what had happened to

resident #014 and they had spent some time with resident #014 as they had been quite shaken by the incident and resident #014 did not have an injury at that time. ADOC #109 they had been made aware of the incident as well as ED #135. ADOC #109 stated the incident was not reported to the MLTC as there was no injury to resident #014 and their level of care did not change.

In an interview, ED #135 stated they were working from home on the specific date, and they would have been made aware of the incident the next day by the Office Manager who was oncall. ED #135 stated the MLTC had not been informed of the incident of resident to resident abuse as there was no injury to resident #014. Inspector #522 asked ED #135 if they were aware of the reporting requirements for abuse and ED #135 stated they were aware of the reporting requirements and that staff needed to follow the abuse decision tree when reporting abuse.

Inspector #522 reviewed the MLTC Reporting Requirements Tip Sheet for Section 24 (1) Mandatory Reports with ED #135 which indicated that the home was required to immediately report abuse of a resident by anyone that resulted in harm or risk of harm and then investigate. ED #135 stated they were not aware of the requirement and the decision not to report was based on the abuse decision tree.

D) Review of resident #004's electronic progress notes in Point Click Care (PCC) noted on a specific date, two incidents of abuse towards two separate residents.

Review of a risk management report in PCC on the specific date, noted the incident involved resident #016. No injury was noted at the time of the incident and resident #016's pain level was noted as a four. The risk management report was documented by ADOC #109.

In an interview, PSW #115 stated they when they started their shift on the specific date, they were made aware of an incident of abuse from resident #004 towards resident #016. PSW #115 stated they then witnessed an incident of abuse from resident #004 towards resident #014. PSW #115 stated right after the incident they went straight to the ED's office to report the incident and ask what was going to be put in place prior to management being away the following day.

In an interview, ADOC #109 stated resident #017 had reported the incident that occurred between resident #004 and resident #016. ADOC #109 they had been

made aware of the incident as well as ED #135. ADOC #109 stated the incident was not reported to the MLTC as there was no injury to resident #016 and their level of care did not change.

In an interview, ED #135 stated they were working from home on the specific date, and they would have been made aware of the incident the next day by the Office Manager who was oncall. ED #135 stated the MLTC had not been informed of the incident of resident to resident abuse as there was no injury to resident #016.

The licensee has failed to comply with s. 24 (1) 2, in that a person who had reasonable grounds to suspect abuse of a resident, that resulted in harm or risk of harm, failed to report the alleged abuse immediately to the Director in accordance with s. 24 (1) 2 of the LTCHA. [s. 24. (1)]

The severity of this issue was determined to be a level 2 as there was minimal risk to residents. The scope of the issue was level 3 as it was widespread, involving four out of five residents. The home has a level 3 compliance history as there was previous non-compliance with the same subsection of the LTCHA that included:
• Compliance Order (CO) issued October 20, 2017, (#2017_607523_0017) with a compliance due date of November 15, 2017. (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 15, 2020(A1)

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: 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

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

The licensee must comply with s. 9. (1) 2 of Ontario Regulation 79/10.

Specifically, the licensee must ensure:
a) all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff;
b) The physiotherapy area remain free from clutter and a specific physio item be locked away at all times, when not in use.

Grounds / Motifs :

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

In an interview, Registered Practical Nurse (RPN) #107 stated that resident #004 currently had a specific intervention in place due to recent behaviours.

Review of resident #004's electronic progress notes in Point Click Care (PCC) noted on a specific date an incident occurred where resident #004 had access to an item that caused risk to staff and residents.

The progress note indicated the manager on call had been informed of the incident.

In an interview, Personal Support Worker (PSW) #115 stated they were working on the specific date when the incident occurred.

PSW #115 stated when they walked in for their shift on the specific date, they were told resident #004 was having behaviours. PSW #115 stated resident #004 then gained access to an item from the physio area which put staff and other residents at risk.

In an interview, PSW #117 stated they were working on resident #004's home area when the incident occurred. PSW #117 stated they observed resident #004 with the item from the physio area. PSW #117 stated they had witnessed resident #004 with this item before. PSW #117 stated staff kept telling management it was not safe in the lounge as physio left all the equipment out and a curtain was not secure like walls and a door.

In an interview, Registered Practical Nurse (RPN) #106 stated they were assigned to resident #004 on the date of the incident. RPN #106 confirmed that resident #004 had gained access to an item from the physio area which put other residents at risk.

In an interview PSW #105 stated resident #004 was their assigned resident. PSW #105 stated that when resident #004 displayed behaviours to ensure the safety of resident #004 and other residents they removed everyone from the area. PSW #105 stated they would try to herd resident #004 away from any items that put others at risk.

Inspectors #522 and #569 observed a specific lounge. Inspectors observed two wheelchairs in the resident sitting area, one was folded and against the wall along with a folding table. A privacy curtain was pulled across to divide the physiotherapy area from the lounge.

In resident #004's home area, inspectors observed an unlocked closet. Inside the closet on the bottom shelf was an identified item.

In an interview, Physiotherapy Aide (PTA)#123 stated that resident #004 had gotten a hold of an item from the physio area. PTA#123 stated the item was now stored downstairs. PTA#123 stated they ensured all items they used for residents were now locked in the closet and other items were now stored downstairs.

Inspector #522 showed PTA#123 the closet on resident #004's home area. Inspector asked if the identified item should be stored in their since it was not locked. PTA#123 looked in the closet and stated they did not know where the identified item was from and that the door to the closet should be locked and locked the closet.

Inspector #522 showed RPN #106 the closet on resident #004's home area. The closet was unlocked. RPN #106 stated the closet should be locked and that it should not be open with the identified item in it. RPN #106 looked through the closet, found the lock and put the lock on the door.

Observation of the same closet three days later noted the door was closed, with the lock hanging on the latch but the lock was not engaged. PSW #105 who was seated in the lounge at the end of hall by the closet stated that the closet should be locked,

but they had just removed their tablet from the closet and they were sitting in the lounge completing their documentation. PSW #105 stated they could see the closet from where they were. PSW #105 stated there was a key to the lock that was hanging around the corner from the closet in the lounge. Inspector #105 observed the key which was hanging within reach on the wall in the lounge.

Observation of the closet sevral days later, noted the door was unlocked with the lock inside on the shelf. On the floor of the closet was the item from physiotherapy that resident #004 had previously gained access to. A resident was observed seated in a wheelchair in the lounge beside the closet door.

Inspector spoke with PTA #123 who was entering the hallway. PTA#123 stated they had stored the item in the closet as the closet was locked. PTA #123 confirmed the closet was left unlocked. PTA #123 took the lock from the shelf in the closet and locked the closet door. PTA#123 stated the closet should have been locked and they would find another spot to store the item.

In an interview, Assistant Director of Care (ADOC) #109 stated they were covering for the DOC at the time of the incident. ADOC #109 stated after the incident the physio item was removed from the area and put downstairs. ADOC #109 stated they were aware that the physio item had been put back in the specific home area closet. ADOC #109 stated the physio item was to be kept out of the area so it could not be picked up again. ADOC #109 stated all storage closets at the end of the hallway in each home area should be locked at all times.

The licensee has failed to ensure all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors were kept closed and locked when they were not being supervised by staff. [s. 9. (1) 2.]

The severity of this issue was determined to be a level 3 as there was actual risk to residents. The scope of the issue was level 2 as it was a pattern. The home has a level 2 compliance history of previous non-compliance to a different subsection of O. Reg 79/10. (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 30, 2020(A1)

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

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: 008

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

Pursuant to / Aux termes de :

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

O.Reg 79/10, s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order / Ordre :

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

The licensee must comply with s. 26 (3) of Ontario Regulation 79/10.

Specifically, the licensee must ensure:
a) The responsive behaviour plan of care for resident #004, #016 and all other residents is based on an interdisciplinary assessment of the resident that includes:
• any identified responsive behaviours;
• any potential behavioural triggers and variations in resident functioning at different times of the day,
b) Approaches/interventions for the identified responsive behaviours and triggers are documented.

Grounds / Motifs :

1. The licensee failed to ensure the resident's responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included:
• any identified responsive behaviours;
• any potential behavioural triggers and variations in resident functioning at different times of the day.

A) In an interview, Registered Practical Nurse (RPN) #107 stated that resident #004 currently had a specific intervention in place due to recent behaviours.

Review of resident #004's electronic progress notes in Point Click Care (PCC) noted on a specific date an incident occurred where resident #004 had access to an item that caused risk to staff and residents.

Further review of resident #004's electronic progress notes noted an entry which indicated specific interventions for the resident at meal time.

There were numerous entries in resident #004's progress notes related to behaviours.

Review of resident #004's most recent electronic care plan on Pont Click Care (PCC) noted that resident #004 had behaviours.

Review of resident #004's electronic care plan, kardex and posted interventions noted no interventions related to certain behaviours and the specific interventions for

resident #004 related to meal time.

In an interview, Personal Support Worker (PSW) #115 stated they worked with resident #004. PSW #115 stated resident #004 had displayed behaviours since their admission.

Inspectors #522 and #569 observed resident #004's room and noted several items accessible to the resident that could put other residents at risk.

Inspector #522 showed RPN #106 the items in resident #004's room. RPN #106 stated the items should not be in resident #004's room. RPN #106 removed the items and stated they would lock the items in the closet in the hallway.

In an interview, Assistant Director of Care (ADOC) #109 reviewed resident #004's plan of care with inspector #522. ADOC #109 acknowledged that resident #004's plan of care did not include specific interventions for meal time. ADOC #109 stated those interventions should be included in resident #004's plan of care. ADOC #109 acknowledged that there was no documentation in resident #004's plan of care related to specific behaviours.

B) Review of resident #016's electronic progress notes in PCC noted three separate incidents of specific behaviours.

Review of resident #016's most recent electronic care plan and posted interventions noted no documentation in resident #016's plan of care related to the specific behaviours.

In a telephone interview, PSW #115 stated that they worked with resident #016 and that resident #016 did display the specific behaviours.

In an interview, Registered Nurse (RN) #108 confirmed resident #016 displayed the specific behaviours. RN #108 reviewed resident #016's care plan, kardex and supportive actions in PCC and posted interventions and confirmed there were no interventions related to resident #016's specific behaviour.

In an interview, Director of Care (DOC) #100 stated resident #016's specific behaviour would be considered a responsive behaviour. DOC #100 stated this

behaviour and interventions should be identified in resident #016's plan of care.

In a telephone interview, DOC #100 stated they had thought about the incidents and felt the incidents were isolated and therefore would not expect them to be included in resident #016's plan of care.

The licensee failed to ensure resident #004's responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included:
• any identified responsive behaviours;
• any potential behavioural triggers and variations in resident functioning at different times of the day. [s. 26. (3) 5.]

The severity of this issue was determined to be a level 3 as there was actual risk to residents. The scope of the issue was level 2 as it was a pattern, involving two out of three residents. The home has a level 3 compliance history as there was previous non-compliance with the same subsection of the O. Reg 79/10 that included:
• Compliance Order (CO) issued May 15, 2017 (#2017_363659_0002) with a compliance due date of September 15, 2017;
• Voluntary Plan of Correction (VPC) issued October 20, 2017 (2017_607523_0017);
• VPC issued October 2, 2019 (2019_725522_0014). (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 15, 2020(A1)

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: 009

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Order / Ordre :

The licensee must comply with s. 101 (3) of LTCHA 2007.

Specifically, the licensee must ensure:
a) Ensure resident care, as per the resident's individualized plan of care, is documented in Point of Care.
b) Develop and implement an auditing process to ensure that all residents receive continence care and assistance with turning and repositioning as per their individualized plan of care and that resident care is documented in Point of Care. The auditing process must be documented. A documented record of these audits must be kept in the home and must include the dates conducted, the names and signatures of the participants, the results of the review and what changes were implemented as a result of the review.
c) Evaluate and revise the home's staffing plan and "Contingency Plan" document to ensure the staffing compliment meets the assessed care and safety needs of the residents of the home, until such a time that the home is fully staffed, according to the staffing plan. The evaluation and revision must be documented including the date it was conducted, the names and signatures of the participants, the results of the evaluation and what was done with the results of the evaluation."

Grounds / Motifs :

1. The licensee has failed to comply with the following requirement of the LTCHA: it is a condition of every licence that the licensee shall comply with every order made

under the LTCHA.

On October 2, 2019, during Complaint inspection #2019_725522_0014 Compliance Order (CO) #001 was issued with a compliance due date of November 29, 2019.

Compliance Order (CO) #001 ordered the licensee to be compliant with s. 31. (3) of the LTCHA related to the home's staffing plan.

Specifically, the licensee was to:
"a) Ensure that residents #002, #003, and #004, and all other residents, are bathed at a minimum twice a week by the method of their choice and bathing is documented.

b) Ensure that residents #001 and #002, and all other residents who require assistance with a specific care task, have the care completed at specific time frames and that the care is documented.
c) Ensure that residents #001 and #002, and all other residents receive specific care before and after meals and the specific care is documented.
d) Ensure resident #003 and all other residents that have specific interventions related to continence, have those interventions provided and documented.
e) Ensure resident #007 and all other residents receive the required assistance with personal care, and personal care is documented.
f) Ensure that resident #002 and all other residents are dressed appropriately, suitable to the time of day and dressing care is documented.
g) Ensure that resident #002 and all other residents that require assistance to get to the dining room for meals are brought down to meals prior to the start of the meal service.
h) Ensure resident care, as per the resident's individualized plan of care, is documented in Point of Care.
i) Develop and implement an auditing process to ensure that all residents receive two baths per week by the method of their choice, receive continence care and assistance with turning and repositioning as per their individualized plan of care and that resident care is documented in Point of Care. A documented record of these audits must be kept in the home and must include the dates conducted, the names and signatures of the participants, the results of the review and what changes were implemented as a result of the review.
j) Evaluate and revise the home's staffing plan and "Contingency Plan" document to ensure the staffing compliment meets the assessed care and safety needs of the

residents of the home, until such a time that the home is fully staffed, according to the staffing plan. The evaluation and revision must be documented including the date it was conducted, the names and signatures of the participants, the results of the evaluation and what was done with the results of the evaluation."

The licensee completed steps a) to g) in CO #001.
The licensee failed to complete steps h), i) and j).

A) On October 2, 2019, during Complaint inspection #2019_725522_0014 Compliance Order (CO) #001 was issued. Part h) of the order stated that the licensee must ensure that resident care, as per the resident's individualized plan of care, was documented in Point of Care. The compliance due date was November 29, 2019.

i) Review of documentation of care provided for resident #008 (resident #002 in CO #001) and resident #009 (resident #003 in CO #001) in Point of Care (POC) for a specific time period noted the absence of required documentation during full or partial shifts for nine identified care tasks.

The prevalence for missing documentation trended towards night shifts for resident #008. For resident #009, missing documentation trended towards day shifts for during one month, and night shifts for another month.

In an interview, Director of Care (DOC) #100 was asked what the home's process was to ensure that resident care documentation was completed. DOC #100 said they ran a POC documentation compliance report in the mornings which included the tasks of turning and repositioning, bladder continence and baths provided. When asked DOC #100 stated they did not focus on daily, evening and night care needs as part of the home's audit of documentation. The documentation audit only focused on resident care such as bathing, turning and repositioning and continence care. DOC #100 stated staff had been given the charting policy for POC and were to read and sign it and staff had also been offered overtime to document but they had refused it.

A document was provided to the inspection team named "EDUCATION IN-SERVICE ATTENDANCE SHEET" with the in-service topic being "Documentation – Electronic Resident Record". The document showed names/signatures of 15 Personal Support Workers (PSWs) out of the home's assignment list of 33 PSW's. The document was

dated December 24, 2019, which was after CO #001's compliance due date of November 29, 2019. No other policy in-service attendance document was provided to the inspection team during this inspection.

Attached to the attendance document was the policy titled "Documentation – Electronic Resident Record", Policy #VII-J-10.00 with a current revision date of April 2019.

Review of the policy showed under the category Procedure:
"The Personal Support Worker / Resident Care Aide will: 1) Complete all Point of Care Documentation for the resident."

Additionally "The PSW / RCA will:
1) Document on POC all pertinent resident care delivery information prior to the end of their shift on the resident's individual record, which includes:
• MDS Observational Record for ADLs
• Nursing Rehab (if applicable)
• Food & Fluid intake following each meal and snack time
• Restraint and or repositioning tool as identified on POC if applicable
• Other assigned areas as identified on the POC system"

ii) Review of resident #007's (resident #001 in CO #001) electronic documentation in POC from for a specific time from noted the absence of documentation for full or partial shifts for 10 identified care tasks.

In a telephone interview, DOC #100 reviewed resident #007's documentation from POC. DOC #100 acknowledged the missing documentation for resident #007. DOC #100 stated if there was missing documentation for resident #007 it must have been because the PSW had something happen during the shift that affected them from completing their documentation.

DOC #100 reviewed the staffing schedule for a specific date, one of the days where documentation was noted as missing for resident #007. DOC #100 stated that the home area was short a PSW and an agency staff member had filled in. DOC #100 stated that it was the expectation that agency staff completed documentation in POC for resident care that was provided.

The licensee failed to comply with section h) of CO #001 to ensure resident care, as per the resident's individualized plan of care, is documented in Point of Care.

B) During the course of this follow-up inspection, various members of the home management team were asked how the home came into compliance with CO #001 part i) which stated "Develop and implement an auditing process to ensure that all residents receive two baths per week by the method of their choice, receive continence care and assistance with turning and repositioning as per their individualized plan of care and that resident care is documented in Point of Care. A documented record of these audits must be kept in the home and must include the dates conducted, the names and signatures of the participants, the results of the review and what changes were implemented as a result of the review." The due date for this compliance order was November 29, 2019.

In an interview, Assistant Director of Care (ADOC) #109 was asked by Inspector #569 what audits were being completed to ensure that care was provided and that all residents received two baths per week, received continence care and assistance with turning and repositioning as per their individualized plan of care. ADOC #109 said they had completed three observational audits. When asked by Inspector #522 if there were any additional audits of care provided, ADOC #109 stated that registered staff were completing audits of care Personal Support Workers provided to residents.

Assistant Director of Care (ADOC) #109 provided a WORD document to Inspector #522. The document showed three visual audits completed by the ADOC. On December 9, 2019, an audit of catheter assistance for resident #009 was documented and an audit of turning and repositioning assistance was documented for resident #008. On December 10, 2019, an audit of turning and repositioning assistance was documented for resident #007. There were no names of the auditors and no associated signatures on the document. Also, there were no audit review results provided that identified what changes were implemented as a result of the review.

On January 24, 2020, in an interview, Registered Nurse (RN) #119 informed Inspector #522 that registered staff had not been recently asked to complete audits or observations of care provided to residents and that there had not been a formal meeting with all registered staff about completing audits of resident care.

RN #119 proved Inspector #522 with the registered staff meeting minutes binder. Inspector #522 reviewed the meeting minutes for November 15, 2019, and noted no discussion related to audits of resident care related to repositioning and turning and continence care. There were no registered staff meeting minutes found for December 2019 in the same binder.

In an interview, Registered Practical Nurse #121 told Inspector #522 that registered staff were never asked to complete resident care audits and that they were unaware of a meeting that directed registered staff to do so. They also shared that they were recently directed to complete a visual audit of care for resident #009 which was done. Inspector #522 asked how the audit was documented and RPN #121 said they sent the observation in an email to ADOC #109.

A review of an email provided by RPN #121 to Inspector #522 and addressed to ADOC #109 documented that RPN #121 went over the catheter care and observed PSW #114. RPN #121 identified the resident referred to in the email to be #009. The email did not indicate the results of the observation and what changes were implemented as a result.

In a telephone interview, RPN #132 informed Inspector #522 that they had received no direction from management for registered staff to complete audits on the care provided to residents by PSWs.

Registered staff had indicated there had been a brief meeting with the Executive Director (ED) and two other registered staff members on January 13, 2020.

Review of the home's "Risk Management Plan – Nursing" policy #XXIII-G-10.00 with a revision date of June 2019, stated "As part of the risk management framework, the risk management plan is developed to monitor process and identify risks and outcomes of care. A series of resident care audits will be completed on a regularly scheduled basis."

During this inspection there were no other resident care audits provided to the inspection team for catheter assistance or turning and repositioning. Also, no auditing schedule was provided for these care tasks.

DOC #100 acknowledged there was no auditing process developed or implemented

to ensure that all residents received continence care and assistance with turning and repositioning with the required documentation as identified in CO #001 part i).

C) ED #135 had provided Inspector #569 a document "Secord Trails Care Community Staffing Plan Review, Review Date – November November 2018 from November 2019".. ED #135 said they had typed up the review document and said it was in error and should read 'November 2018 to November 2019. ED #135 said the review date occurred on November 28, 2019, which was identified in the body of the document as well as the document "Contingency Plan Meeting - November 28, 2019"

In an interview DOC #100 and ADOC #109, ADOC #109 stated the evaluation of the home's Staffing Contingency Plan was completed in March 2019. When asked by Inspector #522 if an evaluation of the Staffing Contingency Plan was completed as part of CO #001, DOC #100 stated an evaluation had not been completed as part of CO #001 as the evaluation was not due to be completed again until March 2020. ADOC #109 stated they did not complete an evaluation, but they did have a meeting in November 2019, regarding the Staffing Contingency Plan.

In an interview, ADOC #109 informed Inspector #522 that they had emailed ED #135 to clarify if there had been an evaluation of the staffing plan and contingency plan in relation to the order. ADOC #109 stated the ED had let them know that the evaluation of the Staffing Plan had taken place in March 2019 and had been reviewed at the Staffing Plan review meeting they held on November 28, 2019.

ED #135 was asked to provide the inspection team the staffing plan evaluation document that was to include the date it was conducted, the names and signatures of the participants, the results of the evaluation and what was done with the results as directed in Order #001, part j). ED #135 said that the home used their "Quality Management – LTC Program/Committee Evaluation Tool' to evaluate their programs including their staffing plan.

The home's "Quality Management – LTC Program/Committee Evaluation Tool' related to their staffing plan evaluation was provided to the inspection team by ED #135. Upon review of the evaluation tool it was documented "Period Reviewed: January – December 2019" and "Date of Report: March 2019". There was no specified date of the evaluation found that correlated with CO #001's due date of

November 29, 2019, and although there was a list of those who participated in the evaluation, there were no associated signatures included.

ED #135 explained that the evaluation tool was a living document and that ongoing additions were made to it throughout the year. ED #135 acknowledged that there were no dates added when changes had been made to it as well as no signatures included with the list of the participants.

The licensee did not comply with Compliance Order #001 part h), i) and j) issued October 2, 2019, in inspection #2019_725522_0014 with a compliance due date of November 29, 2019. They failed to ensure that the provision of care for residents #007, #008 and #009, as per their individualized plan of care, was documented. They did not develop and implement an auditing process to ensure all residents received continence care and assistance with turning and repositioning as per their individualized plan of care with associated documentation. There were no documented records of these audits that included the dates conducted, the names and signatures of the participants, the results of the review and what changes were implemented as a result of the review. The licensee also did not include the date of the evaluation of the staffing plan and contingency plan, as well as the signatures of the participants.

The licensee has failed to comply with the following requirement of the LTCHA: it is a condition of every licence that the licensee shall comply with every order made under the LTCHA. [s. 101. (3)]
The severity of this issue was determined to be a level 2 as there was minimal risk to residents. The scope of the issue was level 3 as it was widespread, effecting all residents of the home. The home has a level 3 compliance history as there was previous non-compliance with the same subsection of the LTCHA that included a Written Notification issued November 22, 2018 (#2018_722630_0022). (522)

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

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

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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

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.

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

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

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

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 15th day of October, 2020 (A3)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Amended by JULIE LAMPMAN (522) - (A3)

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

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