Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 19, 2017	2017_420643_0008	014069-16, 014252-16, 017566-16, 021208-16, 021878-16, 022278-16, 022710-16, 024472-16, 028658-16, 004919-17, 007560-17	Critical Incident System

Licensee/Titulaire de permis

PROVIDENCE HEALTHCARE
3276 St. Clair Avenue East TORONTO ON M1L 1W1

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

PROVIDENCE HEALTHCARE
3276 ST. CLAIR AVENUE EAST SCARBOROUGH ON M1L 1W1

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

ADAM DICKEY (643), BABITHA SHANMUGANANDAPALA (673), JOANNE ZAHUR (589), SUSAN SEMEREDY (501)

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): May 1, 2, 4, 5, 8-12, 15-19, 23-26, 29-31, 2017.

The following critical incidents were inspected concurrently during this inspection:

#014069-16, #014252-16 related to alleged abuse/ neglect;
#021208-16, #022278-16, #024472-16 related to abuse;
#022710-16, #004919-17 related to improper treatment/care;
and #017566-16, #021878-16, #028658-16, #007560-17 related to falls prevention and management.

Written Notifications and Compliance Orders related to LTCHA, 2007, S.O. 2007, C.8, s. 19. (1), s. 24 (1) identified in concurrent inspection #2017_626501_0013 (Log #026677-16, #033728-16, #034179-16) will be issued in this report.

Written Notifications and Compliance Orders related to LTCHA, 2007, S.O. 2007, C.8, s. 19. (1), s. 24 (1) identified in concurrent inspection #2017_630589_0008 (Log #029660-16) will be issued in this report.

A Written Notification and Compliance Order related to LTCHA, 2007, S.O. 2007, C.8, s. 6. (7), identified in concurrent inspection #2017_420643_0010 (Log #0008292-17, 009465-17, 009513-17) will be issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Employee and Labour Relations Manager (ELRM), Assistant Medical Director, Medical Doctors (MD), Resident Care Manager (RCM), Interim Resident Care Managers (IRCM), Patient Care Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Dietitian (RD), Registered Physiotherapist (PT), Social Worker (SW), Resident Assistants (RA), Activation Assistants (AA), Volunteers, Chaplin, Housekeeping Aide, residents, family members, Power of Attorneys (POA), and Substitute Decision Makers (SDM).

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

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

- **8 WN(s)**
- **2 VPC(s)**
- **4 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are free from neglect by the licensee of staff in the home.

A Critical Incident System Report (CIR) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date related to a fall incident involving resident #006 which resulted in injury and transfer to the hospital. Review of the CIR revealed that RA #147 had attempted to assist resident #006 he/she began to exhibit identified behaviours towards RA #147. RA #147 stepped back from resident #006's bedside during which time resident #006 fell.

Review of resident #006's progress notes from an identified date, revealed that RA #139 had called for RPN #137 to respond to resident #006's room. The resident was found on the floor with an identified injury. Resident #006 was displaying signs of pain when an identified area of his/her body was touched by staff. MD on call ordered for resident #006 to be sent to acute care hospital for assessment.

Review of resident #006's written plan of care accessed on an identified date, revealed that he/she was at high risk for falls and he/she had a history of exhibiting identified responsive behaviours. Staff were instructed to provide two person assistance at all times with care.

In an interview, RA #147 stated that he/she had entered resident #006's room to get him/her ready to go to the dining room for an identified meal service. RA #147 further stated that he/she had asked RA #139 to come and assist with transferring resident #006 from bed. RA #147 stated that he/she began to reposition the bed and that resident #006 exhibited identified responsive behaviours toward RA #147. RA #147 further stated that he/she reacted by stepping back from the bedside at which point resident #006 fell. RA #147 acknowledged that resident #006's written plan of care stated he/she was in need of two person assistance for all care, and no other staff members were present in the room at the time.

In an interview, RA #139 stated that RA #147 had asked her to come to resident #006's room and was on his/her way there when the fall took place. RA#139 stated that he/she was not assisting RA #147 with care at the time of the fall. RA#139 acknowledged that he/she was aware that resident #006 required the assistance from two staff members for all care.

In an interview, interim Resident Care Manager (IRCM) #152 stated that resident #006's written plan of care instructed staff to provide care with two people at all times because of his/her responsive behaviours. IRCM #152 further stated that RA #147 was providing

care to the resident alone and should have been completed with two people for safety. He/she acknowledged that the licensee had failed to ensure that resident #006 was free from neglect as assistance by two staff members which was required for safety had not been provided as outlined in resident #006's written plan of care. [s. 19. (1)]

2. The licensee has failed to protect three or more residents from abuse.

Review of a CIR submitted to the MOHLTC on an identified date, revealed that two days prior, RPN #137 observed resident #014 touching an identified area of resident #015's body. A previous incident was also reported in this CIR that occurred one week prior, when resident #014 was touching an identified area of resident #015's body while they sat in a common area which was witnessed by RA #172.

Review of resident #014's progress notes revealed this was not the first time resident #014 had demonstrated identified responsive behaviours toward co-residents. During a nine month period, spanning before and after the above mentioned incidents, resident #014 demonstrated the identified responsive behaviours towards five different co-residents.

In most of the incidents it was noted that resident #014 was successfully redirected from these behaviours without incident. Resident #014 was discharged from the home on an identified date, to another Long-Term Care Home.

Review of resident #014's progress notes revealed that resident #014 was assessed by an external resource on an identified date, and by another resource approximately two weeks later. Recommendations included three identified interventions. Interventions were implemented and appeared to be effective. Resident #014 was discharged from the two above mentioned resources after three months, due to him/her being more settled with no recent documented responsive behaviours.

Review of resident #014's progress notes revealed the first documented incident after being discharged from the above resources occurred approximately 6 weeks later. This incident was reported to the MOHLTC six days later. The progress note indicated staff noted resident #014 inappropriately touching resident #015's body while they sat in a common area. According to the progress notes a meeting was held with staff in regards to the interaction observed between resident #014 and #015. Interventions were discussed to encourage staff to observe for escalating identified responsive behaviours.

In an interview, RA #172 stated that on the above mentioned date, he/she observed resident #014 touching an identified area of resident #015's body. RA #172 stated he/she thought this incident was abusive because resident #015 was not able to provide consent to the activity.

In an interview, RN #134 who was an IRCM during this period, revealed that he/she did not view the incident as abuse because resident #015 did not seem distressed and resident #014 and #015 enjoyed each other's company. RN #134 could not explain to the inspector why he/she called the police regarding this incident but did not report it to the MOHLTC.

Review of resident #014's progress notes revealed the second incident after being discharged from the above resources occurred on an identified date in the month following discharge from the above mentioned resources. This was reported to the MOHLTC the day after the incident occurred. According to the note, resident #014 sat beside resident #015 in a common area, and was observed touching an identified area of resident #015's body. According to the CIR and the progress note, resident #014 continued to attempt to enter resident #015's room that evening and was difficult to redirect.

In an interview, RPN #137 stated that he/she wrote the above noted progress note and did not think it was abuse at the time but now considers it would be abuse because resident #014 did not ask permission and resident #015 did not give consent.

The inspector conducted record reviews and interviews regarding the three identified co-residents which revealed the following:

Record review revealed resident #015 was admitted to the home on an identified date. According to a Minimum Data Set (MDS) assessment, resident #015 was assessed to have impaired cognition. According to progress notes in resident #014's record, resident #014 demonstrated responsive behaviours toward resident #015 on seven identified dates over a ten month period. According to progress notes in resident #015's record, resident #015's SDM was only notified of the incidents that occurred on two of the above mentioned identified dates. Interviews with RN #126, RPN #137, #125, #174 and #176 revealed they did not think resident #015 was capable of providing consent to engage in the identified activity.

Record review revealed resident #028 was admitted to the home on an identified date.

According to an MDS assessment resident #028 was assessed to have impaired cognition. According to progress notes in resident #014's record, resident #014 demonstrated identified responsive behaviours toward resident #028 on two consecutive identified dates. Review of resident #028's progress notes failed to reveal record of the two above mentioned incidents. An interview with RN #126 indicated that resident #028's SDM was not contacted and did not know why the MOHLTC was not notified. In interviews, RN #126, RPN #125 and RPN #176 stated they did not think resident #028 was capable of providing consent to engage in the identified activity.

Record review revealed resident #029 was admitted to the home on an identified date. According to an MDS assessment resident #029 was assessed to have impaired cognition. According to progress notes in resident #014's record, resident #014 demonstrated identified responsive behaviours toward resident #029 an identified date; however there was no progress note related to this incident in resident #029's record. In an interview RPN #137 stated he/she did not report this incident because this was an ongoing problem with resident #014. RPN #137 admitted he/she did not contact resident #029's SDM regarding the incident on the above mentioned identified date. In interviews, RN#126, RPN #125, RPN #137, RPN #174 and RPN #176 stated they did not think resident #029 was capable of providing consent to engage in the identified activity.

Interviews failed to reveal the identity of residents that resident #014 inappropriately touched on two identified dates.

In interviews, the Social Worker (SW) and administrator stated that the home had not determined the capacity for any residents to provide consent to engage in the identified activity. During an interview with the Assistant Medical Director, he/she stated that residents engaging in identified activities have to have an understanding of what the activity is in order to be able to consent to it.

During an interview the Administrator acknowledged the home failed to protect resident #015, #028 and #029 and possibly two other residents from abuse. [s. 19. (1)]

3. The following evidence related to resident #007 was found under inspection report 2017_626501_0013.

The licensee has failed to protect resident #007 from abuse.

Two CIRs were submitted to the MOHLTC on an identified date, related to resident

abuse. According the CIRs, resident #008 was observed during a program demonstrating an identified responsive behaviour toward resident #007 six days earlier. The CIRs state that staff #110 witnessed resident #008 whispering into resident #007's ear and touching an identified area of resident #007's body. Staff #110 removed resident #008 away from resident #007 who was sleepy and unaware of the incident.

Record review revealed resident #008 was admitted to the home on an identified date. Review of resident #008's progress notes revealed he/she demonstrated an identified responsive behaviour towards an unidentified co-resident on an identified date. Two weeks later, when the Substitute Decision Maker (SDM) was informed of the incident, it was revealed that resident #008 had a history identified responsive behavours toward co-residents in a previous facility. Identified responsive behaviours towards staff and co-residents were discussed in behaviour rounds and documented in the progress notes on three identified dates over a three month period. No other identified responsive behaviours toward co-residents were noted. Resident #008's was assessed to have impaired cognition.

Record review revealed resident #007 was admitted to the home on an identified date . Resident #007 was assessed to have impaired cognition. Resident #007 was no longer a resident of the home at the time of inspection.

During an interview with staff #110, he/she stated that during the program on the above mentioned identified date, resident #008 and #007 were sitting next to each other when resident #008 touched an identified area of resident #007's body. Staff #110 was able to remove resident #008 from the area. Staff #110 also observed resident #008 whispering in resident #007's ear but did not hear what was being said. Staff #110 stated he reported this to Activation Assistant #109 and it was decided that staff #110 would document the incident in both residents' progress notes. Staff #110 expressed that he/she did not believe resident #007 had the capacity to provide consent to engage in the identified activity.

In an interview, Activation Assistant (AA) #109 revealed he/she was told about the incident by staff #110 and both had agreed that staff #110 would document the incident in both residents' progress notes. AA #109 indicated he/she was aware resident #008 had a history concerning interactions with co-residents and considered the actions of resident #008 to be abusive as the co-residents did not provide consent to the identified activity.

In interviews, both staff #110 and AA #109 stated that they did not report the incident to any manager of the home or the MOHLTC.

In an interview, the Administrator acknowledged that in the above mentioned incident resident #008 demonstrated an identified responsive behaviour toward resident #007and resident #007 did not have the capacity to provide consent to the identified activity, and therefore was not protected from abuse. [s. 19. (1)]

4. The following evidence related to residents #010 and #011 was found under inspection report 2017_630589_0008.

The licensee has failed to ensure residents are protected from abuse by anyone.

The MOHLTC received a complaint, related to incidents of witnessed abuse towards resident's #010 and #011 that occurred over an identified three week period. The complaint further revealed that these incidents of abuse had been witnessed by a volunteer (V). The V reported these incidents of abuse to the home in an email. The MOHLTC had also received a CIR an identified date, related to incidents of witnessed abuse involving RA #133 towards resident's #010 and #011.

Review of the email letter from volunteer (V) #136 revealed he/she was volunteering on two identified units over an identified three week period. The email revealed he/she witnessed incidents of abuse towards resident's #010 and #011 from RA #133. V #136 reported that RA #133 was providing poor care, lacking compassion to residents #010 and #011. V #136 further reported the following incidents of RA #133 abruptly waking up residents #010 and #011:
-applying identified physical forces to identified areas of the body,
-roughly nudging them, yelling at them to wake them up, and
-abruptly applying an identified device with force while the resident was still asleep. On one occasion, the identified device was applied with physical force to an identified area of the resident's body.

In an interview, V #136 started these incidents of abuse were mostly directed at resident #010. V #136 further stated he/she would normally assist resident #011 with eating and had resident #010 and RA #133 within his/her line of vision where he/she was able to witness RA #133's interactions with resident #010. V #136 stated that resident #010 had difficulty seeing what RA #133 was doing and that resident #011's was able to see RA #133's actions.

In an interview, resident #010 stated that a staff member would apply an identified physical force to wake him/her up. Resident #010 stated this happened daily and that he/she had told the RA he/she would call the police but resident #010 stated he/she never did call the police. Resident #010 could not recall RA #133 applying any other type of physical force or roughly applying the device. Resident #133 further stated these actions were not nice, he/she didn't like how it felt, and that the actions had not caused any identified injury. Resident #010 further stated this person didn't look after him/her anymore and he/she didn't want this person to look after him/her anymore as was not nice towards him/her.

Review of RA #133's personnel file revealed he/she had received discipline regarding the allegations of abuse of resident #010. RA #133 had denied any abuse occurred against residents #010 and #011.

In an interview, RA #133 stated he/she had not been aware that his/her actions were inappropriate and constituted abuse. RA #133 further stated that he/she was in a hurry and tossed an item at resident #011, not realizing that this action was unacceptable. RA #133 acknowledged that after the home's investigation and being disciplined he/she realized that the above mentioned incidents constituted abuse.

In an interview, DRC #161 acknowledged that resident's #010 and #011 had not been protected from abuse. [s. 19. (1)]

5. The licensee has failed to ensure that residents are protected from abuse by anyone.

On an identified date, the MOHLTC received a CIR related to resident to resident abuse. Review of the CIR revealed that on an identified date at an identified time, resident #017 was noted by staff to have an identified injury to an identified area, and resident #016 had identified injury. The CIR further revealed that resident #016 stated that resident #017 came into his/her room and when he/she told resident #017 to get out, resident #017 hit him/her.

Review of resident #017's MDS assessment from an identified date, revealed that resident #017 had impaired cognition with identified responsive behaviours that were not easily altered.

Review of resident #017's identified specialized resource progress note from an identified date, revealed that as per the resident's family member, there was a recent escalation in the resident #017's behaviours with an incident of an identified responsive behaviour toward a co-resident. A progress note from an identified date, by the specialized resource team revealed that resident #017 had been prescribed an identified medication, and continued to demonstrate identified responsive behaviours.

Review of resident #017's plan of care from an identified date, revealed that staff were instructed to supervise him/her when ambulating in specified areas. It further stated that the resident's identified responsive behaviour was triggered by identified social issues. Interventions were identified and included in resident #017's to deal with the above mentioned responsive behaviour.

Review of resident #016's MDS assessment from an identified date, revealed that he/she had identified diagnoses, demonstrated identified responsive behaviours with a deterioration in his/her behavioural symptoms. The Resident Assessment Protocol (RAP) note related to this behaviour stated that resident #016's care plan and interventions were completed to ensure the health and safety of resident #016 and other residents.

Review of resident #016's written plan of care revealed that he/she had identified responsive behaviours. One of the interventions for this focus included being cognizant of invading resident #016's personal space.

Review of resident #016's progress notes revealed that on an identified date, resident #016 made a gesture toward resident #017, and resident #017 was moved. Record review of resident #016's and resident #017's progress notes indicated that resident #017 entered resident #016's room, upsetting resident #016 and causing him/her to yell at resident #017.

Progress notes from an identified date, stated that resident #017 entered resident #016's room and an unwitnessed altercation occurred. Residents #017 and #016 sustained injuries. Both residents were sent to hospital, and resident #016's discharge report stated he/she sustained an injury.

In an interview, resident #016 stated that he had had a few altercations with resident #017 prior to the above mentioned incident, as resident #017 kept entering his/her room. Resident #016 further stated that resident #017 hit him/her first, causing pain.

In an interview, RA #194 stated that resident #017 tended to enter resident #016's room, and required redirection. RA #194 further stated that he/she did not know that the residents had a potential to be demonstrate identified responsive behaviours toward each other, but knew that resident #017 had other identified behavioural issues. RA #194 stated that on the date of the above mentioned incident he/she had been aware that resident #017 was moving about the unit but was not supervising resident #017 as he/she was assisting another resident. RA #194 stated that he/she witnessed resident #017 exiting resident #016's room with marks from the altercation.

In an interview, RPN #192 stated that resident #016 demonstrated identified responsive behaviours toward residents and staff. RPN #192 further stated that if there is previous history of altercations between two residents, some interventions that the home uses are to separate them, offer distractions and activities, change floors or have 1:1 monitoring. RPN #192 stated that not enough steps were taken to minimize the risk of an altercation between resident #016 and #017.

In an interview, RPN #193 stated that resident #017 had a history of going into resident #016's room and this would upset resident #016 and that although there was a device to prevent entry on resident #016's door, the intervention was not effective as resident #017's room was nearby, and he/she would disregard it. RPN #193 stated that other interventions could have been considered. RPN #193 stated that as these steps were not taken, resident #017 and resident #016 were not protected from abuse.

In an interview, RCM #152 stated that resident #016 demonstrated identified responsive behaviours. RCM #152 also stated that resident #017's behaviour was triggered by identified social issues. RCM #152 stated that although resident #017 was being followed by specialized resources, resident #017 could benefited from other interventions.

In an interview, DRC #161, confirmed that not enough steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #016 and resident #017. DOC #161 confirmed that resident #017 and resident #016 were not protected from abuse. [s. 19. (1)]

Multiple incidents of abuse or neglect of residents were identified. The severity of this noncompliance was identified as actual harm, the scope was identified as isolated. A review of the home's compliance history revealed that written notifications and voluntary plan of corrections were issued July 24, 2014, under inspection report #2014_235507_0014 and on December 20, 2016, under inspection report

#2016_484646_0012. Due to the severity of actual harm and ongoing noncompliance with s. 19. (1), a compliance order is warranted.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 following evidence related to residents #010 and #011 was found under inspection report 2017_630589_0008.

The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm has occurred, immediately report the suspicion and the information upon which it was based to the Director.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint on an identified date, related to incidents of witnessed abuse towards resident's #010 and #011 that occurred over an identified three week period.

Review of Providence Healthcare's policy titled: Zero Tolerance for Abuse and Neglect, revised March 2017, revealed on page three, under reporting an incident, that all staff, volunteers, contractors and affiliated personnel are to fulfill their legal obligation to immediately report any witnessed incident or alleged incident of abuse or neglect to the MOHLTC.

In an interview, V #136 stated that over an identified three week period, he/she had observed incidents of abuse towards two resident's by RA #133. V #136 further stated he/she sent an email letter on an identified date, to RCM #134 reporting these incidents of abuse.

Review of a CIR submitted to the MOHLTC revealed that the licensee became aware of the witnessed abuse incidents three days after the email had been sent, and the CIR was subsequently submitted one day later. The CIR further revealed under action taken, that the MOHLTC after hours pager had not been called.

In an interview RCM #134 stated he/she had received the email letter sent by V #136 three days after it had been sent, reporting staff to resident abuse which he/she then endorsed to DRC #161. RCM #134 further stated since the allegations of abuse were significant he/she had wanted to verify with V #136 that he/she would stand by them before notifying the MOHLTC.

In an interview, DRC #161 stated she became aware of the above mentioned incidents of abuse the day after RCM #134 received V #136's email, as he/she was not in the home that day. DRC #161 further stated at the time he/she had been informed of the witnessed abuse, RCM #134 had already submitted the CIR.

In an interview, RCM #134 acknowledged he/she had not called the MOHLTC after-hours pager and therefore had not reported the above mentioned witnessed abuse immediately to the MOHLTC. [s. 24. (1)] (589)

2.The following evidence related to residents #024 and #025 was found under inspection report 2017_630589_0008.

Review of the home's investigation notes related to the above mentioned incidents of abuse revealed that during interviews, RA's #149 and #154 revealed additional incidents of alleged abuse involving RA #133 towards resident's #024 and #025.

In an interview, RA #149 stated resident #024 had reported to him/her that about two years ago RA #133 had thrown an identified object at him/her and was rough when providing care. RA #149 further stated resident #025 would respond in an affectionate manner to RA #149, but when RA #133 would be close by, resident #025 would display identified signs of fear. RA #149 stated he/she had not reported this but picked up resident #025's care needs because he/she felt bad for him/her.

Resident #025 was not available for interview as was not a resident of the home at the time of inspection. In an interview, resident #024 denied the above allegations of abuse.

In an interview, Administrator #129 acknowledged these additional incidents of abuse had been viewed as hearsay and therefore had not been reported to the MOHLTC.

3. Review of a CIR submitted to the MOHLTC on an identified date, revealed that on the previous day, RPN #137 observed resident #014 touching an identified area of resident #015's body. A previous incident was also reported in this CIR that occurred one week prior to the submission of the CIR, when resident #014 was touching an identified area of resident #015's body while they sat in a common area which was witnessed by RA #172. According to the CIR police were contacted regarding the first above mentioned incident.

In an interview, IRCM #152 who submitted the CIR stated he/she did not see the first incident as abuse and could not explain why he/she contacted the police. IRCM #152 could not explain why he/she reported the second incident to the MOHLTC. Interview with the Administrator confirmed that the home should have contacted the MOHLTC immediately after the initial incident, and not six days later with a subsequent incident.

Review of resident #014's progress notes revealed this was not the first time resident #014 had demonstrated identified responsive behaviours toward co-residents. According to these progress notes there were eleven other documented incidents and a review of the CIRs submitted by the home failed to reveal any of these incidents were reported to the MOHLTC. Interviews with RPN #137, RPN #125, RPN #174 and RPN #176 revealed the reason they did not report to managers each of the incidents was because they thought management was aware of resident #014's ongoing identified responsive behaviours.

In an interview, the Administrator confirmed management was aware of resident #014's

ongoing identified responsive behaviours as early as six months prior to submitting the CIR. The Administrator acknowledged the home had reasonable grounds to suspect resident #014 was abusing co-residents and should have immediately reported the suspicion and the information upon which it is based to the Director.

The severity of this noncompliance was identified as potential for actual harm, the scope was identified as a pattern. A review of the home's compliance history revealed that a written notification and voluntary plan of correction was issued April 5, 2016, under inspection report #2016_461552_0011, and a written notification was issued on July 24, 2014, under inspection report #2014_235507_0014. Due to ongoing noncompliance with s. 24. (1), a compliance order is warranted. [s. 24. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

On an identified date, the MOHLTC received a CIR related to resident to resident abuse. Review of the CIR revealed that on an identified date at an identified time, resident #017 was noted by staff to have an injury to an identified area, and resident #016 had an

identified injury. The CIR further revealed that resident #016 stated that resident #017 came into his/her room and when he/she told resident #017 to get out, resident #017 hit him/her.

Review of resident #017's MDS assessment from an identified date, revealed that resident #017 had impaired cognition with identified responsive behaviours that were not easily altered.

Review of resident #017's specialized service progress note from an identified date, revealed that as per the resident's family member, there was a recent escalation in the resident #017's behaviours with an incident of an identified responsive behaviour toward a co-resident. A progress note from an identified date, by the specialized service team revealed that resident #017 had been prescribed an identified medication, and continued to demonstrate identified responsive behaviours.

Review of resident #017's plan of care from an identified date, revealed that staff were instructed to supervise him/her when ambulating in specified areas. It further stated that the resident's identified responsive behaviour was triggered by identified social issues. Interventions were identified and included in resident #017's to deal with the above mentioned responsive behaviour.

Review of resident #016's MDS assessment from an identified date, revealed that he/she had identified diagnoses, demonstrated identified responsive behaviours with a deterioration in his/her behavioural symptoms. The Resident Assessment Protocol (RAP) note related to this behaviour stated that resident #016's care plan and interventions were completed to ensure the health and safety of resident #016 and other residents.

Review of resident #016's written plan of care revealed that he/she had identified responsive behaviours. One of the interventions for this focus included being cognizant of invading resident #016's personal space.

Review of resident #016's progress notes revealed that on an identified date, resident #016 made a gesture toward resident #017, and resident #017 was moved. Record review of resident #016's and resident #017's progress notes indicated that resident #017 entered resident #016's room, upsetting resident #016 and causing him/her to yell at resident #017.

Progress notes from an identified date, stated that resident #017 entered resident #016's

room and an unwitnessed altercation occurred. Residents #017 and #016 sustained injuries. Both residents were sent to hospital, and resident #016's discharge report stated he/she sustained an injury.

In an interview, resident #016 stated that he had had a few altercations with resident #017 prior to the above mentioned incident, as resident #017 kept entering his/her room. Resident #016 further stated that resident #017 hit him/her first, causing pain.

In an interview, RA #191 stated that resident #016 had the potential to be verbally and physically aggressive, and resident #017 had to be supervised to know where he/she is at all times as he/she wanders. RA #191 further stated that resident #017 and #016 would get into each other's space and required redirection.

In an interview, RA #190 stated that an intervention used by the home if someone is exhibiting identified responsive behaviours is to have 1:1 supervision.

In an interview, RA #194 stated that resident #017 tended to enter resident #016's room, and required redirection. RA #194 further stated that he/she did not know that the residents had a potential to be demonstrate identified responsive behaviours toward each other, but knew that resident #017 had other identified behavioural issues. RA #194 stated that on the date of the above mentioned incident he/she had been aware that resident #017 was moving about the unit but was not supervising resident #017 as he/she was assisting another resident. RA #194 stated that he/she witnessed resident #017 exiting resident #016's room with marks from the altercation.

In an interview, RPN #192 stated that resident #016 demonstrated identified responsive behaviours toward residents and staff. RPN #192 further stated that if there is previous history of altercations between two residents, some interventions that the home uses are to separate them, offer distractions and activities, change floors or have 1:1 monitoring. RPN #192 stated that not enough steps were taken to minimize the risk of an altercation between resident #016 and #017.

In an interview, RPN #193 stated that resident #017 had a history of going into resident #016's room and this would upset resident #016 and that although there was a device to prevent entry on resident #016's door, the intervention was not effective as resident #017's room was nearby, and he/she would disregard it. RPN #193 stated that other interventions to consider could have been to move resident #017 or provide 1:1 supervision.

In an interview, RCM #152 stated that resident #016 demonstrated identified responsive behaviours. RCM #152 also stated that resident #017's behaviour was triggered by identified social issues. RCM #152 stated that although resident #017 was being followed by the specialized resources, resident #017 could have been moved to a different unit, provided with 1:1 supervision, or offered activities to engage with in the evenings.

In an interview, DRC #161, confirmed that not enough steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #016 and resident #017, as resident #017 could have been moved to a different unit sooner, or provided with increased monitoring and activities in the evenings.

The severity of this noncompliance was identified as actual harm, the scope was identified as isolated. Review of the home's compliance history revealed there was no previous compliance history related to r. 54. (b). Due to the severity of actual harm to residents #016 and #017, a compliance order is warranted. [s. 54. (b)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care set out clear directions to staff and others who provide direct care to the resident.

A CIR was submitted to the MOHLTC on an identified date, related to a fall incident involving resident #003. Resident #003 had an unwitnessed fall with injury which required transfer to hospital.

Review of resident #003's written plan of care from an identified date, revealed that staff were instructed to provide two-person assistance for safe transfer. The written plan of care further instructed staff to provide one-person extensive guidance and physical assistance for transferring.

In an interview, RA #100 stated that resident #003 required the assistance of two staff members to manually transfer him/her. RA #100 further stated that resident #003 sits at the head of the bed and two staff members help him/her into the mobility device.

In an interview, RA #119 stated that resident #003 required the assistance of one person for transferring. RA #119 further stated that resident #003 is at times able to sit up at the side of the bed and is able to stand and pivot transfer.

In an interview, RPN # 105 stated that resident #003 is transferred by a pivot transfer, and depending on resident #003's mobility and cooperation requires the assistance of one or two staff members for transferring.

In an interview RN # 126 stated that resident #003 is a one person transfer, but for safety should be a two person transfer as he/she occasionally exhibits an identified behaviour. RN #126 stated it is the expectation of the home for the registered staff on the units to update resident care plans in Point Click Care (PCC) with any changes to resident care needs. RN #126 further stated that the direction in the written plan of care was contradictory.

In an interview, IRCM #152 acknowledged that there was conflicting information to direct staff regarding the transferring of resident #003. He/she stated that the instruction was not clear whether to use one or two staff members to assist with transferring. In this case the licensee had failed to ensure that the written plan of care set out clear directions to staff and others who provide direct care to resident #003. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care is provided to

the resident as specified in the plan.

a. The following evidence related to resident #020 was found under inspection report 2017_420643_0010.

Review of a complaint and CIR submitted to the MOHLTC revealed that resident #020 had a fall incident on an identified date, while being assisted by a staff member. This incident resulted in resident #020 sustaining identified injuries requiring transfer to hospital.

Review of resident #020's health records revealed that he/she had identified diagnoses and had a history of falls since admission to the home. Resident #020 was identified as being at high risk for falls. Additionally, resident #020 exhibited identified responsive behaviours which may have affected his/her falls risk.

Review of resident #020's written plan of care from an identified date, revealed that staff were instructed to provide one person physical assistance for transferring, and two person physical assistance for transferring when exhibiting identified behaviours. Staff were instructed to provide two person assistance for dressing when resident #020 exhibited identified behavioural cues.

Review of resident #020's progress notes from the date of the above mentioned fall incident, revealed that he/she had been assessed post fall by RPN #132 and RN #126. According to the progress notes resident #020 fell onto the floor, striking an identified area of his/her body when the RA was assisting with an article of clothing. It was determined that resident #020 should be transferred to hospital for further assessment of his/her injuries.

In an interview, RA #167 stated that resident #020 had been exhibiting identified behavioural cues during an identified hour period and had documented this in the dementia observation system (DOS) monitoring record for that day. RA #167 also stated that he/she knew that resident #020 might exhibit the above mentioned identified behavioural cues as if he/she required an identified care need.

Review of DOS monitoring form for the identified week of the incident, revealed that resident #020 had been documented as exhibiting identified behavioural cues at three consecutive half-hour intervals leading up to the incident.

In an interview, RN #126 stated that it was the expectation of the home for the assigned RA to continue to be responsible for resident care in their assignment even if a 1:1 staff is in place. RN #126 further stated that as resident #020 had been exhibiting identified behavioural cues prior to being assisted with an identified care need on the identified date, he/she should have had two staff members to assist with the identified care need as per resident #020's plan of care. RN #126 acknowledged that the licensee had failed to ensure that the care set out in the plan of care was provided to resident #020 as specified in the plan.

b. On an identified date, the MOHLTC received a CIR related to an identified injury sustained by resident #009. Review of the CIR revealed that six days prior to the CIR submission, resident #009 received care by two staff members and sustained an identified injury to an identified area of his/ her body requiring transfer to hospital for treatment.

Review of resident #009's progress notes from an identified date, revealed an assessment note by his/her most responsible physician, which stated that resident #009 is at risk for impaired skin integrity, and the plan was to monitor, and continue very gentle care.

Review of the home's investigation notes revealed that the RA #141 did not note an identified care instruction which instructed staff to not disturb him/her on an identified shift. In an interview, RA #141 stated that he/she, with the assistance of another RA, provided care to resident #009 and upon repositioning him/her noted that resident #009 had sustained an identified injury.

Review of documentation from the treatment received in hospital revealed that resident #009 sustained an identified injury to an identified area of his/her body, and a more significant identified injury to the same area of his/ her body requiring an identified medical intervention.

In an interview with resident #009's family member, he/she stated that the family had requested the staff approximately a year ago, not to disturb resident #009 on an identified shift as resident #009 may exhibit identified behaviours leading to possible injury.

In an interview, RN #142 stated that the intervention to not disturb resident #009 on the identified shift been in effect for longer than three months. In an interview with RPN #138

and #146 they stated that the intervention had been in effect for approximately one year. RPN #146 stated that this information had been communicated verbally by other staff, and through care instruction posted in the resident's room.

In an interview, RCM #117 stated that care instruction posted in a resident's room are a part of the plan of care, and he/she further confirmed that that on an identified date, RA #141 did not provide care to resident #009 as per resident #009's plan of care.

c. A CIR was submitted to the MOHLTC on an identified date, related to care not being provided. The CIR further revealed that three days earlier, resident #002 had asked RA #113 to assist him/her with an identified care need. A family member who was present at the time stated that resident #002 believed there was a need for assistance.

Review of resident #002's written plan of care from an identified date, which was the same plan of care in place at the time of the incident, as well as the most recent written plan of care, revealed that resident #002 was to be assisted with the above mentioned identified care need in the morning and again routinely after lunch. The written plan of care further revealed that resident #002 should be assisted with the above mentioned identified care need at other times when needed.

In an interview, resident #002 stated there are times he/she has to wait a long time to be assisted with the above mentioned identified care need however he/she could not specify a specific date or time.

In an interview, RA #113 stated resident #002 had been assisted with the above mentioned identified care need and when a family member informed him/her resident #002 was requesting to be assisted with the above mentioned identified care need again, he/she was going on break. RA #113 further stated he/she informed the family member that RA #114 was on the home area and could assist resident #002's with the identified care need.

In an interview, RA #114 stated he/she was aware that resident #002 had requested to be assisted with the above mentioned identified care need but that his/her partner RA #113 was on break and had asked the resident to wait. RA #114 further stated he/she did not seek the assistance of the registered staff or an RA working on the adjacent home area resulting in resident #002 waiting for approximately 25 minutes to be assisted with the above mentioned identified care need.

In an interview, DRC #161 acknowledged care set out in the plan of care was not provided to resident #002 as specified in the plan.

The severity of this noncompliance was identified as actual harm, the scope was identified as isolated. A review of the home's compliance history revealed that written notifications and voluntary plan of corrections were issued January 9, 2017, under inspection report #2017_251512_0001, on December 20, 2016, under inspection report #2016_484646_0012, and on April 4, 2016, under inspection report #2016_327570_0008. Due to the severity of actual harm to resident #020 and #009 and ongoing noncompliance with s. 6. (7), a compliance order is warranted. [s. 6. (7)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity was assessed by a registered dietitian who was a member of the staff of the home.

On an identified date, the MOHLTC received a CIR related to an injury sustained by resident #009. Review of the CIR revealed that on an identified date six days earlier, resident #009 received care by two staff members and sustained injury to an identified area of his/her body requiring transfer to hospital, and an identified medical intervention.

Review of resident #009's progress notes revealed that resident #009 was hospitalized on an identified date, following injury, and returned to the home the following day.

Review of resident #009's correspondence from the emergency room visit revealed that resident #009 sustained injury to an identified area of his/her body and required an identified medical intervention.

Review of weekly skin assessments completed on two identified dates six days apart, noted that a dietitian referral was made. Review of resident #009's progress notes during the inspecton, failed to reveal an assessment by a registered dietitian (RD) related to his/her impaired skin integrity.

In interviews, RPN #146 and #138 stated that a referral to the RD is made if a resident obtains has an area of impaired skin integrity. RPN #146 further stated that he/she completed a weekly skin assessment on an identified date, and documented that a referral to the RD was made; however, was unable to find documentation that the RD assessment was completed.

In an interview, RD #145 stated that referrals were made through email, and did not receive a referral for resident #009 related to altered skin integrity. RD #145 further stated that he/she had not assessed resident #009 following the incident of altered skin integrity.

In an interview, RCM #117 acknowledged that an assessment by the RD should have been completed for resident #009 who exhibited altered skin integrity. [s. 50. (2) (b) (iii)]

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 with ensuring that, each resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that actions are taken to respond to the needs of the resident, including assessment, reassessments, interventions, and documentation of the resident's responses to the interventions.

Review of a CIR submitted to the MOHLTC on an identified date, revealed that on the previous day, RPN #137 observed resident #014 touching an identified area of resident #015's body. A previous incident was also reported in this CIR that occurred one week prior, when resident #014 was touching an identified area of resident #015's body while they sat in a common area which was witnessed by RA #172.

Review of resident #014's progress notes revealed this was not the first time resident #014 had demonstrated identified responsive behaviours toward co-residents. During a nine month period, spanning before and after the above mentioned incidents, resident #014 demonstrated the identified responsive behaviours towards five different co-residents.

Review of resident #014's progress notes revealed that resident #014 was assessed by an external resource on an identified date, and by another resource approximately two weeks later. Recommendations included three identified interventions. Interventions were implemented and appeared to be effective. Resident #014 was discharged from the two above mentioned resources after three months, due to him/her being more settled with no recent documented responsive behaviours.

Review of a progress notes revealed that resident #014 was reviewed in behaviour rounds due to exhibiting identified responsive behaviours towards a co-resident. Neither resident appeared distressed by the identified behaviour. Recommendations included to refer to specialized services. The inspector noted that this review did not take into consideration an additional date on which resident #014 exhibited an identified responsive behaviour towards a co-resident.

Interview with the Social Worker who wrote the above progress note revealed he/she was aware there was only one co-resident involved and confirmed he/she had not performed any cognitive assessments to determine capacity for consent for any residents within the home. Interview with the RN from the specialized service team revealed that resident #014 could have been reassessed and additional interventions could have been considered. Interview with specialized service RN #187 revealed resident #014 was not referred back to the team and stated that further interventions could have been put into place for resident #014.

During an interview, the Administrator acknowledged the home failed to take actions to respond to the needs of resident #014, including reassessment. [s. 53. (4) (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 with ensuring that, for each resident demonstrating responsive behaviours actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #7: 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 immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect that caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

Review of a CIR submitted to the MOHLTC on an identified date, revealed that two days prior, RPN #137 observed resident #014 touching an identified area of resident #015's body. A previous incident was also reported in this CIR that occurred one week prior, when resident #014 was touching an identified area of resident #015's body while they sat in a common area.

Review of resident #014's progress notes revealed this was not the first time resident #014 had demonstrated identified responsive behaviours toward co-residents. During a nine month period, spanning before and after the above mentioned incidents, resident #014 demonstrated the identified responsive behaviours towards five different co-residents. Review of progress notes revealed that resident #015's SDM was only contacted after the incidents on two identified dates as submitted in the CIR.

In interviews, RN #126, RPN #125, RPN #137, RPN #174 and RPN #176 stated they were not aware if any of the SDMs for residents involved in all incidents before and after the above mentioned dates noted in the CIR, had been contacted.

In an interview, the Administrator acknowledged that the SDMs for female residents #015, #018 and #029 related to incidents that occurred on seven occasions over a six month period, should have been contacted due to the possible distress caused by the incidents. The other incidents related to resident #015 were documented as not having caused the resident any distress so the Administrator did not confirm the SDM needed to be contacted. [s. 97. (1) (a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence.

Review of a CIR submitted to the MOHLTC on an identified date, revealed that on the previous day, RPN #137 observed resident #014 touching an identified area of resident #015's body. A previous incident was also reported in this CIR that occurred one week earlier, when resident #014was touching an identified area of resident #015's body while they sat in a common area.

Interview with the IRCM #152 who submitted the CIR stated he/she did not see the first incident as abuse but could not explain why he/she contacted the police for the first abov mentioned incident but not the second.

Review of resident #014's progress notes revealed this was not the first time resident #014 had demonstrated identified responsive behaviours toward co-residents. According to these progress notes there were eleven other incidents before and after these incidents when resident #014 demonstrated identified responsive behaviours towards co-residents.

Interview with the Administrator revealed he/she could not explain why the first identified incident was reported to the police and why other identified incidents involving resident #014 residents were not reported. [s. 98.]

Issued on this 12th day of July, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ADAM DICKEY (643), BABITHA SHANMUGANANDAPALA (673), JOANNE ZAHUR (589), SUSAN SEMEREDY (501)
Inspection No. / No de l'inspection :	2017_420643_0008
Log No. / Registre no:	014069-16, 014252-16, 017566-16, 021208-16, 021878-16, 022278-16, 022710-16, 024472-16, 028658-16, 004919-17, 007560-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 19, 2017
Licensee / Titulaire de permis :	PROVIDENCE HEALTHCARE 3276 St. Clair Avenue East, TORONTO, ON, M1L-1W1
LTC Home / Foyer de SLD :	PROVIDENCE HEALTHCARE 3276 ST. CLAIR AVENUE EAST, SCARBOROUGH, ON, M1L-1W1
	Pat Colucci

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

To PROVIDENCE HEALTHCARE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that residents are protected from abuse by anyone and are not neglected by the licensee or staff.

The plan will include, at a minimum, the following elements:

- The licensee shall review and revise its policy to provide appropriate and more comprehensive guidance to staff to ensure that capacity is assessed in residents with cognitive impairment, to support good decision-making in staff interventions and on-going monitoring, to support appropriate mandatory reporting under s. 24 (1) of the LTCHA, 2007, to ensure only consensual activity is occurring between residents, and to further ensure that residents are not vulnerable to abuse;
- Develop and implement a process to ensure that the capacity of residents with cognitive impairment who demonstrate identified responsive behaviours are being assessed; and to ensure that interventions put in place to manage identified responsive behaviours, such as 1:1 monitoring, are being consistently implemented; and
- Ensure that resident #006 receives the assistance from two staff members at all times as required for safety.

Please submit the plan to Adam.Dickey@ontario.ca no later than July 5, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that residents are free from neglect by the licensee of staff in the home.

A Critical Incident System Report (CIR) was submitted to the Ministry of Health

and Long-Term Care (MOHLTC) on an identified date related to a fall incident involving resident #006 which resulted in injury and transfer to the hospital. Review of the CIR revealed that RA #147 had attempted to assist resident #006 he/she began to exhibit identified behaviours towards RA #147. RA #147 stepped back from resident #006's bedside during which time resident #006 fell.

Review of resident #006's progress notes from an identified date, revealed that RA #139 had called for RPN #137 to respond to resident #006's room. The resident was found on the floor with an identified injury. Resident #006 was displaying signs of pain when an identified area of his/her body was touched by staff. MD on call ordered for resident #006 to be sent to acute care hospital for assessment.

Review of resident #006's written plan of care accessed on an identified date, revealed that he/she was at high risk for falls and he/she had a history of exhibiting identified responsive behaviours. Staff were instructed to provide two person assistance at all times with care.

In an interview, RA #147 stated that he/she had entered resident #006's room to get him/her ready to go to the dining room for an identified meal service. RA #147 further stated that he/she had asked RA #139 to come and assist with transferring resident #006 from bed. RA #147 stated that he/she began to reposition the bed and that resident #006 exhibited identified responsive behaviours toward RA #147. RA #147 further stated that he/she reacted by stepping back from the bedside at which point resident #006 fell. RA #147 acknowledged that resident #006's written plan of care stated he/she was in need of two person assistance for all care, and no other staff members were present in the room at the time.

In an interview, RA #139 stated that RA #147 had asked her to come to resident #006's room and was on his/her way there when the fall took place. RA#139 stated that he/she was not assisting RA #147 with care at the time of the fall. RA#139 acknowledged that he/she was aware that resident #006 required the assistance from two staff members for all care.

In an interview, interim Resident Care Manager (IRCM) #152 stated that resident #006's written plan of care instructed staff to provide care with two people at all times because of his/her responsive behaviours. IRCM #152 further stated that RA #147 was providing care to the resident alone and should have

been completed with two people for safety. He/she acknowledged that the licensee had failed to ensure that resident #006 was free from neglect as assistance by two staff members which was required for safety had not been provided as outlined in resident #006's written plan of care. [s. 19. (1)]

2. The licensee has failed to protect three or more residents from abuse.

Review of a CIR submitted to the MOHLTC on an identified date, revealed that two days prior, RPN #137 observed resident #014 touching an identified area of resident #015's body. A previous incident was also reported in this CIR that occurred one week prior, when resident #014 was touching an identified area of resident #015's body while they sat in a common area which was witnessed by RA #172.

Review of resident #014's progress notes revealed this was not the first time resident #014 had demonstrated identified responsive behaviours toward co-residents. During a nine month period, spanning before and after the above mentioned incidents, resident #014 demonstrated the identified responsive behaviours towards five different co-residents.

In most of the incidents it was noted that resident #014 was successfully redirected from these behaviours without incident. Resident #014 was discharged from the home on an identified date, to another Long-Term Care Home.

Review of resident #014's progress notes revealed that resident #014 was assessed by an external resource on an identified date, and by another resource approximately two weeks later. Recommendations included three identified interventions. Interventions were implemented and appeared to be effective. Resident #014 was discharged from the two above mentioned resources after three months, due to him/her being more settled with no recent documented responsive behaviours.

Review of resident #014's progress notes revealed the first documented incident after being discharged from the above resources occurred approximately 6 weeks later. This incident was reported to the MOHLTC six days later. The progress note indicated staff noted resident #014 inappropriately touching resident #015's body while they sat in a common area. According to the progress notes a meeting was held with staff in regards to the interaction

observed between resident #014 and #015. Interventions were discussed to encourage staff to observe for escalating identified responsive behaviours.

In an interview, RA #172 stated that on the above mentioned date, he/she observed resident #014 touching an identified area of resident #015's body. RA #172 stated he/she thought this incident was abusive because resident #015 was not able to provide consent to the activity.

In an interview, RN #134 who was an IRCM during this period, revealed that he/she did not view the incident as abuse because resident #015 did not seem distressed and resident #014 and #015 enjoyed each other's company. RN #134 could not explain to the inspector why he/she called the police regarding this incident but did not report it to the MOHLTC.

Review of resident #014's progress notes revealed the second incident after being discharged from the above resources occurred on an identified date in the month following discharge from the above mentioned resources. This was reported to the MOHLTC the day after the incident occurred. According to the note, resident #014 sat beside resident #015 in a common area, and was observed touching an identified area of resident #015's body. According to the CIR and the progress note, resident #014 continued to attempt to enter resident #015's room that evening and was difficult to redirect.

In an interview, RPN #137 stated that he/she wrote the above noted progress note and did not think it was abuse at the time but now considers it would be abuse because resident #014 did not ask permission and resident #015 did not give consent.

The inspector conducted record reviews and interviews regarding the three identified co-residents which revealed the following:

Record review revealed resident #015 was admitted to the home on an identified date. According to a Minimum Data Set (MDS) assessment, resident #015 was assessed to have impaired cognition. According to progress notes in resident #014's record, resident #014 demonstrated responsive behaviours toward resident #015 on seven identified dates over a ten month period. According to progress notes in resident #015's record, resident #015's SDM was only notified of the incidents that occurred on two of the above mentioned identified dates. Interviews with RN #126, RPN #137, #125, #174 and #176 revealed they did not

think resident #015 was capable of providing consent to engage in the identified activity.

Record review revealed resident #028 was admitted to the home on an identified date. According to an MDS assessment resident #028 was assessed to have impaired cognition. According to progress notes in resident #014's record, resident #014 demonstrated identified responsive behaviours toward resident #028 on two consecutive identified dates. Review of resident #028's progress notes failed to reveal record of the two above mentioned incidents. An interview with RN #126 indicated that resident #028's SDM was not contacted and did not know why the MOHLTC was not notified. In interviews, RN #126, RPN #125 and RPN #176 stated they did not think resident #028 was capable of providing consent to engage in the identified activity.

Record review revealed resident #029 was admitted to the home on an identified date. According to an MDS assessment resident #029 was assessed to have impaired cognition. According to progress notes in resident #014's record, resident #014 demonstrated identified responsive behaviours toward resident #029 an identified date; however there was no progress note related to this incident in resident #029's record. In an interview RPN #137 stated he/she did not report this incident because this was an ongoing problem with resident #014. RPN #137 admitted he/she did not contact resident #029's SDM regarding the incident on the above mentioned identified date. In interviews, RN#126, RPN #125, RPN #137, RPN #174 and RPN #176 stated they did not think resident #029 was capable of providing consent to engage in the identified activity.

Interviews failed to reveal the identity of residents that resident #014 inappropriately touched on two identified dates.

In interviews, the Social Worker (SW) and administrator stated that the home had not determined the capacity for any residents to provide consent to engage in the identified activity. During an interview with the Assistant Medical Director, he/she stated that residents engaging in identified activities have to have an understanding of what the activity is in order to be able to consent to it.

During an interview the Administrator acknowledged the home failed to protect resident #015, #028 and #029 and possibly two other residents from abuse. [s. 19. (1)]

3. The following evidence related to resident #007 was found under inspection report 2017_626501_0013.

The licensee has failed to protect resident #007 from abuse.

Two CIRs were submitted to the MOHLTC on an identified date, related to resident abuse. According the CIRs, resident #008 was observed during a program demonstrating an identified responsive behaviour toward resident #007 six days earlier. The CIRs state that staff #110 witnessed resident #008 whispering into resident #007's ear and touching an identified area of resident #007's body. Staff #110 removed resident #008 away from resident #007 who was sleepy and unaware of the incident.

Record review revealed resident #008 was admitted to the home on an identified date. Review of resident #008's progress notes revealed he/she demonstrated an identified responsive behaviour towards an unidentified co-resident on an identified date. Two weeks later, when the Substitute Decision Maker (SDM) was informed of the incident, it was revealed that resident #008 had a history identified responsive behavours toward co-residents in a previous facility. Identified responsive behaviours towards staff and co-residents were discussed in behaviour rounds and documented in the progress notes on three identified dates over a three month period. No other identified responsive behaviours toward co-residents were noted. Resident #008's was assessed to have impaired cognition.

Record review revealed resident #007 was admitted to the home on an identified date . Resident #007 was assessed to have impaired cognition. Resident #007 was no longer a resident of the home at the time of inspection.

During an interview with staff #110, he/she stated that during the program on the above mentioned identified date, resident #008 and #007 were sitting next to each other when resident #008 touched an identified area of resident #007's body. Staff #110 was able to remove resident #008 from the area. Staff #110 also observed resident #008 whispering in resident #007's ear but did not hear what was being said. Staff #110 stated he reported this to Activation Assistant #109 and it was decided that staff #110 would document the incident in both residents' progress notes. Staff #110 expressed that he/she did not believe resident #007 had the capacity to provide consent to engage in the identified activity.

In an interview, Activation Assistant (AA) #109 revealed he/she was told about the incident by staff #110 and both had agreed that staff #110 would document the incident in both residents' progress notes. AA #109 indicated he/she was aware resident #008 had a history concerning interactions with co-residents and considered the actions of resident #008 to be abusive as the co-residents did not provide consent to the identified activity.

In interviews, both staff #110 and AA #109 stated that they did not report the incident to any manager of the home or the MOHLTC.

In an interview, the Administrator acknowledged that in the above mentioned incident resident #008 demonstrated an identified responsive behaviour toward resident #007and resident #007 did not have the capacity to provide consent to the identified activity, and therefore was not protected from abuse. [s. 19. (1)]

4. The following evidence related to residents #010 and #011 was found under inspection report 2017_630589_0008.

The licensee has failed to ensure residents are protected from abuse by anyone.

The MOHLTC received a complaint, related to incidents of witnessed abuse towards resident's #010 and #011 that occurred over an identified three week period. The complaint further revealed that these incidents of abuse had been witnessed by a volunteer (V). The V reported these incidents of abuse to the home in an email. The MOHLTC had also received a CIR an identified date, related to incidents of witnessed abuse involving RA #133 towards resident's #010 and #011.

Review of the email letter from volunteer (V) #136 revealed he/she was volunteering on two identified units over an identified three week period. The email revealed he/she witnessed incidents of abuse towards resident's #010 and #011 from RA #133. V #136 reported that RA #133 was providing poor care, lacking compassion to residents #010 and #011. V #136 further reported the following incidents of RA #133 abruptly waking up residents #010 and #011:
-applying identified physical forces to identified areas of the body,
-roughly nudging them, yelling at them to wake them up, and
-abruptly applying an identified device with force while the resident was still asleep. On one occasion, the identified device was applied with physical force to

an identified area of the resident's body.

In an interview, V #136 started these incidents of abuse were mostly directed at resident #010. V #136 further stated he/she would normally assist resident #011 with eating and had resident #010 and RA #133 within his/her line of vision where he/she was able to witness RA #133's interactions with resident #010. V #136 stated that resident #010 had difficulty seeing what RA #133 was doing and that resident #011's was able to see RA #133's actions.

In an interview, resident #010 stated that a staff member would apply an identified physical force to wake him/her up. Resident #010 stated this happened daily and that he/she had told the RA he/she would call the police but resident #010 stated he/she never did call the police. Resident #010 could not recall RA #133 applying any other type of physical force or roughly applying the device. Resident #133 further stated these actions were not nice, he/she didn't like how it felt, and that the actions had not caused any identified injury. Resident #010 further stated this person didn't look after him/her anymore and he/she didn't want this person to look after him/her anymore as was not nice towards him/her.

Review of RA #133's personnel file revealed he/she had received discipline regarding the allegations of abuse of resident #010. RA #133 had denied any abuse occurred against residents #010 and #011.

In an interview, RA #133 stated he/she had not been aware that his/her actions were inappropriate and constituted abuse. RA #133 further stated that he/she was in a hurry and tossed an item at resident #011, not realizing that this action was unacceptable. RA #133 acknowledged that after the home's investigation and being disciplined he/she realized that the above mentioned incidents constituted abuse.

In an interview, DRC #161 acknowledged that resident's #010 and #011 had not been protected from abuse. [s. 19. (1)]

5. The licensee has failed to ensure that residents are protected from abuse by anyone.

On an identified date, the MOHLTC received a CIR related to resident to

resident abuse. Review of the CIR revealed that on an identified date at an identified time, resident #017 was noted by staff to have an identified injury to an identified area, and resident #016 had identified injury. The CIR further revealed that resident #016 stated that resident #017 came into his/her room and when he/she told resident #017 to get out, resident #017 hit him/her.

Review of resident #017's MDS assessment from an identified date, revealed that resident #017 had impaired cognition with identified responsive behaviours that were not easily altered.

Review of resident #017's identified specialized resource progress note from an identified date, revealed that as per the resident's family member, there was a recent escalation in the resident #017's behaviours with an incident of an identified responsive behaviour toward a co-resident. A progress note from an identified date, by the specialized resource team revealed that resident #017 had been prescribed an identified medication, and continued to demonstrate identified responsive behaviours.

Review of resident #017's plan of care from an identified date, revealed that staff were instructed to supervise him/her when ambulating in specified areas. It further stated that the resident's identified responsive behaviour was triggered by identified social issues. Interventions were identified and included in resident #017's to deal with the above mentioned responsive behaviour.

Review of resident #016's MDS assessment from an identified date, revealed that he/she had identified diagnoses, demonstrated identified responsive behaviours with a deterioration in his/her behavioural symptoms. The Resident Assessment Protocol (RAP) note related to this behaviour stated that resident #016's care plan and interventions were completed to ensure the health and safety of resident #016 and other residents.

Review of resident #016's written plan of care revealed that he/she had identified responsive behaviours. One of the interventions for this focus included being cognizant of invading resident #016's personal space.

Review of resident #016's progress notes revealed that on an identified date, resident #016 made a gesture toward resident #017, and resident #017 was moved. Record review of resident #016's and resident #017's progress notes indicated that resident #017 entered resident #016's room, upsetting resident

#016 and causing him/her to yell at resident #017.

Progress notes from an identified date, stated that resident #017 entered resident #016's room and an unwitnessed altercation occurred. Residents #017 and #016 sustained injuries. Both residents were sent to hospital, and resident #016's discharge report stated he/she sustained an injury.

In an interview, resident #016 stated that he had had a few altercations with resident #017 prior to the above mentioned incident, as resident #017 kept entering his/her room. Resident #016 further stated that resident #017 hit him/her first, causing pain.

In an interview, RA #194 stated that resident #017 tended to enter resident #016's room, and required redirection. RA #194 further stated that he/she did not know that the residents had a potential to be demonstrate identified responsive behaviours toward each other, but knew that resident #017 had other identified behavioural issues. RA #194 stated that on the date of the above mentioned incident he/she had been aware that resident #017 was moving about the unit but was not supervising resident #017 as he/she was assisting another resident. RA #194 stated that he/she witnessed resident #017 exiting resident #016's room with marks from the altercation.

In an interview, RPN #192 stated that resident #016 demonstrated identified responsive behaviours toward residents and staff. RPN #192 further stated that if there is previous history of altercations between two residents, some interventions that the home uses are to separate them, offer distractions and activities, change floors or have 1:1 monitoring. RPN #192 stated that not enough steps were taken to minimize the risk of an altercation between resident #016 and #017.

In an interview, RPN #193 stated that resident #017 had a history of going into resident #016's room and this would upset resident #016 and that although there was a device to prevent entry on resident #016's door, the intervention was not effective as resident #017's room was nearby, and he/she would disregard it. RPN #193 stated that other interventions could have been considered. RPN #193 stated that as these steps were not taken, resident #017 and resident #016 were not protected from abuse.

In an interview, RCM #152 stated that resident #016 demonstrated identified

responsive behaviours. RCM #152 also stated that resident #017's behaviour was triggered by identified social issues. RCM #152 stated that although resident #017 was being followed by specialized resources, resident #017 could benefited from other interventions.

In an interview, DRC #161, confirmed that not enough steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #016 and resident #017. DOC #161 confirmed that resident #017 and resident #016 were not protected from abuse. [s. 19. (1)]

Multiple incidents of abuse or neglect of residents were identified. The severity of this noncompliance was identified as actual harm, the scope was identified as isolated. A review of the home's compliance history revealed that written notifications and voluntary plan of corrections were issued July 24, 2014, under inspection report #2014_235507_0014 and on December 20, 2016, under inspection report #2016_484646_0012. Due to the severity of actual harm and ongoing noncompliance with s. 19. (1), a compliance order is warranted. (643)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 19, 2017

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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 shall prepare, submit and implement a plan to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone shall immediately report the suspicion and the information it is based on to the Director.

The plan will include, at a minimum, the following elements:

Ensure all staff complete a mandatory, comprehensive and interactive education session offered in various formats to meet the learning needs of adult learners specific to Zero Tolerance of Abuse. The education should include, but not be limited to:

- Definitions of abuse as defined by Ontario Regulation 79/10, section 2, with a heightened emphasis of the definition of abuse;
- The meaning of "consent" and how it is determined for residents who are cognitively impaired and where cognition fluctuates depending on the situation;
- An explanation of 'duty to report' as it relates to LTCHA, 2007, s. 24 and the requirements relating to making mandatory reports with the use of the MOHLTC Abuse Decision Tree Algorithms (as a guide);
- Persons who are to be notified in incidences of alleged, suspected or witnessed incidents of abuse; and
- A review of the home's specific policies relating to Resident Abuse and any other home related policy specific to Resident Abuse , Resident Bill of Rights, and Mandatory Reporting.

Please submit the plan to Adam.Dickey@ontario.ca no later than July 5, 2017.

Grounds / Motifs :

1. 1. The following evidence related to residents #010 and #011 was found under inspection report 2017_630589_0008.

The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm has occurred, immediately report the suspicion and the information upon which it was based to the Director.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint on an identified date, related to incidents of witnessed abuse towards resident's #010 and #011 that occurred over an identified three week period.

Review of Providence Healthcare's policy titled: Zero Tolerance for Abuse and Neglect, revised March 2017, revealed on page three, under reporting an incident, that all staff, volunteers, contractors and affiliated personnel are to fulfill their legal obligation to immediately report any witnessed incident or alleged incident of abuse or neglect to the MOHLTC.

In an interview, V #136 stated that over an identified three week period, he/she had observed incidents of abuse towards two resident's by RA #133. V #136 further stated he/she sent an email letter on an identified date, to RCM #134 reporting these incidents of abuse.

Review of a CIR submitted to the MOHLTC revealed that the licensee became aware of the witnessed abuse incidents three days after the email had been sent, and the CIR was subsequently submitted one day later. The CIR further revealed under action taken, that the MOHLTC after hours pager had not been called.

In an interview RCM #134 stated he/she had received the email letter sent by V #136 three days after it had been sent, reporting staff to resident abuse which he/she then endorsed to DRC #161. RCM #134 further stated since the allegations of abuse were significant he/she had wanted to verify with V #136 that he/she would stand by them before notifying the MOHLTC.

In an interview, DRC #161 stated she became aware of the above mentioned incidents of abuse the day after RCM #134 received V #136's email, as he/she was not in the home that day. DRC #161 further stated at the time he/she had been informed of the witnessed abuse, RCM #134 had already submitted the CIR.

In an interview, RCM #134 acknowledged he/she had not called the MOHLTC after-hours pager and therefore had not reported the above mentioned witnessed abuse immediately to the MOHLTC. [s. 24. (1)] (589)

2.The following evidence related to residents #024 and #025 was found under inspection report 2017_630589_0008.

Review of the home's investigation notes related to the above mentioned incidents of abuse revealed that during interviews, RA's #149 and #154 revealed

additional incidents of alleged abuse involving RA #133 towards resident's #024 and #025.

In an interview, RA #149 stated resident #024 had reported to him/her that about two years ago RA #133 had thrown an identified object at him/her and was rough when providing care. RA #149 further stated resident #025 would respond in an affectionate manner to RA #149, but when RA #133 would be close by, resident #025 would display identified signs of fear. RA #149 stated he/she had not reported this but picked up resident #025's care needs because he/she felt bad for him/her.

Resident #025 was not available for interview as was not a resident of the home at the time of inspection. In an interview, resident #024 denied the above allegations of abuse.

In an interview, Administrator #129 acknowledged these additional incidents of abuse had been viewed as hearsay and therefore had not been reported to the MOHLTC.

3. Review of a CIR submitted to the MOHLTC on an identified date, revealed that on the previous day, RPN #137 observed resident #014 touching an identified area of resident #015's body. A previous incident was also reported in this CIR that occurred one week prior to the submission of the CIR, when resident #014 was touching an identified area of resident #015's body while they sat in a common area which was witnessed by RA #172. According to the CIR police were contacted regarding the first above mentioned incident.

In an interview, IRCM #152 who submitted the CIR stated he/she did not see the first incident as abuse and could not explain why he/she contacted the police. IRCM #152 could not explain why he/she reported the second incident to the MOHLTC. Interview with the Administrator confirmed that the home should have contacted the MOHLTC immediately after the initial incident, and not six days later with a subsequent incident.

Review of resident #014's progress notes revealed this was not the first time resident #014 had demonstrated identified responsive behaviours toward co-residents. According to these progress notes there were eleven other documented incidents and a review of the CIRs submitted by the home failed to

reveal any of these incidents were reported to the MOHLTC. Interviews with RPN #137, RPN #125, RPN #174 and RPN #176 revealed the reason they did not report to managers each of the incidents was because they thought management was aware of resident #014's ongoing identified responsive behaviours.

In an interview, the Administrator confirmed management was aware of resident #014's ongoing identified responsive behaviours as early as six months prior to submitting the CIR. The Administrator acknowledged the home had reasonable grounds to suspect resident #014 was abusing co-residents and should have immediately reported the suspicion and the information upon which it is based to the Director.

The severity of this noncompliance was identified as potential for actual harm, the scope was identified as a pattern. A review of the home's compliance history revealed that a written notification and voluntary plan of correction was issued April 5, 2016, under inspection report #2016_461552_0011, and a written notification was issued on July 24, 2014, under inspection report #2014_235507_0014. Due to ongoing noncompliance with s. 24. (1), a compliance order is warranted. [s. 24. (1)] (501)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 19, 2017

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

Upon receipt of this Compliance Order the licensee shall:

Identify and implement interventions to minimize the risk of altercations and potentially harmful interactions between residents #017 and #016 and all other residents who have been identified as having the risk of altercations and potentially harmful interactions.

Grounds / Motifs :

1. The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

On an identified date, the MOHLTC received a CIR related to resident to resident abuse. Review of the CIR revealed that on an identified date at an identified time, resident #017 was noted by staff to have an injury to an identified area, and resident #016 had an identified injury. The CIR further revealed that resident #016 stated that resident #017 came into his/her room and when he/she told resident #017 to get out, resident #017 hit him/her.

Review of resident #017's MDS assessment from an identified date, revealed that resident #017 had impaired cognition with identified responsive behaviours that were not easily altered.

Review of resident #017's specialized service progress note from an identified date, revealed that as per the resident's family member, there was a recent escalation in the resident #017's behaviours with an incident of an identified responsive behaviour toward a co-resident. A progress note from an identified date, by the specialized service team revealed that resident #017 had been prescribed an identified medication, and continued to demonstrate identified responsive behaviours.

Review of resident #017's plan of care from an identified date, revealed that staff were instructed to supervise him/her when ambulating in specified areas. It further stated that the resident's identified responsive behaviour was triggered by identified social issues. Interventions were identified and included in resident #017's to deal with the above mentioned responsive behaviour.

Review of resident #016's MDS assessment from an identified date, revealed that he/she had identified diagnoses, demonstrated identified responsive behaviours with a deterioration in his/her behavioural symptoms. The Resident Assessment Protocol (RAP) note related to this behaviour stated that resident #016's care plan and interventions were completed to ensure the health and safety of resident #016 and other residents.

Review of resident #016's written plan of care revealed that he/she had identified responsive behaviours. One of the interventions for this focus included being cognizant of invading resident #016's personal space.

Review of resident #016's progress notes revealed that on an identified date, resident #016 made a gesture toward resident #017, and resident #017 was moved. Record review of resident #016's and resident #017's progress notes indicated that resident #017 entered resident #016's room, upsetting resident #016 and causing him/her to yell at resident #017.

Progress notes from an identified date, stated that resident #017 entered resident #016's room and an unwitnessed altercation occurred. Residents #017 and #016 sustained injuries. Both residents were sent to hospital, and resident #016's discharge report stated he/she sustained an injury.

In an interview, resident #016 stated that he had had a few altercations with resident #017 prior to the above mentioned incident, as resident #017 kept

entering his/her room. Resident #016 further stated that resident #017 hit him/her first, causing pain.

In an interview, RA #191 stated that resident #016 had the potential to be verbally and physically aggressive, and resident #017 had to be supervised to know where he/she is at all times as he/she wanders. RA #191 further stated that resident #017 and #016 would get into each other's space and required redirection.

In an interview, RA #190 stated that an intervention used by the home if someone is exhibiting identified responsive behaviours is to have 1:1 supervision.

In an interview, RA #194 stated that resident #017 tended to enter resident #016's room, and required redirection. RA #194 further stated that he/she did not know that the residents had a potential to be demonstrate identified responsive behaviours toward each other, but knew that resident #017 had other identified behavioural issues. RA #194 stated that on the date of the above mentioned incident he/she had been aware that resident #017 was moving about the unit but was not supervising resident #017 as he/she was assisting another resident. RA #194 stated that he/she witnessed resident #017 exiting resident #016's room with marks from the altercation.

In an interview, RPN #192 stated that resident #016 demonstrated identified responsive behaviours toward residents and staff. RPN #192 further stated that if there is previous history of altercations between two residents, some interventions that the home uses are to separate them, offer distractions and activities, change floors or have 1:1 monitoring. RPN #192 stated that not enough steps were taken to minimize the risk of an altercation between resident #016 and #017.

In an interview, RPN #193 stated that resident #017 had a history of going into resident #016's room and this would upset resident #016 and that although there was a device to prevent entry on resident #016's door, the intervention was not effective as resident #017's room was nearby, and he/she would disregard it. RPN #193 stated that other interventions to consider could have been to move resident #017 or provide 1:1 supervision.

In an interview, RCM #152 stated that resident #016 demonstrated identified

responsive behaviours. RCM #152 also stated that resident #017's behaviour was triggered by identified social issues. RCM #152 stated that although resident #017 was being followed by the specialized resources, resident #017 could have been moved to a different unit, provided with 1:1 supervision, or offered activities to engage with in the evenings.

In an interview, DRC #161, confirmed that not enough steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #016 and resident #017, as resident #017 could have been moved to a different unit sooner, or provided with increased monitoring and activities in the evenings.

The severity of this noncompliance was identified as actual harm, the scope was identified as isolated. Review of the home's compliance history revealed there was no previous compliance history related to r. 54. (b). Due to the severity of actual harm to residents #016 and #017, a compliance order is warranted. [s. 54. (b)] (673)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 06, 2017

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the care set out in the plan of care is provided to residents #020, #009 and #002 as specified in the plan.

The plan will include, at minimum, the following elements:

- A monitoring process to ensure that resident #020 and other residents whose plan of care requires the assistance of two staff members for toileting receive the appropriate assistance as specified in the plan;
- Ensure that resident #009 is not disturbed at specified times as specified in the plan; and
- Ensure that resident #002 is toileted at the times set out in the plan of care and at other times as needed as specified in the plan.

Please submit the plan to Adam.Dickey@ontario.ca no later than July 5, 2017.

Grounds / Motifs :

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

a. The following evidence related to resident #020 was found under inspection report 2017_420643_0010.

Review of a complaint and CIR submitted to the MOHLTC revealed that resident #020 had a fall incident on an identified date, while being assisted by a staff member. This incident resulted in resident #020 sustaining identified injuries requiring transfer to hospital.

Review of resident #020's health records revealed that he/she had identified diagnoses and had a history of falls since admission to the home. Resident #020 was identified as being at high risk for falls. Additionally, resident #020 exhibited identified responsive behaviours which may have affected his/her falls risk.

Review of resident #020's written plan of care from an identified date, revealed that staff were instructed to provide one person physical assistance for transferring, and two person physical assistance for transferring when exhibiting identified behaviours. Staff were instructed to provide two person assistance for dressing when resident #020 exhibited identified behavioural cues.

Review of resident #020's progress notes from the date of the above mentioned fall incident, revealed that he/she had been assessed post fall by RPN #132 and RN #126. According to the progress notes resident #020 fell onto the floor, striking an identified area of his/her body when the RA was assisting with an article of clothing. It was determined that resident #020 should be transferred to hospital for further assessment of his/her injuries.

In an interview, RA #167 stated that resident #020 had been exhibiting identified behavioural cues during an identified hour period and had documented this in the dementia observation system (DOS) monitoring record for that day. RA #167 also stated that he/she knew that resident #020 might exhibit the above mentioned identified behavioural cues as if he/she required an identified care need.

Review of DOS monitoring form for the identified week of the incident, revealed that resident #020 had been documented as exhibiting identified behavioural cues at three consecutive half-hour intervals leading up to the incident.

In an interview, RN #126 stated that it was the expectation of the home for the assigned RA to continue to be responsible for resident care in their assignment even if a 1:1 staff is in place. RN #126 further stated that as resident #020 had been exhibiting identified behavioural cues prior to being assisted with an identified care need on the identified date, he/she should have had two staff members to assist with the identified care need as per resident #020's plan of care. RN #126 acknowledged that the licensee had failed to ensure that the care set out in the plan of care was provided to resident #020 as specified in the plan.

b. On an identified date, the MOHLTC received a CIR related to an identified injury sustained by resident #009. Review of the CIR revealed that six days prior to the CIR submission, resident #009 received care by two staff members and sustained an identified injury to an identified area of his/ her body requiring transfer to hospital for treatment.

Review of resident #009's progress notes from an identified date, revealed an assessment note by his/her most responsible physician, which stated that resident #009 is at risk for impaired skin integrity, and the plan was to monitor, and continue very gentle care.

Review of the home's investigation notes revealed that the RA #141 did not note an identified care instruction which instructed staff to not disturb him/her on an identified shift. In an interview, RA #141 stated that he/she, with the assistance of another RA, provided care to resident #009 and upon repositioning him/her noted that resident #009 had sustained an identified injury.

Review of documentation from the treatment received in hospital revealed that resident #009 sustained an identified injury to an identified area of his/her body, and a more significant identified injury to the same area of his/ her body requiring an identified medical intervention.

In an interview with resident #009's family member, he/she stated that the family had requested the staff approximately a year ago, not to disturb resident #009 on an identified shift as resident #009 may exhibit identified behaviours leading to possible injury.

In an interview, RN #142 stated that the intervention to not disturb resident #009 on the identified shift been in effect for longer than three months. In an interview with RPN #138 and #146 they stated that the intervention had been in effect for approximately one year. RPN #146 stated that this information had been communicated verbally by other staff, and through care instruction posted in the resident's room.

In an interview, RCM #117 stated that care instruction posted in a resident's room are a part of the plan of care, and he/she further confirmed that that on an identified date, RA #141 did not provide care to resident #009 as per resident #009's plan of care.

c. A CIR was submitted to the MOHLTC on an identified date, related to care not being provided. The CIR further revealed that three days earlier, resident #002 had asked RA #113 to assist him/her with an identified care need. A family member who was present at the time stated that resident #002 believed there was a need for assistance.

Review of resident #002's written plan of care from an identified date, which was the same plan of care in place at the time of the incident, as well as the most recent written plan of care, revealed that resident #002 was to be assisted with the above mentioned identified care need in the morning and again routinely after lunch. The written plan of care further revealed that resident #002 should be assisted with the above mentioned identified care need at other times when needed.

In an interview, resident #002 stated there are times he/she has to wait a long time to be assisted with the above mentioned identified care need however he/she could not specify a specific date or time.

In an interview, RA #113 stated resident #002 had been assisted with the above mentioned identified care need and when a family member informed him/her resident #002 was requesting to be assisted with the above mentioned identified care need again, he/she was going on break. RA #113 further stated he/she informed the family member that RA #114 was on the home area and could assist resident #002's with the identified care need.

In an interview, RA #114 stated he/she was aware that resident #002 had requested to be assisted with the above mentioned identified care need but that his/her partner RA #113 was on break and had asked the resident to wait. RA #114 further stated he/she did not seek the assistance of the registered staff or an RA working on the adjacent home area resulting in resident #002 waiting for approximately 25 minutes to be assisted with the above mentioned identified care need.

In an interview, DRC #161 acknowledged care set out in the plan of care was not provided to resident #002 as specified in the plan.

The severity of this noncompliance was identified as actual harm, the scope was identified as isolated. A review of the home's compliance history revealed that

written notifications and voluntary plan of corrections were issued January 9, 2017, under inspection report #2017_251512_0001, on December 20, 2016, under inspection report #2016_484646_0012, and on April 4, 2016, under inspection report #2016_327570_0008. Due to the severity of actual harm to resident #020 and #009 and ongoing noncompliance with s. 6. (7), a compliance order is warranted. [s. 6. (7)] (589)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 06, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 19th day of June, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Adam Dickey

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