Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection 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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 7, 2017	2017_420643_0001	035323-16	Resident Quality Inspection

Licensee/Titulaire de permis

City of Toronto
55 JOHN STREET METRO HALL, 11th FLOOR TORONTO ON M5V 3C6

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

SEVEN OAKS
9 NEILSON ROAD SCARBOROUGH ON M1E 5E1

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

ADAM DICKEY (643), JOANNE ZAHUR (589), STELLA NG (507)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 3, 4, 5, 6, 9, 10, 11, 12, 13, 16, 17 and 18, 2017.

The following critical incident reports were inspected concurrently with the Resident Quality Inspection (RQI): #028158-16 related to falls prevention, #014678-16, #030623-16 and #032416-16 related to resident to resident abuse.

The following compliance order follow-up was inspected concurrently with the RQI: #021569-16 related to prevention of resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Assistant Administrator, Director of Nursing (DON), Nurse Practitioner (NP), Nurse Managers (NM), Building Services Manager, Manager of Resident Services (MRS), Nutrition Manager, Social Worker, Registered Nurses (RN), Registered Practical Nurses (RPN), Practical Care Assistants (PCA), Recreation Services Assistants (RSA), Laundry Aides (LA), residents, family members, Substitute Decision Makers (SDM), Residents' Council and Family Council Representatives.

During the course of the inspection, the inspector(s) conducted a tour of the home, observations of meal service, medication administration system, staff and resident interactions and the provision of care, record review of health records, staff training records, meeting minutes for Residents' Council and Family Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

8 WN(s)
3 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 protected from abuse by anyone.

Two critical incident reports (CIR) were submitted to the Ministry of Health and Long Term (MOHLTC) related to two incidents of resident to resident abuse in an one month period.

Record review of resident #013's health record revealed he/she had been admitted to the home with a history of identified responsive behaviours prior to admission. Review of the written plan of care and progress notes revealed that he/she began to exhibit responsive behaviours toward co-residents on an identified date, after admission. Further record review revealed that resident #013 was referred to the home's behavioural support ontario (BSO) team on an identified date. Review of resident #013's progress notes revealed that there was an identified safety measure in place and had one to one (1:1) close monitoring in place related to exhibiting an identified responsive behaviour.

Record review of a compliance order with a compliance date of July 2016, revealed that resident #013 had a history of exhibiting responsive behaviours toward co-residents. The order had directed the licensee to take immediate or appropriate actions to ensure that effective measures are in place to protect all residents from abuse by resident #013 as identified in this report.

1.Review of a CIR submitted to the MOHLTC revealed that #013 was observed to be standing in front of resident #014 touching him/her inappropriately by personal care assistant (PCA) #158.

Record review of resident #014's health record revealed he/she has a history of responsive behaviours. On three identified dates, observations conducted by the inspector revealed resident #014 was wandering the hallway independently, and was not observed to demonstrate the identified responsive behaviour.

In an interview, PCA #149 stated he/she it was the beginning of his/her day shift and was in an identified room when he/she heard PCA #158 shouting. PCA #149 exited the identified room and observed resident #013 demonstrating an identified responsive behaviour toward resident #014. PCA #149 further stated that the residents were separated and redirected to their rooms. PCA #149 stated he/she had not heard resident #013's responsive behaviour intervention while in the identified room which would have alerted him/her that resident #013 had exited his/her room.

In an interview, registered practical nurse (RPN) #150 stated he/she had been on the opposite side of the unit assisting PCA #143 and was not aware of the incident until it

was reported to him/her by the PCA's #149 and #158. RPN #150 further stated there had not been one to one (1:1) close monitoring in place for that shift and that he/she had not heard the identified intervention. RPN #150 also stated that resident #013 was able to turn off the identified intervention independently. RPN #150 further stated that the RN in charge (RN I/C) was not able to assist with monitoring the floor while he/she and the PCA were providing care due to registered staff absence on an identified resident home area and was required to do floor duties.

In an interview, registered nurse (RN) #156 who was also the RN I/C the identified shift stated that he/she had been notified of an incident involving residents #013 and #014 by RPN #150. Upon arriving on the unit RPN #156 observed residents #013 and #014 in their rooms. RN #156 further stated that the job routine directs the RN I/C to return to the identified floor at an identified time for floor work consisting of administering medications and treatments and monitoring of residents until the oncoming shift arrives. RN #156 stated on that identified shift he/she had to cover floor duties on another floor due to a registered staff absence and was unable to go the identified floor at the identified time.

Record review of the job routine titled: RNIC shift work routine responsibilities of the lead RN confirmed the above mentioned job responsibilities of the RNIC.

2.Review of a CIR submitted to the MOHLTC revealed that resident #013 and resident #015 were located in an identified area demonstrating identified responsive behaviours by PCA #143.

Record review of resident #015's health record revealed he/she has a history of responsive behaviours.

Record review of the licensee's staffing schedule revealed that PCA #153 had been scheduled to provide 1:1 monitoring of resident #013 on an identified date on an identified shift.

In an interview, PCA #153 stated that the above mentioned date had been the first time he/she had done 1:1 monitoring for resident #013. PCA #153 stated that a nurse had provided instruction and direction related to 1:1 responsibilities but he/she could not remember the name of the nurse that had provided this direction at the time of this interview. PCA #153 further stated he/she was seated in an identified room located in the same hallway where resident #013's room was however, he/she would have to physically get up to actually visualize resident #013's room. PCA #153 also stated he/she was

aware of the identified safety measure but didn’t check to see if it was actually turned on at any time during his/her shift. PCA #153 stated that due to an underlying health condition he/she had misread the time on the clock. At this time PCA #153 took his/her coat and told the RN #156 he/she was leaving as it was the end of the shift without waiting for the oncoming 1:1 staff member to relieve him/her. PCA #153 also stated that prior to leaving at he/she had gone to the bathroom without telling any co-workers.

In an interview, RN #156 stated that PCA #153 had worked on the identified floor previously doing 1:1 duties with resident #013. RN #156 further stated that when PCA #153 had told him/her he/she was leaving had initially responded by saying okay but then checked his/her own watch and realized that it was actually one hour earlier. RN #156 caught up with PCA #153 at the punch clock and instructed him/her of the correct time and to return to his/her duties as 1:1. RN #156 observed that upon returning to the floor PCA #153 sat in the lounge conversing with residents that were awake and seated in the lounge. RN #156 stated he/she did not re-direct PCA #153 to resume 1:1 monitoring of resident #013 as he/she should have known his/her job responsibilities however now in hindsight RN #156 should have provided re-direction to PCA #153.

Further review of the staffing schedule revealed that PCA #153 had previously worked on an identified resident home area on two consecutive identified dates, doing 1:1 monitoring for resident #013 therefore, the day following the two previously mentioned identified dates, was the third time.

In an interview, PCA #143 stated that upon opening the door of resident #016 that is shared with resident #013, he/she observed residents #013 and #015 standing face to face in an identified manner.

In an interview, PCA #148 stated that he/she was on care rounds with PCA #143 when they entered resident #016’s room at an identified time. When PCA #143 opened the bathroom door they observed residents #013 and #015 standing face to face in an identified manner. PCA #148 went to notify RN #156 while PCA # 143 separated the two residents.

Upon returning to the above mentioned identified resident home area at an identified time HR, RN #156 was informed of an incident that had occurred between resident #013 and resident #015 that had been discovered by PCA #143.

In interviews PCA #143 and #148 stated they did not recall hearing resident #013's

responsive behaviour safety intervention at the time of the occurrence.

Record review of resident #013's progress notes from a seven month period, revealed the resident had been observed turning off the identified safety intervention on two identified dates. On the second identified date the administrator, director of nursing (DON) #139 and nurse manager (NM) #151 had been notified that resident #013 had been observed turning off his/her identified safety intervention. On the following day, the identified safety intervention was moved to a different position however a progress note entry from two weeks later, revealed that resident #013 had been observed turning the identified safety intervention off. There were no further progress note entries that indicated the identified safety intervention placement had been readjusted.

In an interview, DON #139 confirmed that based on the above mentioned findings, residents #014 and #015 had not been protected from abuse by resident #013 on two occasions in an one month period.

The scope was identified to be isolated to two residents; severity was identified to be minimum risk to potential for harm as resident #013 has a documented history of exhibiting responsive behaviours toward co-residents since admission to the home. Also the licensee was aware that resident #013 was able to turn off the identified safety intervention as evidenced by documentation notes. The home's compliance history revealed a compliance order had been issued under O. Reg., 79/10, s. 19, critical incident inspection #2016_219211_0008 with a compliance date of July 2016, specifically identifying that the licensee must ensure there are immediate or appropriate actions, and effective measures in place to protect all residents from abuse by resident #013. Due to ongoing noncompliance with O. Reg., 79/10, s. 19, a compliance order is warranted. [s. 19. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the following are documented:

1. The provision of care set out in the plan of care,
2. The outcomes of the care set out in the plan of care, and
3. The effectiveness of the plan of care.

Two CIR reports were submitted to the MOHLTC related to two incidents of abuse involving residents #013, #014 and #015 on two identified dates in a one month period.

Review of a CIR submitted to the MOHLTC revealed that resident #013 was observed by personal care assistant (PCA) #158 to have demonstrated an inappropriate responsive behaviour toward resident #014.

Review of a CIR submitted to the MOHLTC revealed that resident #013 and resident #015 were located in resident #013's room by PCA #143 in an identified manner.

Record review of resident #013's health record revealed he/she had been admitted to the home with a history of identified responsive behaviours prior to admission. Review of the written plan of care and progress notes revealed that he/she began to exhibit responsive behaviours toward co-residents on an identified date. Further record review revealed that resident #013 was referred to the home's behavioural support Ontario (BSO) team three days after the responsive behaviours began.

Record review of resident #013's behavioural assessment tool (BAT) revealed that the dementia observation system (DOS) tool was initiated on the same date the resident was referred to BSO.

Record review of the home's policy #RC-0517-07 titled "Behavioural Response-Care Strategies: Modified Dementia Observation System" dated March 1, 2015, indicated the

modified dementia observation system (DOS) is used as a component of the assessment for new or escalating behaviours in order to gain a better insight and understanding of the time, pattern and antecedents leading to behavioural response when the root cause or triggers are difficult to identify.

Record review of resident #013’s DOS tool for a two month period, revealed that it was not completed hourly on 27 days.

In an interview, RPN #133 stated it is the responsibility of the RPN to ensure the DOS tool is completed hourly by the 1:1 PCA. RPN #133 further stated that when 1:1 monitoring was completed by an agency staff or a family member the home staff were responsible to ensure completion of every hour of the DOS tool.

In an interview, RPN #144 who is also a BSO team member stated that the DOS tool is to be completed hourly by the PCA. RPN #144 further stated that he/she analyzes the DOS tool for residents in the BSO program to identify for trends, patterns and/or triggers to develop interventions to address any responsive behaviours that were being exhibited. RPN #144 confirmed there were gaps in the DOS tool for resident #013 for two consecutive identified months.

In an interview, DON #139 confirmed that it was the home’s expectation for staff to complete all DOS monitoring hourly for resident #013. [s. 6. (9)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following are documented:
1.The provision of care set out in the plan of care,
2.The outcomes of the care set out in the plan of care, and
3.The effectiveness of the plan of care, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that, for resident #033 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.

A CIR report was submitted to the MOHLTC related to a fall incident with resident #033.

Record review of resident #033's progress notes and interviews with PCA #136 and RPN #138 revealed that since admission on an identified date, resident #033 had been demonstrating identified responsive behaviours. Interventions included an identified medication, DOS monitoring of his/her behaviour trends hourly and an identified device monitoring record (RDMR) every two hours.

a) Record review of resident #033’s physician’s order revealed that the resident was prescribed an identified medication. Review of the medication administration record (MAR) and progress notes from a four-month period, indicated that the resident was given the identified medication an identified number of times. Review of the progress notes and MAR for the above mentioned four months failed to reveal the assessment of the effectiveness of the medication given on two separate identified dates at identified times.

Interviews with NM #123 and DON #139 revealed that registered staff should assess and document the effectiveness of the PRN medication at the back of the MAR. If there was not enough time allowed to assess the effectiveness of the PRN medication, the outgoing

nurse should communicate to the incoming nurse for follow up. NM #123 and DON #139 confirmed that it was not acceptable that registered staff had not assessed and documented the effectiveness of the PRN medication.

b) Record review of resident #033's progress notes and interviews with PCA #136 and RPN #138 revealed that resident #033 was placed on DOS monitoring over an identified four-month period. Review of the DOS records for resident #033 for the above mentioned four months revealed there were entries missing on 42 days.

Interviews with PCA # 100 and #147, RPN #140 revealed that when a resident was placed on DOS monitoring, the assigned PCA should check the resident hourly, and document on the DOS record according to the code indicated on the DOS record.

Interviews with NM #123 and DON #139 revealed that when a resident is placed on DOS, PCAs are required to monitor the resident's behaviour trend and location hourly, and document on the DOS record accordingly. NM #123 and DON #139 further stated that staff should indicate on the DOS if the resident is not on the unit, and the DOS should not be left blank. NM #123 and DON #139 confirmed that it was the home's expectation for staff to complete all DOS monitoring hourly 24 hours a day for residents placed on DOS monitoring.

c) Record review of resident #033's progress notes and interviews with PCA #136 and RPN #138 revealed that the resident was placed on RDMR in regards to the resident's identified intervention. Review of the RDMR for resident #033 from an identified four-month period, revealed there were entries missing on 58 days.

In an interview, DON #139 stated that when a resident was under RDMR, PCAs were required to reposition the resident hourly, and registered staff were required to reassess the identified intervention every two hours. DON #139 confirmed that when a resident was placed under RDMR, staff should document as required, and the record should not be left blank.

The home is not in compliance with documenting resident #033's responses to interventions related to his/her responsive behaviours. [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 to ensure 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 #4: 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 resident #033 and other residents, including identifying and implementing interventions.

Record review of resident #033's progress notes and interviews with PCA #136 and RPN #138 revealed that since admission on an identified date, resident #033 had been exhibiting identified responsive behaviours.

Record review of resident #033's progress notes revealed that he/she had exhibiting identified responsive behaviours involving other residents on two identified dates in a two week period. Progress notes also revealed that on another identified date in the above mentioned two week period, resident #033 exhibited an identified responsive behaviour toward another resident when he/she attempted to exit the unit via the elevator.

Record review of resident #033's written plan of care revealed that the initial care plan developed on an identified date, included interventions for his/her identified responsive behaviours. On an identified date four months after admission, resident #034 had exhibited identified responsive behaviours toward resident #033. Review of resident #033's care plan revealed that interventions for resident #033'sidentified responsive behaviorus involving other residents were not developed until the day after the above mentioned incident.

Interviews with NM #123 and DON #139 confirmed that interventions should have been developed and implemented to minimize the risk of altercations and potentially harmful interactions between resident #033 and other residents when the altercations between resident #033 and other residents were identified in the month following admission as indicated in the progress notes. Therefore, the home was not in compliance with taking steps to minimize the risk of altercations and potentially harmful interactions between resident #033 and other residents, including identifying and implementing interventions. [s. 54. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On an identified date, at an identified time, observations conducted by the inspector on an identified resident home area during the initial tour of the home revealed a door marked servery was unlocked. A sign was posted outside the door instructing staff to ensure the door was locked. Staff members were not present inside the kitchen servery area at the time of observation.

The inspector observed seven cleaning and disinfecting agents accessible in the servery. The observations also revealed a hot beverage dispensing unit with a temperature gauge reading 92.5 degrees Celsius.

In an interview with Nutrition Manager #137, he/she stated that the expectation of the home was to keep the servery door locked at all times. In this case the licensee had failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and were kept closed and locked when they were not supervised by staff. [s. 9. (1) 2.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team was held within six weeks following resident #033's admission to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any.

Record review of resident #033's health record revealed that the resident was admitted on an identified date.

Record review of resident #033's health record and interviews with NM #123 and DON #139 confirmed that a care conference of the interdisciplinary team providing a resident's care was not held within six weeks following the resident's admission to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker. [s. 27. (1) (a)]

WN #7: 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #011 received a skin assessment by a member of the registered nursing staff upon any return from an absence of greater than 24 hours.

During stage two of the resident quality inspection (RQI) hospitalization and change in condition triggered for resident #011.

Record review of the home's policy titled: skin care and wound prevention management, policy number RC-0518-02, published April 1, 2016, revealed that a head-to-toe assessment of skin, feet and mouth are to be completed on admission within 24 hours, upon any return from hospital after an absence greater than 24 hours and following a leave of absence (LOA) greater than 24 hours.

Record review of resident #011's progress notes revealed he/she had been hospitalized for greater than 24 hours on two occasions over a three month period.

Record review of resident #011's health record revealed that after each hospitalization and readmission to the home, a head-to-toe assessment of skin, feet and mouth had not been completed.

In an interview, RN #108 stated that skin assessments are to be completed on admission, after return from a hospital admission and after any LOA greater than 24 hours. RN #108 further stated that head-to-toe assessments of skin, feet and mouth had not been completed after the above two mentioned hospitalizations for resident #011.

Review of treatment administration record (TAR) for an identified month, revealed resident #011 had altered skin integrity. The TAR further revealed that daily treatments were required. The most recent braden skin assessment scale revealed a score of 17, which indicated low risk for altered skin integrity.

In an interview, RN #108 stated that resident #011 developed altered skin integrity as a result of the above two mentioned hospital stays. RN #108 further stated that prior to the hospitalizations resident #011 ambulated independently and had not exhibited any altered skin integrity.

In an interview, DON #139 confirmed that head to toe assessments of skin, feet and mouth had not been completed for resident #011 upon returning from two hospitalizations that had been greater than 24 hours each. [s. 50. (2) (a) (iii)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to respond to the Family Council in writing within 10 days of receiving advice of concerns or recommendations from the Council about the operation of the home under paragraph 8 of s. 60. (1).

Record Review of Family Council meeting minutes from an identified date, revealed concerns were brought forward by the Council regarding telephone calls not being responded to on an identified home area. Review of Family Council meeting minutes from an identified date, revealed the Council made recommendations for instituting deadlines for responding to telephone calls and emails from resident families. No record of written responses to the Family Council was found relating to these concerns and recommendations.

In an interview, manager of resident services (MRS) #131 stated that the concerns and recommendations from the Family Council were brought forward to the nurse managers to address. MRS #131 stated that the concerns were not addressed in writing as the Family Council did not submit a written follow-up form for the home to address. MRS #131 stated it had not been the practice of the home to respond in writing unless a follow-up form was submitted. MRS #131 confirmed that the licensee had failed to respond to the Family Council in writing within 10 days of receiving advice of concerns or recommendations from the Council about the operation of the home. [s. 60. (2)]

Issued on this 14th day of February, 2017

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

Original report signed by the inspector.

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), JOANNE ZAHUR (589), STELLA NG (507)
Inspection No. / No de l'inspection :	2017_420643_0001
Log No. / Registre no:	035323-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 7, 2017
Licensee / Titulaire de permis :	City of Toronto 55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6
LTC Home / Foyer de SLD :	SEVEN OAKS 9 NEILSON ROAD, SCARBOROUGH, ON, M1E-5E1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gayle Campbell

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

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2016_219211_0008, CO #001;

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 :

Upon receipt of this compliance order the licensee will:
i) Review the findings of this compliance order as an example of abuse and neglect in the home;
ii) Discussion with the care staff outlining each individual staff person's role in how this incident of abuse and neglect could have been prevented; and
iii) Discussion with all direct care staff to ensure they are provided with clear directions related to their role including one to one (1:1) close monitoring for resident #013 and any other resident requiring 1:1 monitoring for responsive behaviour.

Grounds / Motifs :

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

Two critical incident reports (CIR) were submitted to the Ministry of Health and Long Term (MOHLTC) related to two incidents of resident to resident abuse in an one month period.

Record review of resident #013's health record revealed he/she had been admitted to the home with a history of identified responsive behaviours prior to admission. Review of the written plan of care and progress notes revealed that he/she began to exhibit responsive behaviours toward co-residents on an identified date, after admission. Further record review revealed that resident #013 was referred to the home's behavioural support ontario (BSO) team on an identified date. Review of resident #013's progress notes revealed that there

was an identified safety measure in place and had one to one (1:1) close monitoring in place related to exhibiting an identified responsive behaviour.

Record review of a compliance order with a compliance date of July 2016, revealed that resident #013 had a history of exhibiting responsive behaviours toward co-residents. The order had directed the licensee to take immediate or appropriate actions to ensure that effective measures are in place to protect all residents from abuse by resident #013 as identified in this report.

1.Review of a CIR submitted to the MOHLTC revealed that #013 was observed to be standing in front of resident #014 touching him/her inappropriately by personal care assistant (PCA) #158.

Record review of resident #014's health record revealed he/she has a history of responsive behaviours. On three identified dates, observations conducted by the inspector revealed resident #014 was wandering the hallway independently, and was not observed to demonstrate the identified responsive behaviour.

In an interview, PCA #149 stated he/she it was the beginning of his/her day shift and was in an identified room when he/she heard PCA #158 shouting. PCA #149 exited the identified room and observed resident #013 demonstrating an identified responsive behaviour toward resident #014. PCA #149 further stated that the residents were separated and redirected to their rooms. PCA #149 stated he/she had not heard resident #013's responsive behaviour intervention while in the identified room which would have alerted him/her that resident #013 had exited his/her room.

In an interview, registered practical nurse (RPN) #150 stated he/she had been on the opposite side of the unit assisting PCA #143 and was not aware of the incident until it was reported to him/her by the PCA's #149 and #158. RPN #150 further stated there had not been one to one (1:1) close monitoring in place for that shift and that he/she had not heard the identified intervention. RPN #150 also stated that resident #013 was able to turn off the identified intervention independently. RPN #150 further stated that the RN in charge (RN I/C) was not able to assist with monitoring the floor while he/she and the PCA were providing care due to registered staff absence on an identified resident home area and was required to do floor duties.

In an interview, registered nurse (RN) #156 who was also the RN I/C the

identified shift stated that he/she had been notified of an incident involving residents #013 and #014 by RPN #150. Upon arriving on the unit RPN #156 observed residents #013 and #014 in their rooms. RN #156 further stated that the job routine directs the RN I/C to return to the identified floor at an identified time for floor work consisting of administering medications and treatments and monitoring of residents until the oncoming shift arrives. RN #156 stated on that identified shift he/she had to cover floor duties on another floor due to a registered staff absence and was unable to go the identified floor at the identified time.

Record review of the job routine titled: RNIC shift work routine responsibilities of the lead RN confirmed the above mentioned job responsibilities of the RNIC.

2.Review of a CIR submitted to the MOHLTC revealed that resident #013 and resident #015 were located in an identified area demonstrating identified responsive behaviours by PCA #143.

Record review of resident #015's health record revealed he/she has a history of responsive behaviours.

Record review of the licensee's staffing schedule revealed that PCA #153 had been scheduled to provide 1:1 monitoring of resident #013 on an identified date on an identified shift.

In an interview, PCA #153 stated that the above mentioned date had been the first time he/she had done 1:1 monitoring for resident #013. PCA #153 stated that a nurse had provided instruction and direction related to 1:1 responsibilities but he/she could not remember the name of the nurse that had provided this direction at the time of this interview. PCA #153 further stated he/she was seated in an identified room located in the same hallway where resident #013's room was however, he/she would have to physically get up to actually visualize resident #013's room. PCA #153 also stated he/she was aware of the identified safety measure but didn't check to see if it was actually turned on at any time during his/her shift. PCA #153 stated that due to an underlying health condition he/she had misread the time on the clock. At this time PCA #153 took his/her coat and told the RN #156 he/she was leaving as it was the end of the shift without waiting for the oncoming 1:1 staff member to relieve him/her. PCA #153 also stated that prior to leaving at he/she had gone to the bathroom without telling any co-workers.

In an interview, RN #156 stated that PCA #153 had worked on the identified floor previously doing 1:1 duties with resident #013. RN #156 further stated that when PCA #153 had told him/her he/she was leaving had initially responded by saying okay but then checked his/her own watch and realized that it was actually one hour earlier. RN #156 caught up with PCA #153 at the punch clock and instructed him/her of the correct time and to return to his/her duties as 1:1. RN #156 observed that upon returning to the floor PCA #153 sat in the lounge conversing with residents that were awake and seated in the lounge. RN #156 stated he/she did not re-direct PCA #153 to resume 1:1 monitoring of resident #013 as he/she should have known his/her job responsibilities however now in hindsight RN #156 should have provided re-direction to PCA #153.

Further review of the staffing schedule revealed that PCA #153 had previously worked on an identified resident home area on two consecutive identified dates, doing 1:1 monitoring for resident #013 therefore, the day following the two previously mentioned identified dates, was the third time.

In an interview, PCA #143 stated that upon opening the door of resident #016 that is shared with resident #013, he/she observed residents #013 and #015 standing face to face in an identified manner.

In an interview, PCA #148 stated that he/she was on care rounds with PCA #143 when they entered resident #016's room at an identified time. When PCA #143 opened the bathroom door they observed residents #013 and #015 standing face to face in an identified manner. PCA #148 went to notify RN #156 while PCA # 143 separated the two residents.

Upon returning to the above mentioned identified resident home area at an identified time HR, RN #156 was informed of an incident that had occurred between resident #013 and resident #015 that had been discovered by PCA #143.

In interviews PCA #143 and #148 stated they did not recall hearing resident #013's responsive behaviour safety intervention at the time of the occurrence.

Record review of resident #013's progress notes from a seven month period, revealed the resident had been observed turning off the identified safety intervention on two identified dates. On the second identified date the

administrator, director of nursing (DON) #139 and nurse manager (NM) #151 had been notified that resident #013 had been observed turning off his/her identified safety intervention. On the following day, the identified safety intervention was moved to a different position however a progress note entry from two weeks later, revealed that resident #013 had been observed turning the identified safety intervention off. There were no further progress note entries that indicated the identified safety intervention placement had been readjusted.

In an interview, DON #139 confirmed that based on the above mentioned findings, residents #014 and #015 had not been protected from abuse by resident #013 on two occasions in an one month period.

The scope was identified to be isolated to two residents; severity was identified to be minimum risk to potential for harm as resident #013 has a documented history of exhibiting responsive behaviours toward co-residents since admission to the home. Also the licensee was aware that resident #013 was able to turn off the identified safety intervention as evidenced by documentation notes. The home's compliance history revealed a compliance order had been issued under O. Reg., 79/10, s. 19, critical incident inspection #2016_219211_0008 with a compliance date of July 2016, specifically identifying that the licensee must ensure there are immediate or appropriate actions, and effective measures in place to protect all residents from abuse by resident #013. Due to ongoing noncompliance with O. Reg., 79/10, s. 19, a compliance order is warranted. (589)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 17, 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 7th day of February, 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