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 prévue le Loi de 2007 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 Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jun 06, 2017;	2017_414110_0005 (A1)	006589-17	Complaint

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

DIANE BROWN (110) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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Issued on this 6 day of June 2017 (A1)

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

Original report signed by the inspector.

Ontario

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DIANE BROWN (110) - (A1)

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 3, 4, 5, 6, 18,19, 21, 2017

Intake log #006589-17 related to dealing with complaints, reporting certain matters to Director, transferring and positioning technique was inspected.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Nursing, Nurse Manager, Registered Nurse, Registered Practical Nurse, Personal Care Aides, Resident and Substitute Decision Maker.

During the course of the inspection, the inspector conducted observations of staff and

resident interactions, record review for identified resident, and review of identified policies

and procedures.

The following Inspection Protocols were used during this inspection:

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

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

7 WN(s)
4 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that appropriate action is taken in response to every alleged, suspected or witnessed incident that the licensee knows of.

Two complaints were received by the MOH, related to suspicious injuries sustained by resident #001. Both injuries resulted in transfer to hospital.

Complaint #1.

Record review revealed on an identified date and time registered nurse #112 was called by PCA #108 to resident #001's room stating resident was expressing an identified concern. The documentation further identified the RN's assessment and confirmed the identified concern brought forward by the resident. Resident was transferred to the hospital and later diagnosed with an injury.

Interview with PCA #108 revealed he/she clearly remembered the events of the identified shift, related to resident #001's injury and transfer to hospital. PCA #108 revealed that he/she worked the shift, and that he/she was assigned to resident

#001 who was in bed when he/she arrived on shift. PCA #108 stated that when he/she went to assist the resident with an identified meal the resident stated an area of his/her body hurt. The PCA stated he/she asked resident #001 what happened and resident #001 stated an allegation of abuse.

PCA #108 further stated he/she immediately sought out and reported to RN #112 resident's identified concern and allegation then returned to resident along with RN #112. The PCA identified that RN #112 completed his/her assessment of the resident and confirmed that resident #001 expressed the same allegation to RN #112. PCA #108 revealed resident #001 stated the allegation not only on that day but repeatedly for sometime afterwards.

Interview with RN #112 confirmed that PCA #108 reported to him/her resident #001's allegation. RN #112 stated that upon initial assessment of resident #001, the resident complained of an identified concern and reported a second allegation of abuse.

Further interview with RN #112 confirmed that both statements expressed by the resident were of concern and had not been documented by him/her as alleged abuse, nor reported further.

A few days later, record review and interview with RN #112 revealed that an identified individual known to resident #001 spoke with RN #112 and stated he/she wanted an investigation to get to the bottom of what happened. The RN further indicated that he/she had informed NM #101 via voice mail message.

An interview with the NM and DON confirmed that the comments made by the resident were allegations of abuse. The DON revealed that the registered staff receiving these allegations should have documented the resident's statements and initiated the abuse protocol as per the home's abuse policy for further investigation.

Interview with an identified individual known to resident #001 revealed that three months later, he/she upon his/her request received a status update on the home's investigation from the NM #101, whom he/she had called one week prior. The NM confirmed the investigation was complete and there were no findings to support what actually had occurred and the cause of the injury.

Record review of a Critical Incident (CI) report submitted to the MOH revealed that

resident #001 was transferred to hospital related to a significant injury that occurred on the identified date. The report failed to include the allegations from resident #001 of abuse.

A review of the home's investigation file revealed it was incomplete with no record of a resident or staff interviews available for review. NM #101 who conducted the investigation confirmed parts of the investigation were missing and further confirmed that he/she did not interview staff who had worked an identified shift, prior to the shift's report of resident's identified concern and subsequent transfer to hospital.
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Interviews with two direct care staff that had been assigned to resident #001 on the identified shift, the shift prior to resident #001's hospital transfer, revealed that they had not been interviewed by the home.

The licensee failed to take appropriate action when staff #112 failed to document, report and recognize resident #001's allegations of abuse, as a result the home failed to immediately report the allegation of abuse to the Director under section 24 (1) 2 of the LTCHA. Further the licensee failed to take action when NM #101 neglected to interview all staff involved in resident's care on the identified date, and resident #001 when investigating the incident related to an unknown injury of a non ambulatory resident.

Complaint #2.

Record review identified documentation by RN #102 as follows:
On an identified date and time, an identified individual known to resident #001 visited resident. At this time while writer was in room attending to co resident, writer heard resident telling the identified individual that he/she had an identified concern. When the identified individual asked what happened, resident stated an allegation of abuse. Documentation further revealed RN #102 assessed the resident and the protocol to transfer the resident to hospital was followed.

Record review revealed an injury to an identified area of resident's body.

Interview with RN #102 confirmed documentation and knowledge that resident stated his/her identified concerns and how it happened. RN #102 revealed resident's comment was an allegation of abuse which had not been documented as such by him/her or reported to prompt an investigation.

Record review identified documentation by RPN #103 as follows:
On an identified date and time writer spoke with an identified individual known to resident #001 who stated an allegation of abuse by a staff member. Documentation revealed that RPN #103 gave the identified individual the phone numbers of NM #101 and the DON. Documentation further revealed RPN #103 spoke with NM #101 thereafter regarding the statement of the identified individual and documented that NM #101 stated, I'll look into it.

Interview with RPN #103 revealed knowledge of the conversation on the identified date. RPN #103 revealed that the identified individual sounded serious and that he/she reported his/her concern to NM #101 right away. RPN #103 revealed that the details shared were a reason to consider abuse. RPN #103 also identified that the DON approached him/her a few days following stating that when he/she gives out his/her number to inform him/her of same and assumed that the identified individual must have contacted the DON about the resident's concern.

Interview with NM #101 recalled receiving a verbal report from RPN #103 but the concern and allegation of abuse was not shared. The NM stated that RPN #103 should have initiated the protocol for abuse by calling the police.

Interview with the identified individual revealed that he/she left messages for the DON, identifying that the resident had reported to him/her an allegation of abuse by a staff. The identified individual stated that a returned voice message was received by the DON, however the DON did not acknowledge his/her concern around the allegation of abuse by a staff member, and only reported an upcoming appointment for resident #001 on an identified date.

Interview with DON revealed he/she could not recall receiving a message from the identified individual on the identified date.

Interview with RN #105 revealed awareness and had assessed the altered skin integrity of resident #001. When questioned what his/her knowledge was related to the injury, RN #105 stated he/she spoke directly with resident #001 who told him/her what happened. When questioned by inspector if resident #001 had ever complained prior to this incident, RN #105 stated yes, that resident #001 was accusing PCA #107 of identified interactions but he/she had nothing to back it up. RN #105 revealed when questioned what he/she did with the information that NM #101 was aware of the resident's concern.

Interview with RPN #104 revealed knowledge of the conversation with the identified individual known to resident #001 on the identified date, whereby the identified individual stated he/she did not want PCA #107 providing care to the resident.

Interview with identified individual revealed that on an identified date, he/she spoke with resident #001, who identified an allegation of staff abuse. The individual identified at that point requested to RPN #104 that PCA not provide care to the resident. The identified individual revealed that he/she called the police.

Record review and staff interviews revealed that the police arrived onsite on an identified date and conducted an investigation of alleged abuse by PCA #107 towards resident #001. It was at this time, after the police had arrived on the unit in response to a call by the identified individual, that the home submitted a Critical Incident (CI) related to an injury of bruising, by which the resident was taken to hospital a week prior.

The licensee failed to take appropriate action when RPN #104 failed to document and report the identified individual's request that PCA #107 not provide care to resident #001's. Further RN #105 had knowledge that resident #001 was accusing PCA #107 of abuse and confirmed that the NM #101 had knowledge of resident's concern.

The scope of this non compliance is isolated to resident #001. The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

The licensee failed to recognize and manage allegations of abuse reported by both resident #001 and an identified individual related to two incidents when resident sustained injury.

The home does have a compliance history under the LTCHA, 2007,.c.8,s. 23. [s. 23. (1) (b)]

2. The licensee failed to report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

Record review of CI report submitted on an identified date, revealed resident #001 with injury for which the resident was taken to hospital and which resulted in a

significant change in the resident's health status.

Further review of the CI report revealed a general note from the triage and assessment officer at Centralized Intake, Assessment and Triage Team (CIATT). The note stated to please amend the CI with the outcome of your investigation, when complete.

Interview with NM #101 confirmed that he/she was not made aware of the need to amend the CI until an inspector from the MOH was onsite March, 2016, inspecting the incident .The CI was then amended on March 3, 2016.

Interview with an identified individual known to resident #001 revealed that the home's investigation was complete and a meeting was held with him/her.

The licensee failed to submit an amended CI reporting the results of the investigation as requested by the Director [s. 23. (2)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

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

Two complaints were received by the MOH, related to an unknown cause of injury to resident #001 noted on identified dates. The resident was transferred to hospital on both occasions.

Record review of the home's Zero Tolerance of Abuse and Neglect Policy – RC-0305-00 revised date- January 10, 2014, identified under the Investigation And Reporting section that registered staff are to contact the counsellor/spiritual and religious care services to provide emotional/psychological support and counseling to all residents involved in the incident and in accordance with the resident's wishes, provide access to resident for private communication with independent advocates.

Interview with the Nurse Manager (NM) #101 revealed residents who are involved in incidents of the above nature are referred to a social worker and offered counseling. The NM confirmed that resident #001 was not referred and did not receive counseling, as required related to the two incidents of allegation of abuse. [s. 20. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm has occurred or may occur or abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm immediately report the suspicion and the information upon which it was based to the Director.

Two complaints were received by the MOH. Both complaints were related to suspicious injuries sustained by resident #001. Both injuries resulted in transfer to

hospital.

Complaint #1.

A review of resident #001's written plan of care, at the time of the first complaint, identified the resident as cognitively aware and required total dependence of two staff with a mechanical lift for all transfers.

Record review identified that on an identified date and time Registered Nurse (RN) #112 was called by Personal Care Aide (PCA) #108 to resident #001's room stating resident is complaining of an identified concern. The documentation further identified that the RN's assessment and that the resident confirmed the identified concern. The resident was transferred to the hospital and later diagnosed with an identified injury.

Interview with PCA #108 revealed he/she clearly remembered the events of the identified shift, related to resident #001's injury and transfer to hospital. PCA #108 revealed that he/she worked the shift, and that he/she was assigned to resident #001 who was in bed when he/she arrived on shift. PCA #108 stated that when he/she went to assist the resident with an identified meal the resident stated an area of his/her body hurt. The PCA stated he/she asked resident #001 what happened and resident #001 stated an allegation of abuse.

PCA #108 further stated he/she immediately sought out and reported to RN #112 resident's identified concern and allegation then returned to resident along with RN #112. The PCA identified that RN #112 completed his/her assessment of the resident and confirmed that resident #001 expressed the same allegation to RN #112. PCA #108 revealed resident #001 stated the allegation not only on that day but repeatedly for sometime afterwards

Interview with RN #112 confirmed that PCA #108 reported to him/her resident #001's allegation. RN #112 stated that upon initial assessment of resident #001, the resident complained of an identified concern and reported a second allegation of abuse.

Further interview with RN #112 confirmed that both statements expressed by the resident were of concern and had not been documented by him/her as alleged abuse, nor reported further.

An interview with the NM and DON confirmed that the identified resident comments were allegations of abuse and had not been reported immediately to the Director. The DON revealed that the registered staff receiving these allegations should have documented the resident's statements and initiated the abuse protocol as per the home's abuse policy for further investigation and immediate reporting.

Complaint #2

Record review identified documentation by RN #102 as follows:
On an identified date and time, an identified individual known to resident #001 visited resident. At this time while writer was in room attending to co resident, writer heard resident telling the identified individual that he/she had an identified concern. When the identified individual asked what happened, resident stated an allegation of abuse. Documentation further revealed RN #102 assessed the resident and the protocol to transfer the resident to hospital was followed.

Record review revealed an injury to an identified area of resident's body.

Interview with RN #102 confirmed documentation and knowledge that resident stated his/her identified concerns and how it happened. RN #102 revealed resident's comment was an allegation of abuse which had not been documented as such by him/her or reported to prompt an investigation.

Interview with RN #105 revealed awareness and had assessed the altered skin integrity of resident #001. When questioned what his/her knowledge was related to the injury, RN #105 stated he/she spoke directly with resident #001 who told him/her what happened. When questioned by inspector if resident #001 had ever complained prior to this incident, RN #105 stated yes, that resident #001 was accusing PCA #107 of identified interactions but he/she had nothing to back it up. RN #105 revealed when questioned what he/she did with the information that NM #101 was aware of the resident's concern.

Interview with RPN #104 revealed knowledge of the conversation with the identified individual known to resident #001 on the identified date, whereby the identified individual stated he/she did not want PCA #107 providing care to the resident.

Record review and staff interviews revealed that police arrived onsite on an identified date, a call initiated by the identified individual. The police conducted an

investigation of an allegation of abuse by PCA #107 towards resident #001. No charges were laid.

The licensee failed to report to the Director staff awareness of resident #001's reported allegations of abuse in on both identified occasions. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the person who had reasonable grounds to suspect improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm or has occurred or may occur or abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

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

Findings/Faits saillants :

The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A complaint was received by the MOH, related to an unknown cause of injury of resident #001's, whereby the resident was transferred to hospital.

Record review of the hospital report revealed an injury to an identified area of resident's body.

A review of resident #001's written plan of care, identified the resident as cognitively aware and required total dependence of two staff with a mechanical lift for all transfers.

Record review of the progress notes revealed that on an identified date and time RN #102 overheard resident #001 telling an identified individual that he/she had an identified concern. When the identified individual asked what happened, resident described what happened during a transfer. When the identified individual asked him/her what time and how care was provided the resident responded and revealed evidence that care related to safe transferring was not provided.

Interview with RN #105 revealed awareness and had assessed the altered skin integrity of resident #001. When questioned what his/her knowledge was related to the injury, RN #105 stated he/she spoke directly with resident #001 who told him/her what happened which was evidence that care related to safe transferring as not provided.
RN #105 also reported when questioned, that PCA #114 approached him/her after the home investigated the altered skin integrity stating he/she did not assist PCA #107 with transferring the resident on the identified shift and date.

Interview with PCA #107 who provided primary care to resident #001's during the identified shift and date, revealed that resident #001 required a two person transfer with a mechanical lift and was transferred from bed to chair before lunch with the assistance of PCA #114 .

Interview with PCA #114 denied assisting PCA #107 on the identified shift and date with the resident transfer.

A review of the Home's Policy titled Mechanical Lifting Device #NU-0606-00 dated January 12, 2010 stated all residents who are unable to weight bear will be lifted with a mechanical lift and the assistance of two (2) staff.

An interview with NM #101 confirmed that the home's investigation identified that PCA #107 did not use safe transferring and positioning techniques, by way of two staff, when assisting resident #001. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home:
• been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and
• where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

A complaint was received by the MOH, on two identified occasions, related to suspicious circumstances surrounding a injury to resident #001.

Record review identified on an identified date and time registered nurse #112 was called by PCA #108 to resident #001's room stating resident was expressing an identified concern. The documentation further identified that the RN's assessment and confirmed residents identified concern. Resident was transferred to the hospital and later diagnosed with an injury.

Interview with PCA #108 revealed he/she clearly remembered the events of the identified shift, related to resident #001's injury and transfer to hospital. PCA #108 revealed that he/she worked the shift, and that he/she was assigned to resident #001 who was in bed when he/she arrived on shift. PCA #108 stated that when he/she went to assist the resident with an identified meal the resident stated an area of his/her body hurt. The PCA stated he/she asked resident #001 what happened and resident #001 stated an allegation of abuse.

Interview with RN #112 confirmed that PCA #108 approached him/her reporting the resident's identified concern and comment of an allegation of abuse.

Record review identified a day later that an identified individual known to resident #001 spoke with RN #112 and said he/she wanted to get to the bottom of the issue as it appeared that someone had cause an injury to the resident.

Further record review revealed documentation by NM #101 that a teleconference was held with the identified individual along with the DON and that the home was to conduct an internal investigation.

Interview with the identified individual confirmed he/she had a teleconference with NM #101 and the DON and awareness that the home would be conducting an internal investigation. The identified individual revealed that on an identified date, months later, he/she left a message for NM #101 inquiring as to the status of the investigation and that one week later his/her call was returned.

Interview with NM revealed that there was no evidence that the home followed up within 10 business days of the identified individual's expressed concern. [s. 101. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, has the investigation commenced immediately, to be implemented voluntarily.

WN #6: 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 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 of the resident that:

• resulted in a physical injury or pain to the resident, or
• caused distress to the resident that could potentially be detrimental to the resident' s health or well-being.

Record review revealed on an identified date and time, registered nurse #112 was called by PCA #108 to resident #001's room stating resident is complaining of an identified concern. The documentation further identified that the RN's assessment and confirmed resident's identified concern. Resident was transferred to the hospital and later diagnosed with an injury.

Interview with PCA #108 revealed he/she clearly remembered the events of the identified day, related to resident #001's injury and transfer to hospital. PCA #108 revealed that he/she worked the shift on the identified day, and that he/she was assigned to resident #001 who was in bed when he/she arrived on shift. PCA #108 stated that when he/she went to assist the resident with an identified meal the resident stated identified concern. The PCA stated he/she asked resident #001 what happened and resident #001 stated an allegation of abuse.

PCA #108 further stated he/she immediately sought out and reported to RN #112 resident's identified concern and allegation then returned to resident along with RN #112. The PCA identified that RN #112 completed his/her assessment of the resident and confirmed that resident #001 expressed the same allegation to RN #112. PCA #108 revealed resident #001 stated the allegation not only on that day but repeatedly for sometime afterwards.

Interview with RN #112 confirmed that PCA #108 reported to him/her resident #001's allegation. RN #112 stated that upon initial assessment of resident #001, the resident reported a second allegation of abuse.

Further interview with RN #112 confirmed that both statements by the resident were of concern and had not been documented by him/her as alleged abuse, nor reported further.

Record review and an interview with resident #001's SDM revealed he/she was not notified by the home on this identified date of the resident's allegations of abuse.

Interview with RN #105 revealed awareness and had assessed the altered skin integrity of resident #001. When questioned what his/her knowledge was related to

the injury, RN #105 stated he/she spoke directly with resident #001 who told him/her what happened. When questioned by inspector if resident #001 had ever complained prior to this incident, RN #105 stated yes, that resident #001 was accusing PCA #107 of identified interactions but he/she had nothing to back it up. RN #105 revealed when questioned what he/she did with the information that NM #101 was aware of the resident's concern.

Record review and an interview with an identified individual known to resident #001 revealed that he/she was not notified by the home of any time, prior to, on, or after the second identified date, of the resident's allegations. [s. 97. (1) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. An injury in respect of which a person is taken to hospital.

Record review identified documentation on an identified date, by RN #102 that writer overheard resident #001 telling the identified individual that he/she had an identified concern. Documentation further revealed RN #102 assessed the resident and the resident was transferred to hospital that evening.

Interview with RN #102 confirmed that resident complained of an identified concern and he/she transferred him/her to hospital. The resident returned to the home, requiring an immobility device and medication.

Days later, record review and staff interviews revealed that police arrived onsite and conducted an investigation of alleged staff abuse towards resident #001.

The home failed to inform the Director of resident #001's injury resulting in his/her being taken to hospital. The home only informed the Director over a week later, after the police had arrived in the home. [s. 107. (3) 4.]

Issued on this 6 day of June 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

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

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : DIANE BROWN (110) - (A1)

Inspection No. / No de l'inspection : 2017_414110_0005 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 006589-17 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Jun 06, 2017;(A1)

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

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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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 23. (1) Every licensee of a long-term care home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:

(i) abuse of a resident by anyone,

(ii) neglect of a resident by the licensee or staff, or

(iii) anything else provided for in the regulations;

(b) appropriate action is taken in response to every such incident; and

(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Order / Ordre :

Ontario

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Upon receipt of this order the licensee shall,
1. Develop and submit a plan that includes the following requirements and the
person responsible for completing the tasks:
2. Provide re-education and training to all staff in the home on the home's policy
to promote zero tolerance of abuse and neglect of residents.
3. Ensure all staff are educated on how to identify abuse including allegations.
4. Ensure all staff are aware of the procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents.
5. Educate all registered staff on their responsibility to document all allegations of abuse and follow the home reporting procedures.
6. The plan shall include maintaining investigation notes on any and all allegations of abuse and documentation to support that appropriate and timely communication has been conducted with any SDM.

The plan shall be submitted to Diane.Brown@ontario.ca by May 31, 2017.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that appropriate action is taken in response to every alleged, suspected or witnessed incident that the licensee knows of.

Two complaints were received by the MOH, related to suspicious injuries sustained by resident #001. Both injuries resulted in transfer to hospital.

Complaint #1.

Record review revealed on an identified date and time registered nurse #112 was called by PCA #108 to resident #001's room stating resident was expressing an identified concern. The documentation further identified the RN's assessment and confirmed the identified concern brought forward by the resident. Resident was transferred to the hospital and later diagnosed with an injury.

Interview with PCA #108 revealed he/she clearly remembered the events of the identified shift, related to resident #001's injury and transfer to hospital. PCA #108

revealed that he/she worked the shift, and that he/she was assigned to resident #001 who was in bed when he/she arrived on shift. PCA #108 stated that when he/she went to assist the resident with an identified meal the resident stated an area of his/her body hurt. The PCA stated he/she asked resident #001 what happened and resident #001 stated an allegation of abuse.

PCA #108 further stated he/she immediately sought out and reported to RN #112 resident's identified concern and allegation then returned to resident along with RN #112. The PCA identified that RN #112 completed his/her assessment of the resident and confirmed that resident #001 expressed the same allegation to RN #112. PCA #108 revealed resident #001 stated the allegation not only on that day but repeatedly for sometime afterwards.

Interview with RN #112 confirmed that PCA #108 reported to him/her resident #001's allegation. RN #112 stated that upon initial assessment of resident #001, the resident complained of an identified concern and reported a second allegation of abuse.

Further interview with RN #112 confirmed that both statements expressed by the resident were of concern and had not been documented by him/her as alleged abuse, nor reported further.

A few days later, record review and interview with RN #112 revealed that an identified individual known to resident #001 spoke with RN #112 and stated he/she wanted an investigation to get to the bottom of what happened. The RN further indicated that he/she had informed NM #101 via voice mail message.

An interview with the NM and DON confirmed that the comments made by the resident were allegations of abuse. The DON revealed that the registered staff receiving these allegations should have documented the resident's statements and initiated the abuse protocol as per the home's abuse policy for further investigation.

Interview with an identified individual known to resident #001 revealed that three months later, he/she upon his/her request received a status update on the home's investigation from the NM #101, whom he/she had called one week prior. The NM confirmed the investigation was complete and there were no findings to support what actually had occurred and the cause of the injury.

Record review of a Critical Incident (CI) report submitted to the MOH revealed that

resident #001 was transferred to hospital related to a significant injury that occurred on the identified date. The report failed to include the allegations from resident #001 of abuse.

A review of the home's investigation file revealed it was incomplete with no record of a resident or staff interviews available for review. NM #101 who conducted the investigation confirmed parts of the investigation were missing and further confirmed that he/she did not interview staff who had worked an identified shift, prior to the shift's report of resident's identified concern and subsequent transfer to hospital.
.
Interviews with two direct care staff that had been assigned to resident #001 on the identified shift, the shift prior to resident #001's hospital transfer, revealed that they had not been interviewed by the home.

The licensee failed to take appropriate action when staff #112 failed to document, report and recognize resident #001's allegations of abuse, as a result the home failed to immediately report the allegation of abuse to the Director under section 24 (1) 2 of the LTCHA. Further the licensee failed to take action when NM #101 neglected to interview all staff involved in resident's care on the identified date, and resident #001 when investigating the incident related to an unknown injury of a non ambulatory resident.

Complaint #2.

Record review identified documentation by RN #102 as follows:
On an identified date and time, an identified individual known to resident #001 visited resident. At this time while writer was in room attending to co resident, writer heard resident telling the identified individual that he/she had an identified concern. When the identified individual asked what happened, resident stated an allegation of abuse. Documentation further revealed RN #102 assessed the resident and the protocol to transfer the resident to hospital was followed.

Record review revealed an injury to an identified area of resident's body.

Interview with RN #102 confirmed documentation and knowledge that resident stated his/her identified concerns and how it happened. RN #102 revealed resident's comment was an allegation of abuse which had not been documented as such by him/her or reported to prompt an investigation.

Record review identified documentation by RPN #103 as follows:
On an identified date and time writer spoke with an identified individual known to resident #001 who stated an allegation of abuse by a staff member. Documentation revealed that RPN #103 gave the identified individual the phone numbers of NM #101 and the DON. Documentation further revealed RPN #103 spoke with NM #101 thereafter regarding the statement of the identified individual and documented that NM #101 stated, I'll look into it.

Interview with RPN #103 revealed knowledge of the conversation on the identified date. RPN #103 revealed that the identified individual sounded serious and that he/she reported his/her concern to NM #101 right away. RPN #103 revealed that the details shared were a reason to consider abuse. RPN #103 also identified that the DON approached him/her a few days following stating that when he/she gives out his/her number to inform him/her of same and assumed that the identified individual must have contacted the DON about the resident's concern.

Interview with NM #101 recalled receiving a verbal report from RPN #103 but the concern and allegation of abuse was not shared. The NM stated that RPN #103 should have initiated the protocol for abuse by calling the police.

Interview with the identified individual revealed that he/she left messages for the DON, identifying that the resident had reported to him/her an allegation of abuse by a staff. The identified individual stated that a returned voice message was received by the DON, however the DON did not acknowledge his/her concern around the allegation of abuse by a staff member, and only reported an upcoming appointment for resident #001 on an identified date.

Interview with DON revealed he/she could not recall receiving a message from the identified individual on the identified date.

Interview with RN #105 revealed awareness and had assessed the altered skin integrity of resident #001. When questioned what his/her knowledge was related to the injury, RN #105 stated he/she spoke directly with resident #001 who told him/her what happened. When questioned by inspector if resident #001 had ever complained prior to this incident, RN #105 stated yes, that resident #001 was accusing PCA #107 of identified interactions but he/she had nothing to back it up. RN #105 revealed when questioned what he/she did with the information that NM #101

was aware of the resident's concern.

Interview with RPN #104 revealed knowledge of the conversation with the identified individual known to resident #001 on the identified date, whereby the identified individual stated he/she did not want PCA #107 providing care to the resident.

Interview with identified individual revealed that on an identified date, he/she spoke with resident #001, who identified an allegation of staff abuse. The individual identified at that point requested to RPN #104 that PCA not provide care to the resident. The identified individual revealed that he/she called the police.

Record review and staff interviews revealed that the police arrived onsite on an identified date and conducted an investigation of alleged abuse by PCA #107 towards resident #001. It was at this time, after the police had arrived on the unit in response to a call by the identified individual, that the home submitted a Critical Incident (CI) related to an injury of bruising, by which the resident was taken to hospital a week prior.

The licensee failed to take appropriate action when RPN #104 failed to document and report the identified individual's request that PCA #107 not provide care to resident #001's. Further RN #105 had knowledge that resident #001 was accusing PCA #107 of abuse and confirmed that the NM #101 had knowledge of resident's concern.

The scope of this non compliance is isolated to resident #001. The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

The licensee failed to recognize and manage allegations of abuse reported by both resident #001 and an identified individual related to two incidents when resident sustained injury.

The home does have a compliance history under the LTCHA, 2007,.c.8,s. 23. [s. 23. (1) (b)]

2. The licensee failed to report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

Record review of CI report submitted on an identified date, revealed resident #001

with injury for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

Further review of the CI report revealed a general note from the triage and assessment officer at Centralized Intake, Assessment and Triage Team (CIATT). The note stated to please amend the CI with the outcome of your investigation, when complete.

Interview with NM #101 confirmed that he/she was not made aware of the need to amend the CI until an inspector from the MOH was onsite March, 2016, inspecting the incident .The CI was then amended on March 3, 2016.

Interview with an identified individual known to resident #001 revealed that the home's investigation was complete and a meeting was held with him/her.

The licensee failed to submit an amended CI reporting the results of the investigation as requested by the Director [s. 23. (2)]
(110)

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

Sep 29, 2017(A1)

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

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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
Toronto ON M5S 2B1
Télécopieur : 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 6 day of June 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DIANE BROWN

Service Area Office /
Bureau régional de services : Toronto