Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 12, 2019	2019_573581_0005	017184-18, 004862-19, 008683-19, 009186-19, 009233-19, 010371-19, 011351-19	Critical Incident System

Licensee/Titulaire de permis

City of Hamilton
28 James Street North 4th Floor HAMILTON ON L8R 2K1

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

Wentworth Lodge
41 South Street West DUNDAS ON L9H 4C4

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

DIANNE BARSEVICH (581), DARIA TRZOS (561)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 13, 14, 15, 16, 17, 21, 22, 23, 24, 27, 28, 29, June 5 and 6, 2019.

The following Critical Incident System (CIS) Inspections were completed:
017184-18, M536-000039-17 - related to fracture with unknown cause,
004862-19, M536-000002-19 - related to resident to resident alleged abuse,
004862-19, M536-000004-19 - related to resident to resident alleged abuse,
004862-19, M536-000005-19 - related to resident to resident alleged abuse,
008683-19, M536-000012-19 - related to resident to resident alleged abuse,
009186-19, M536-000014-19 - related to resident to resident alleged abuse,
009233-19, M536-000015-19 - related to resident to resident alleged abuse,
010371-19, M536-000018-19 - related to resident to resident alleged abuse,
011351-19, M536-000024-19 - related to resident to resident alleged abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Nurse Managers (NM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Recreation staff, Behaviour Support Ontario (BSO) staff, Housekeeping staff and residents.

During the course of the inspection, the inspectors observed the provision of care, reviewed clinical records, reviewed policies and procedures, reviewed investigation notes, training materials and records and any other relevant documentation pertaining to the inspection.

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

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A. Review of the progress notes dated on September 2018, identified that Personal Support Worker (PSW) #117 witnessed an incident of inappropriate behaviour by resident #002 towards resident #001 and this was confirmed through an interview with PSW #117 on an identified date in May 2019. The incident was reported to Registered Practical Nurse (RPN) #120.

Registered Nurse (RN) #118 was interviewed and stated they worked on the specified day of the incident and assessed the resident and there were no injuries noted. They acknowledged they reported the incident to the Nurse Manager (NM) on call; however, did not report it to the Ministry of Health and Long Term Care (MOHLTC).

The Director of Nursing (DON) confirmed that resident #001 was not protected from abuse from resident #002.

B. A review of the progress notes dated on January 2019, identified that PSW #121 witnessed an incident of inappropriate behaviour by resident #002 towards resident #001 and this was confirmed in an interview with PSW #121 on an identified date in June 2019. This incident was reported to the registered staff.

During an interview with RN #110 on an identified date in May 2019, they acknowledged that the incident was reported to them and they reported the incident to the NM on call; however, did not report it to the MOHLTC.

The DON confirmed that resident #001 was not protected from abuse from resident #002.

C. A review of the progress notes dated on January 2019, identified that housekeeping staff #119 witnessed an incident of inappropriate behaviour by resident #002 towards

resident #005. This was confirmed in an interview with housekeeping staff #119 on an identified date in May 2019. They reported the incident to RN #110.

RN #110 notified the on-call manager and documented they would continue with specific interventions for resident #002 and closely monitor the resident for their specific behaviours.

During an interview with RN #110 on an identified day in May 2019, they stated they assessed the resident and there were no injuries noted. They informed the on-call manager; however, confirmed they did not report this incident to the MOHLTC.

During an interview with PSW #125 on an identified date in June 2019, who provided a specific intervention for resident #002 stated at the time of the incident they were not with the resident.

On an identified day in May 2019, the DON was interviewed and confirmed the specific intervention was in place when this incident happened; however, when PSW #125 took their breaks they were to be replaced with staff from the floor to continue with the specific intervention for resident #002 so that these incidents did not occur.

The DON confirmed that resident #005 was not protected from abuse from resident #002 on an identified date in January 2019.

D. A review of the progress notes dated February 2019, identified that PSW #102 witnessed an incident of inappropriate behaviour by resident #002 towards resident #001 and this was confirmed in an interview with PSW #102. The PSW staff reported the incident to RPN #103

On an identified day in May 2019, RPN #103 was interviewed and stated the incident in February 2019, was reported to them; however, they did not recall if they reported the incident to RN #101. Resident #001 was assessed, there were no injuries noted and they stated that resident #002's behaviour was inappropriate.

The DON confirmed that resident #001 was not protected from abuse from resident #002 on an identified date in February 2019.

E. A CIS was submitted to the Director on an identified date in February 2019, related to allegations of abuse towards resident #001 from resident #002.

In an interview with PSW #112 on an identified date in May 2019, stated they witnessed an incident of inappropriate behavior by resident #002 towards resident #001. PSW #112 reported the incident to RPN #103.

RPN #103 was interviewed and stated they assessed resident #001, no injury was noted.

Review of a specific intervention on an identified date in February 2019, indicated it was in place during the specified time period for resident #002.

In an interview with PSW #111 on an identified date in May 2019, who provided a specific intervention to resident #002 identified they were not with the resident when the incident happened.

During an interview with the DON on an identified date in May 2019, they stated the specific intervention was in place at the time of the incident.

The DON confirmed that resident #001 was not protected from abuse from resident #002 on an identified date in February 2019.

F. A CIS was submitted to the Director on an identified date in March 2019, related to allegations of abuse towards resident #003 by resident #002.

A review of the progress notes dated March 2019, identified that PSW #122 witnessed an incident of inappropriate behaviour from resident #002 towards resident #003. PSW #122 reported the incident to RN #110.

During an interview with RN #110, they stated they assessed resident #003 and there were no injuries noted. They informed the DON of the incident.

The DON confirmed that resident #003 was not protected from abuse from resident #002 on an identified dated in March 2019.

G. A CIS was submitted to the Director on an identified date in March 2019, related to allegations of abuse towards resident #004 from resident #002.

A review of the progress notes dated in March 2019 identified that an incident of

inappropriate behaviour occurred between resident #002 and resident #004.

Review of the specific intervention on an identified date in March 2019, identified the intervention was in place during a specified time period; however, when the LTCH's inspector interviewed the PSW staff that were to provide the specific intervention, they stated they did not provide the intervention to resident #002 on that specific shift.

During an interview with RPN #109 on an identified date in May 2019, they assessed the resident and no injury was noted and reported the incident to the RN.

The DON confirmed that resident #004 was not protected from abuse from resident #002 on an identified date in March 2019.

H. A review of the progress notes documented on an identified date in April 2019, identified that PSW staff witnessed an incident of inappropriate behaviour from resident #002 towards resident #003.

During an interview with RPN #109 on an identified date in May 2019, they stated they did not recall which PSW staff reported the incident to them. Following the incident they assessed resident #003 and did not observe any injury.

The DON confirmed that resident #003 was not protected from abuse from resident #002 on an identified date in April 2019.

I. A CIS was submitted to the Director on an identified date in April 2019, related to allegation of abuse towards resident #005 by resident #002.

A review of the progress notes dated on April 2019, identified that PSW #125 observed an incident of inappropriate behavior by resident #002 toward resident #005 and this was confirmed during an interview on an identified date in May 2019. PSW #125 reported the incident to RPN #124 who assessed the resident and there was no injury noted.

During an interview with RN #110 on an identified date in May 2019, they stated they were informed of the incident by RN #124, they reported the incident to the NM on call and a specific intervention was put in place.

During an interview with DON on an identified date in May 2019, they stated that resident #002 had a specific intervention in place until an identified date in April 2019; however, it

was discontinued as the resident's behaviours had improved. They stated that after the incident the specific intervention was implemented immediately and resident #002 continued to have the intervention to monitor their behaviours on identified shifts.

The DON confirmed that resident #005 was not protected from abuse from resident #002 on an identified day in April 2019.

J. A CIS was submitted to the Director on May 2, 2019, related to allegations of abuse towards resident #005 from resident #002.

A review of the progress notes on an identified date in 2019, identified that a visitor observed an identified incident between resident #002 and resident #005. They reported this incident to RN #101 immediately.

During an interview with RN #101, they stated they assessed the resident and there were no injuries noted.

The DON was interviewed and confirmed the incident did occur and resident #005 was not protected from abuse from resident #002.

K. A CIS was submitted to the Director on an identified date in 2019, related to allegations of abuse towards resident #006 from resident #002.

A review of the progress notes identified that resident #002 was observed by PSW #114 having an inappropriate behaviour towards resident #006. The incident was reported to registered staff.

During an interview with PSW #114, who was the PSW that provided care to resident #002, on the identified shift, they observed the inappropriate behaviour from resident #002 towards resident #006. They reported the incident to registered staff.

RN #110 was interviewed and stated resident #006 was assessed and there were no injuries noted.

During an interview with DON, they confirmed that one of the interventions was in place for resident #002; however, the incident did occur.

The DON confirmed that resident #006 was not protected from abuse from resident

#002.

L. A CIS was submitted to the Director on an identified date in May 2019, related to allegations of abuse towards resident #009 from resident #010.

Review of the progress notes, for an identified date in May 2019, identified that PSW #129 observed an incident between resident #010 and resident #009's.

During an interview with RPN #130, they acknowledged the incident was reported to them by PSW #130 and there was a history of this behaviour.

During an interview with DON, they stated resident #010 displayed inappropriate responsive behaviours and interventions were put in place. They stated the incident was not reported to the on-call manager or MOHLTC until several days later.

The DON confirmed that resident #009 was not protected from abuse from resident #010.

M. A CIS was submitted to the Director on an identified date in 2019, related to allegations of abuse towards resident #011 from resident #002.

Review of the progress notes identified that there was an incident between resident #011 and resident #002 which was observed by PSW #126.

During an interview with PSW #126, they stated the identified intervention was in place; however, the incident occurred. They also stated resident #011 had a history of this behaviour.

RN #110 was interviewed and stated they assessed resident #011 after the incident, there were no injuries noted.

During an interview with the DON they stated that resident #011 did have a history of the identified behaviour.

Following a review of the clinical record, interview of registered and PSW staff and the observation of the residents, the licensee failed to protect resident #011 from abuse. [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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

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

A. Review of the written plan of care for resident #001 identified that a specific device was to be applied on a specified location.

On two identified dates in May 2019, the specified location was observed and the specific device was not in place.

On an identified date in May 2019, PSW #102 was interviewed and stated the resident was to have the specific device in place on a specified location; however, confirmed the device was not in place and did not know where it was.

During an interview with RN #101 on an identified date in May 2019, they stated that resident #001 was to have the device on a specified location as an intervention to manage responsive behaviours, specifically resident #002.

RN #101 confirmed that the care set out in the plan of care was not provided to resident #001 as specified in the plan.

B. Review of the plan of care for resident #002 identified that a specific intervention was in place on various days and times from an identified date in December 2018 to present as an intervention to manage their responsive behaviours.

During an interview on a identified date in May 2019 with RN #101, they stated the specific intervention was provided for resident #002 at various times since admission and stated that it was currently in place due to their inappropriate behaviours.

On an identified date in May 2019, the DON provided inspector with the specific intervention schedule for resident #002. After review of the schedule with the DON they confirmed that the intervention was in place when inappropriate incidents occurred on the following dates: on an identified date in January 2019, two identified dates in February 2019 and one identified date in March 2019.

During an interview with the DON, they stated that specific intervention was to be in place at all times to manage the behaviours of resident #002 and prevent the incidents. They were not able to identify why the specific intervention was not in place when the above incidents occurred. It was the home's expectation that the specific intervention was in place for resident #002.

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

C. Review of the clinical health record identified on an identified date in February 2019, as an intervention due to behaviours towards specific residents, that resident #002 was to have an intervention in place related to nutrition.

Review of the progress note on an identified date in May 2019, documented by the DON indicated as a new intervention that resident #002 was to have their specific interventions related to nutrition.

On two identified dated in May 2019, resident #002 was observed in a specified location related to nutrition and this was confirmed during an interview with PSW #102.

On an identified date in May 2019, RN #101 was interviewed, reviewed the plan of care and stated that resident #002 had an intervention in place for nutrition but it was not being followed.

During an interview with DON they stated they were not aware the resident was not following the intervention in place related to nutrition. They stated this was an intervention to manage resident #002's responsive behaviours.

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

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any system or procedure, the licensee was required to ensure that the system and procedure were complied with.

In accordance with LTCHA s. 84 the licensee was required to implement a quality improvement and utilization review system that monitored, analyzed and improved the quality of the care, services and programs provided to the resident in the long-term care home.

Specifically, the licensee did not comply with their risk management system which included the procedure, which was documented under the licensee's policy, Risk Management, last reviewed on September 3, 2016, which indicated that, "all resident

incidents will be thoroughly investigated, documented and followed-up for purposes of resident safety, potential prevention and analysis. Incidents will be documented in Point Click Care (PCC) and reported according to the following procedure. The registered staff will complete the Risk Management Incident Report Form along with progress notes in PCC, on the shift that the incident occurs on."

A. Review of the progress notes documented on an identified date in January 2019, identified that resident #002 exhibited responsive behaviours towards resident #001. This incident was observed by PSW #121 and was reported to RN #110.

During an interview on an identified date in May 2019, with RN #110, they stated that the incident was documented in the progress notes; however, confirmed that the risk management report was not completed according to the licensee's policy for resident #001 and #002.

The licensee failed to ensure that the Risk Management Policy was complied with.

B. A review of the progress notes on an identified date in March 2019, indicated that resident #002 exhibited inappropriate responsive behaviours towards resident #004.

On an identified date in May 2019, RPN #109 was interviewed and stated that the Risk Management report was to be completed after any incident and on all residents that were involved in the incident. After a review of the clinical record they confirmed that the risk management report was not completed for resident #002 and #004 according to the licensee's policy.

The licensee failed to ensure that the Risk Management Policy was complied with.

C. On an identified date in May 2019, resident #002's progress notes were reviewed which identified that resident #002 exhibited inappropriate behaviours towards resident #006.

During an interview with RN #110 they stated that after any type of incident that occurred with residents, the Risk Management report was to be completed. After a review of the clinical record, they confirmed that the Risk Management Report was not completed for either resident.

The licensee failed to ensure that the Risk Management Policy was complied with.

D. A review of the progress notes documented on an identified date in April 2019 by RPN #109 identified that resident #002 displayed inappropriate responsive behaviours towards resident #003.

RPN #109 was interviewed, reviewed the clinical record and confirmed that the risk management report was not completed for resident #002 and #003 and was to be completed by registered staff at the time of the incident.

The licensee failed to ensure that the Risk Management Policy was complied with.

E. A review of the progress notes documented on an identified date in May 2019, by RPN #130, identified that resident #010 exhibited inappropriate responsive behaviours towards resident #009.

During an interview with RPN #130 they confirmed they did not complete the Risk Management report after the incident occurred.

In an interview with RN #127 they confirmed they did not complete the risk management report on the shift that the incident occurred but stated they did complete it five days later, after directed by DON.

The licensee failed to ensure that the Risk Management Policy was complied with.

F. A CIS report was submitted to the Director which indicated that resident#007 sustained an injury of unknown cause and was transferred to hospital with significant change in status on an identified day in June 2018.

Resident #007's clinical records were reviewed and identified the Risk Management report was not completed for this incident in Point Click Care (PCC). The DON indicated that it was the responsibility of the registered staff to complete the risk management report on the same day of the incident.

The DON confirmed that the report was not completed for this incident and the Risk Management Policy was not complied with. (561) [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any system or procedure, the licensee is required to ensure that the system or procedure was complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A review of the licensee's policy, "Prevention, Reporting & Elimination of Abuse of Residents of LTC Homes", policy number: AM-06-07, last updated on June 19, 2018, directed that all staff and volunteers were required to report abuse. "Staff and volunteers at Macassa/Wentworth Lodge who witness or suspect the abuse of a resident, or who receive complaints of abuse should report the matter immediately to the Mascassa/Wentworth Lodge Administrator (or delegate). Any person may report witnessed or suspected abuse to any of the following: the Administrator (or delegate) of Macassa/Wentworth Lodge, the Ministry of Health and Long Term Care (MOHLTC) and the toll-free Long Term Care Action Line, (calls to the action line may be made anonymously)."

A. Review of the progress notes on an identified date in February 2019, identified that resident #002 exhibited inappropriate responsive behaviours towards resident #001

which resulted in an incident.

During an interview on identified date in May 2019, with PSW #102, they stated they reported the incident to RPN #103.

On an identified date in May 2019, RPN #103 was interviewed and reviewed the progress notes they documented that day which did not identify that they reported the incident to RN #101, a delegate for the Administrator. They stated they did not recall if they informed the RN of the incident.

During an interview with RN #101 on an identified date in May 2019, they stated they did not recall the incident on an identified date in February 2019, being reported to them and stated they would have submitted a Critical Incident System (CIS) report to the MOHLTC.

On an identified date in May 2019, DON was interviewed and confirmed that the requirements for reporting alleged abuse was not reported immediately to the Administrator (or delegate) or to the MOHLTC and it should have been after the incident on an identified date in February 2019. They stated that all allegations of abuse were to be reported to the Administrator or the nurse manager on call immediately.

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

B. Review of the progress notes dated in April 2019, identified that RPN #109 documented that resident #002 was observed by a PSW when they exhibited responsive behaviours towards resident #003.

During an interview with RPN #109 they acknowledged this incident was reported to them by a PSW but could not recall which PSW reported it to them. They stated they would have reported the incident to the RN but after they reviewed their note they confirmed it was not documented that they notified the RN or called the nurse manager on call.

RN #127 was interviewed and did not recall if this incident was reported to them from RPN #109 on an identified date in April 2019. They stated they would have notified the nurse manager on-call and reported the incident to the MOHLTC.

The DON was interviewed and confirmed the requirements for reporting alleged abuse

was not reported immediately to the Administrator (or delegate) or to the MOHLTC and it should have been after the incident occurred on an identified date in April 2019. They stated that all allegations of abuse were to be reported to the Administrator or the nurse manager on call immediately after the incident.

The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with. [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 to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A. On an identified date in September 2018, there was a witnessed incident between resident #001 and resident #002. There were two more witnessed incidents which occurred on an identified dates in January and February 2019, between resident #001 and resident #002.

During an interview with DON, they stated these incidents were reported to management; however confirmed that an immediate investigation of these witnessed abuse incidents by resident #002 towards resident #001 were not initiated.

B. Review of the clinical record indicated on an identified date in January 2019, there was an incident between resident #002 and resident #005 which was witnessed by housekeeping staff.

On an identified date in April 2019, there was an incident between resident #002 and resident #005 which was witnessed by PSW staff.

There was another incident between the same residents witnessed by a visitor on an identified date in May 2019.

During an interview with the DON, they stated the identified incidents noted above between resident #002 and resident #005 were reported to management; however, confirmed an immediate investigation of the witnessed incidents of abuse was not initiated.

C. On an identified date in March 2019, PSW #122 witnessed an incident between resident #002 and resident #003. The incident was reported to management.

During an interview with DON, they stated the resident was to have a specific intervention in place at the time of the incident; however, was unable to state why it was not in place. The DON stated that there was no immediate investigation to determine why the intervention was not in place during a specific time period and that no interviews were completed with the residents or PSW staff.

The DON stated the incident was reported to management; however, confirmed and an immediate investigation of the witnessed abuse was not initiated.

D. On an identified dated in March 2019, resident #002 exhibited responsive behaviours

towards resident #004 and an incident occurred. This incident was reported to management.

In an interview with the DON they stated a specific intervention was to be in place at the time of this incident. The DON acknowledged there was no immediate investigation to determine why the intervention was not in place when the incident occurred and that no interviews were completed with the residents or PSW staff who witnessed the incident.

The DON acknowledged the incident was reported to management; however, confirmed an immediate investigation of the witnessed abuse was not initiated.

E. On an identified date in May 2019, there was a witnessed incident between resident #002 and resident #006. This incident was reported to management.

During an interview with the DON, they acknowledged that the incident was reported to management; however, confirmed an immediate investigation of the witnessed abuse was not initiated. [s. 23. (1) (a)]

2. The licensee failed to ensure that appropriate action was taken in response to every such incident.

On an identified day in May 2019, there was a witnessed incident between resident #010 and resident #009.

During an interview with RPN #130 they acknowledged this incident was reported to them; however, they did not speak to resident #009 or assess the resident post incident for any injuries. They stated they observed resident #009 after the incident with no concerns noted.

RN #127 was interviewed and they stated the RPN reported the incident to them and confirmed they did not assess resident #009 for any injuries.

The licensee failed to ensure that appropriate action was taken in response to every such incident. [s. 23. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that is reported to the licensee is immediately investigated, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of the progress on an identified date in September 2018, identified that resident #002 was observed by PSW #117 exhibiting responsive behaviours towards resident #001 and this was confirmed by PSW #117 in an interview. PSW #117 reported the incident to the RPN.

RN #118 was interviewed and stated they worked on an identified date in September 2018 and this incident was reported to them by RPN #120. They said they assessed the resident, there were no injuries noted. They acknowledged they reported the incident to the Nurse Manager on call; however, confirmed they did not report it to the Ministry of Health and Long Term Care (MOHLTC).

During an interview with DON they acknowledged the incident was reported to them and RN #118 had reasonable grounds to suspect abuse had occurred. They stated RN #118 should have reported this incident to the Long Term Care Homes (LTCH) action line and completed the Critical Incident report to the MOHLTC.

The DON confirmed this incident of alleged abuse was not reported to the Director.

B. A review of the progress notes documented on an identified date in January 2019 and documented by RN #110, identified there was an incident between resident #002 and resident #001. This incident was observed by PSW #121.

PSW #121 was interviewed and confirmed they witnessed the incident, intervened and reported the incident to registered staff.

During an interview with RN #110 they acknowledged the incident documented above was reported to them and they reported the incident to the Nurse Manager on call; however, did not report it to the MOHLTC. RN #110 stated that this was inappropriate behaviour and both residents were unable to make informed decisions and had an identified cognitive status.

During an interview with the DON they acknowledged the incident was reported to them and RN #110 had reasonable grounds to suspect abuse had occurred. They stated RN #110 should have reported this incident to the Long Term Care Homes action line and completed the Critical Incident System (CIS) report to the MOHLTC.

The DON confirmed this incident of alleged abuse was not reported to the Director.

C. A CIS report was submitted to the Director in March 2019, related to allegations of abuse towards resident #004 from resident #002.

A review of the progress notes documented on an identified date in March 2019,

identified there was an incident between resident #002 and resident #004.

During an interview with RPN #109 they stated that resident #004 was affected by the incident, they assessed the resident and there was no injury noted. The incident was reported to the RN.

During an interview with DON, they stated the RN did not notify the Nurse Manager on call of the incident and did not report this incident to the LTCH action line when it happened on an identified date in March 2019. DON stated they submitted the CIS report two days later after the incident was brought to their attention.

The DON confirmed this incident was not reported immediately to the Director when registered staff had reasonable grounds to suspect abuse.

D. A review of the progress notes on an identified date in January 2019, identified resident #002 was observed by housekeeping staff #119 exhibiting responsive behaviours towards resident #005 which resulted in an incident. They reported the incident to RN #110

During an interview with RN #110 they stated they assessed the resident and there were no injuries noted. They informed the on-call manager but stated they did not report this incident to the MOHLTC.

In an interview with housekeeper #119 they acknowledged they witnessed an incident between resident #002 and resident #005, intervened and reported the incident to RN #110.

During an interview with the DON they acknowledged the on-call manager was informed of the incident; however, it was not reported to the LTCH action line when the incident happened and a CIS report was not submitted to the Director. They stated that the RN on duty at the time of the incident should have reported the incident to the MOHLTC.

The DON confirmed this incident was not reported immediately to the Director when registered staff had reasonable grounds to suspect abuse.

E. A CIS report was submitted to the Director on an identified date in May 2019, related to allegations of abuse towards resident #009 from resident #010.

Review of the progress notes documented on an identified date in May 2019, identified that PSW #129 observed the incident between resident #010 and resident #009 and intervened.

During an interview with RPN #130, they stated that PSW #129 reported the incident and they reported the incident to RN #127.

RN #127 was interviewed and acknowledged that the incident was reported to them by RPN #130; however, confirmed they did not report the incident to the on-call manager or to the MOHLTC.

During an interview with DON they stated the incident was not reported to the on-call manager and they were informed of the incident four days later. They confirmed that RN #127 had reasonable grounds to suspect abuse had occurred and they should have reported this incident to the Long Term Care Homes action line and completed the Critical Incident System report to the MOHLTC.

The DON confirmed this incident was not reported to the Director until four days after the incident occurred. [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 a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director including abuse of a resident by anyone that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #7: 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 failed to ensure that for each resident who demonstrated responsive behaviours had strategies developed and implemented to respond to these behaviours.

Review of the clinical record for resident #002 identified between an identified date in September 2018 and June 2019, they had 12 incidents of inappropriate behaviour involving several different identified residents.

Following a referral for an assessment on and identified date in January 2019, the home received a detailed assessment from an external consultant after they assessed resident #002. The assessment noted several possible triggers of resident #002's responsive behaviours and they recommended that the staff may want to try several strategies which they outlined in the report.

A referral was sent for another assessment related to resident #002's ongoing behaviours towards specified residents and additional suggestions were made.

During an interview with Recreation staff #132 and the Supervisor of Resident Services, who reviewed the external report and recommendation and they stated they had never seen the identified report nor discussed the contents/interventions with other members of the care team. Recreation staff #132 stated they were not involved in specific activities for the resident to do in an identified location but did provide specific programming at specified times.

In an interview with the full time evening RN #110 following a review of the specialist recommendations confirmed that most of the recommendations were not considered or implemented in the care for resident #002 and were not able to identify why this was not completed.

In an interview with the DON they confirmed that the recommendations made by the specialized resources were not reviewed and implemented into resident #002's plan of care and were not able to provide a reason why this was not completed. They stated moving forward that all external resource staff would be attending their monthly responsive behaviour meetings and would trial/implement interventions identified by the outside resources in an effort to manage the resident's behaviours.

The DON confirmed the licensee failed to implement strategies to respond to resident #002's responsive behaviours. [s. 53. (4) (b)]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A. Review of the clinical record revealed that on an identified date in April 2019, resident #002 exhibited responsive behaviours towards resident #003, which resulted in an incident.

During an interview with Nurse Manager (NM) #001, they confirmed the incident was documented in resident #002's clinical record; however, was not documented in the clinical record of resident #003. They stated that all registered staff were expected to document all incidents between residents in both resident's charts.

NM #001 confirmed that not all actions taken with respect to the incident involving resident #003 under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

B. A review of the clinical record revealed that on an identified date in May, 2019, resident #002 exhibited responsive behaviours towards resident #006, which resulted in an incident.

During an interview with the DON, they confirmed that the incident was documented in resident #002's clinical record; however, was not documented in the clinical record of resident #006. They stated that the incident should have been documented in both charts.

The DON confirmed that not all actions taken with respect to the incident involving resident #006 under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented. [s. 30. (2)]

WN #9: 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 substitute decision maker, if any, and any other person specified by the resident, were notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse of the resident.

A. Review of the clinical record identified on an identified date in April 2019, resident #002 exhibited responsive behaviours towards resident #003, which resulted in an incident. This incident was reported to the RPN #109.

During an interview and review of the clinical record with RPN #109, they stated they did not notify resident #003's substitute decision maker (SDM) after resident #002 exhibited responsive behaviours towards resident #003, which resulted in an incident.

RPN #109 confirmed that resident #003's SDM was not notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse of the resident.

B. Review of the clinical record identified on an identified date in March 2019, resident #002 was observed by PSW staff exhibiting responsive behaviours towards resident #004, which resulted in an incident.

During an interview and review of the clinical record with RPN #109, they acknowledged that this incident was reported to them. They stated they did not notify resident #004's

SDM after they were informed of the witnessed incident.

RPN #109 confirmed that resident #004's SDM was not notified within 12 hours upon the licensee becoming aware of any witnessed incident of abuse of the resident.

C. A CIS report was submitted to the Director in May 2019, related to allegations of abuse towards resident #009 from resident #010.

Review of the progress notes on an identified date in May 2019, indicated that PSW #129 observed resident #010 when they exhibited responsive behaviours towards resident #009, which resulted in an incident.

During an interview with RPN #130, they acknowledged that PSW #129 reported the incident and they reported the incident to RN #127; however, confirmed they did not notify the SDMs for resident #009 and #010.

In an interview with RN #127 they confirmed the incident was reported to them; however, they did not notify resident #009 and #010's SDM that the incident had occurred.

RPN #130 and RN #127 confirmed that resident #009 and #010's SDM's were not notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse of the resident. [s. 97. (1) (b)]

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

Findings/Faits saillants :

1. The licensee failed to ensure that an analysis of every incident of abuse was undertaken promptly after the licensee became aware of it.

In an interview with the DON it was confirmed that an analysis of all incidents of abuse were not completed in the home's 2018 program evaluation for Abuse and Neglect. [s. 99. (a)]

2. The licensee failed to ensure that a written record of everything provided for in the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents, including the date, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented was prepared.

In an interview with the DON they stated that a program evaluation of abuse was completed for 2018; however confirmed it did not include the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented. [s. 99. (e)]

Issued on this 8th day of August, 2019

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DIANNE BARSEVICH (581), DARIA TRZOS (561)
Inspection No. / No de l'inspection :	2019_573581_0005
Log No. / No de registre :	017184-18, 004862-19, 008683-19, 009186-19, 009233-19, 010371-19, 011351-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 12, 2019
Licensee / Titulaire de permis :	City of Hamilton 28 James Street North, 4th Floor, HAMILTON, ON, L8R-2K1
LTC Home / Foyer de SLD :	Wentworth Lodge 41 South Street West, DUNDAS, ON, L9H-4C4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Karen Allcroft

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

To City of Hamilton, 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)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with LTCHA, 2007 s. 19 (1).
Specifically the licensee shall ensure:
a) Resident #001, #003, #004, #005, #006, #009, #011 and all other residents, be protected from abuse by resident #002 and #010.
b) Resident #002 and #010, and all other residents, that are known to staff to demonstrate responsive behaviours, have interventions in place to monitor the resident(s) for their behaviours and interventions are implemented to protect other residents from abuse.
c) All staff receive training on the definition of abuse and the licensee's policy on mandatory reporting of any alleged, suspected or witnessed abuse.

Grounds / Motifs :

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

A. Review of the progress notes dated on September 2018, identified that Personal Support Worker (PSW) #117 witnessed an incident of inappropriate behaviour by resident #002 towards resident #001 and this was confirmed through an interview with PSW #117 on an identified date in May 2019. The incident was reported to Registered Practical Nurse (RPN) #120.

Registered Nurse (RN) #118 was interviewed and stated they worked on the specified day of the incident and assessed the resident and there were no injuries noted. They acknowledged they reported the incident to the Nurse Manager (NM) on call; however, did not report it to the Ministry of Health and Long Term Care (MOHLTC).

The Director of Nursing (DON) confirmed that resident #001 was not protected from abuse from resident #002.

B. A review of the progress notes dated on January 2019, identified that PSW #121 witnessed an incident of inappropriate behaviour by resident #002 towards resident #001 and this was confirmed in an interview with PSW #121 on an identified date in June 2019. This incident was reported to the registered staff.

During an interview with RN #110 on an identified date in May 2019, they acknowledged that the incident was reported to them and they reported the incident to the NM on call; however, did not report it to the MOHLTC.

The DON confirmed that resident #001 was not protected from abuse from resident #002.

C. A review of the progress notes dated on January 2019, identified that housekeeping staff #119 witnessed an incident of inappropriate behaviour by resident #002 towards resident #005. This was confirmed in an interview with housekeeping staff #119 on an identified date in May 2019. They reported the incident to RN #110.

RN #110 notified the on-call manager and documented they would continue with specific interventions for resident #002 and closely monitor the resident for their specific behaviours.

During an interview with RN #110 on an identified day in May 2019, they stated they assessed the resident and there were no injuries noted. They informed the on-call manager; however, confirmed they did not report this incident to the MOHLTC.

During an interview with PSW #125 on an identified date in June 2019, who provided a specific intervention for resident #002 stated at the time of the incident they were not with the resident.

On an identified day in May 2019, the DON was interviewed and confirmed the specific intervention was in place when this incident happened; however, when PSW #125 took their breaks they were to be replaced with staff from the floor to

continue with the specific intervention for resident #002 so that these incidents did not occur.

The DON confirmed that resident #005 was not protected from abuse from resident #002 on an identified date in January 2019.

D. A review of the progress notes dated February 2019, identified that PSW #102 witnessed an incident of inappropriate behaviour by resident #002 towards resident #001 and this was confirmed in an interview with PSW #102. The PSW staff reported the incident to RPN #103

On an identified day in May 2019, RPN #103 was interviewed and stated the incident in February 2019, was reported to them; however, they did not recall if they reported the incident to RN #101. Resident #001 was assessed, there were no injuries noted and they stated that resident #002's behaviour was inappropriate.

The DON confirmed that resident #001 was not protected from abuse from resident #002 on an identified date in February 2019.

E. A CIS was submitted to the Director on an identified date in February 2019, related to allegations of abuse towards resident #001 from resident #002.

In an interview with PSW #112 on an identified date in May 2019, stated they witnessed an incident of inappropriate behavior by resident #002 towards resident #001. PSW #112 reported the incident to RPN #103.

RPN #103 was interviewed and stated they assessed resident #001, no injury was noted.

Review of a specific intervention on an identified date in February 2019, indicated it was in place during the specified time period for resident #002.

In an interview with PSW #111 on an identified date in May 2019, who provided a specific intervention to resident #002 identified they were not with the resident when the incident happened.

During an interview with the DON on an identified date in May 2019, they stated the specific intervention was in place at the time of the incident.

The DON confirmed that resident #001 was not protected from abuse from resident #002 on an identified date in February 2019.

F. A CIS was submitted to the Director on an identified date in March 2019, related to allegations of abuse towards resident #003 by resident #002.

A review of the progress notes dated March 2019, identified that PSW #122 witnessed an incident of inappropriate behaviour from resident #002 towards resident #003. PSW #122 reported the incident to RN #110.

During an interview with RN #110, they stated they assessed resident #003 and there were no injuries noted. They informed the DON of the incident.

The DON confirmed that resident #003 was not protected from abuse from resident #002 on an identified dated in March 2019.

G. A CIS was submitted to the Director on an identified date in March 2019, related to allegations of abuse towards resident #004 from resident #002.

A review of the progress notes dated in March 2019 identified that an incident of inappropriate behaviour occurred between resident #002 and resident #004.

Review of the specific intervention on an identified date in March 2019, identified the intervention was in place during a specified time period; however, when the LTCH's inspector interviewed the PSW staff that were to provide the specific intervention, they stated they did not provide the intervention to resident #002 on that specific shift.

During an interview with RPN #109 on an identified date in May 2019, they assessed the resident and no injury was noted and reported the incident to the RN.

The DON confirmed that resident #004 was not protected from abuse from resident #002 on an identified date in March 2019.

H. A review of the progress notes documented on an identified date in April 2019, identified that PSW staff witnessed an incident of inappropriate behaviour from resident #002 towards resident #003.

During an interview with RPN #109 on an identified date in May 2019, they stated they did not recall which PSW staff reported the incident to them. Following the incident they assessed resident #003 and did not observe any injury.

The DON confirmed that resident #003 was not protected from abuse from resident #002 on an identified date in April 2019.

I. A CIS was submitted to the Director on an identified date in April 2019, related to allegation of abuse towards resident #005 by resident #002.

A review of the progress notes dated on April 2019, identified that PSW #125 observed an incident of inappropriate behavior by resident #002 toward resident #005 and this was confirmed during an interview on an identified date in May 2019. PSW #125 reported the incident to RPN #124 who assessed the resident and there was no injury noted.

During an interview with RN #110 on an identified date in May 2019, they stated they were informed of the incident by RN #124, they reported the incident to the NM on call and a specific intervention was put in place.

During an interview with DON on an identified date in May 2019, they stated that resident #002 had a specific intervention in place until an identified date in April 2019; however, it was discontinued as the resident's behaviours had improved. They stated that after the incident the specific intervention was implemented immediately and resident #002 continued to have the intervention to monitor their behaviours on identified shifts.

The DON confirmed that resident #005 was not protected from abuse from resident #002 on an identified day in April 2019.

J. A CIS was submitted to the Director on May 2, 2019, related to allegations of

abuse towards resident #005 from resident #002.

A review of the progress notes on an identified date in 2019, identified that a visitor observed an identified incident between resident #002 and resident #005. They reported this incident to RN #101 immediately.

During an interview with RN #101, they stated they assessed the resident and there were no injuries noted.

The DON was interviewed and confirmed the incident did occur and resident #005 was not protected from abuse from resident #002.

K. A CIS was submitted to the Director on an identified date in 2019, related to allegations of abuse towards resident #006 from resident #002.

A review of the progress notes identified that resident #002 was observed by PSW #114 having an inappropriate behaviour towards resident #006. The incident was reported to registered staff.

During an interview with PSW #114, who was the PSW that provided care to resident #002, on the identified shift, they observed the inappropriate behaviour from resident #002 towards resident #006. They reported the incident to registered staff.

RN #110 was interviewed and stated resident #006 was assessed and there were no injuries noted.

During an interview with DON, they confirmed that one of the interventions was in place for resident #002; however, the incident did occur.

The DON confirmed that resident #006 was not protected from abuse from resident #002.

L. A CIS was submitted to the Director on an identified date in May 2019, related to allegations of abuse towards resident #009 from resident #010.

Review of the progress notes, for an identified date in May 2019, identified that

PSW #129 observed an incident between resident #010 and resident #009's.

During an interview with RPN #130, they acknowledged the incident was reported to them by PSW #130 and there was a history of this behaviour.

During an interview with DON, they stated resident #010 displayed inappropriate responsive behaviours and interventions were put in place. They stated the incident was not reported to the on-call manager or MOHLTC until several days later.

The DON confirmed that resident #009 was not protected from abuse from resident #010.

M. A CIS was submitted to the Director on an identified date in 2019, related to allegations of abuse towards resident #011 from resident #002.

Review of the progress notes identified that there was an incident between resident #011 and resident #002 which was observed by PSW #126.

During an interview with PSW #126, they stated the identified intervention was in place; however, the incident occurred. They also stated resident #011 had a history of this behaviour.

RN #110 was interviewed and stated they assessed resident #011 after the incident, there were no injuries noted.

During an interview with the DON they stated that resident #011 did have a history of the identified behaviour.

Following a review of the clinical record, interview of registered and PSW staff and the observation of the residents, the licensee failed to protect resident #011 from abuse. [s. 19. (1)]

This order is made up on the application of the factors of severity (2), scope (3) and compliance history (3). This is in respect to the severity of minimal harm or minimal risk that the identified residents experienced, the scope of this being widespread incidents. The home had a level 3 history as they had previous non-

compliances to the same subsection of the LTCHA that included:
- written notification (WN) issued October 9, 2018, (2018_689586_0022),
- WN issued September 2017, (2017_556168_0024),
- Compliance Order (CO) by Director issued December 7, 2018, (2018_689586_022), (A1), (Appeal/Dir# DR# 099),
- Follow-Up Director Order complied March 25, 2019, (2019_560632_006).

(581)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 11, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 12th day of July, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Dianne Barsevich

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