Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
May 25, 2020	2019_808535_0017 (A2)	009571-19, 010689-19	Complaint

Licensee/Titulaire de permis

West Park Healthcare Centre
82 Buttonwood Avenue TORONTO ON M6M 2J5

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

West Park Long Term Care Centre
82 Buttonwood Avenue TORONTO ON M6M 2J5

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

Amended by VERON ASH (535) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Home requested extension to compliance due dates for orders #001, #002 and #003 due to COVID-19 outbreak. CDD extended to September 24, 2020.

Issued on this 25th day of May, 2020 (A2)

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

Original report signed by the inspector.

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Ministry of Long-Term Care

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

Amended by VERON ASH (535) - (A2)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 23, 24, 25, 28, 29, 30, 31, November 1, 4, 6, Off-site 7, 8, 13, 14, 15, 21, 22, 25, 2019.

The following intakes were completed during this inspection: Log #010689-19 (related to verbal abuse and neglect) and log #009571-19 (related to personal support services).

PLEASE NOTE: A Written Notification and Compliance Order and a Written Notification and Compliance Order related to LTCHA, 2007, c. 8, s. 24 (1) and O. Reg. 79/10, s. 53 (4) (a) & s. 53 (4) (c), identified in a concurrent critical incident inspection #2019_808535_0018, were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant DOCs (ADOCs), Resident Assessment Instrument (RAI) Coordinator, Behavior Support Outreach (BSO) Manager, Resident Program Manager (RPM), Recreation Assistant (RA), nursing clerk, receptionist, housekeeping staff, registered staff RN/RPN; personal support worker (PSW), Substitute Decision Makers (SDMs) and residents.

During the course of the inspection, inspectors made observations related to the home's care processes; staff to resident, and resident to resident interactions; conducted record reviews, and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Responsive Behaviours
Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.
6 WN(s)
3 VPC(s)
3 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #017 and #009's rights to be treated with courtesy and respect and in a way that fully recognized their individuality and respects their dignity, were fully respected and promoted.

The Ministry of Long-Term Care (MLTC) received a complaint on an identified date, related to neglect of a resident.

Record review indicated that resident #017 was admitted to the home on an identified date and was assessed using the home's Resident Assessment Instrument - Minimum Data Set (RAI-MDS).

On an identified date, while sitting in their wheelchair in their room, Inspector #535 approached and communicated with resident #017 regarding resident #009's responsive behaviors. Resident #017 responded immediately and was visibly affected negatively by witnessing the behavior.

During the interview, resident #017 stated that they reported how they felt about the situation to staff numerous times, but nothing happened in the end.

During separate interviews, PSW #101 and registered staff RPN #129 verified that resident #009 displayed that responsive behavior sometimes once or multiple times each day. According to PSWs, registered staff and housekeeping staff working on the unit, the resident displayed this behavior spontaneously and sporadically.

During an interview, BSO Manager #131 verified that resident #009 was assessed by the appropriate BSO team, and that the resident was referred to an external BSO team and was waiting for an appointment to be transferred to an external

facility for further assessment and treatment.

During an interview, ADOC #118 verified that they have witnessed resident #009's display responsive behavior; and agreed that there was a breach in privacy, dignity and respect related to resident #009 and #017 who were subjected to this behavior repeatedly. The ADOC acknowledged that resident #009's behavior would have a negative impact on other residents and visitors in the home as well, although they might not have complained about it. The staff seem to have accepted resident #009's behavior because they have normalized the behavior and were looking to management to provide new ways of managing the resident's responsive behavior. [s. 3. (1) 1.]
(535)

2. On an identified date, while conducting an inspection in the home, Inspectors #535 and #762 observed resident #015 displaying a responsive behavior outside the consultant room where the inspectors were working.

Approximately 20 - 30 minutes later, the inspectors heard another resident calling loudly outside the door of the consultant room where they were working. Inspector #535 observed that resident #016 was visibly affected by resident #015's displayed responsive behavior which prompted them to calling for help.

Record review indicated resident #015 was admitted to the home on an identified date; and was assessed using the RAI-MDS tool.

During an interview, the resident's family member and substitute decision-maker (SDM) stated that they had never seen their family member displaying the responsive behavior; and that they would not want to witness the behavior. Furthermore, they commented that staff, residents and other people visiting the home would see them displaying the behavior, and the SDM stated the lack of dignity witnessing the behavior.

During an interview, PSW #101 and RPN #133 verified the resident's responsive behavior. RPN #133 stated that since their admission to the home, the resident displayed the behavior at times. The RPN verified that visitors have also seen the resident's displayed responsive behavior. [s. 3. (1) 1.] (535)

3. The Ministry of Long-Term Care received a complaint on an identified date, related to verbal abuse and neglect.

Record review indicated that resident #009 was admitted to the home on an identified date and was assessed using the home's RAI-MDS tool.

Record review of the complaint and an interview with the complainant who was also a resident in the home (resident #008), indicated that on an identified date, resident #008 visited the unit were resident #009 resided. Upon entry to the unit, resident #008 observed that resident #009 was displaying a responsive behavior close to the dining room and the nursing station.

Record review indicated that resident #009 had an identified responsive behavior which occurred almost daily and often multiple times each day. According to multiple staff and the complainant, this identified behavior was displayed because of a possible trigger.

On an identified date, the inspector visited the resident's room with the intent to speak with the resident. Upon initial entry to the room, the inspector observed that the resident was displaying a responsive behavior; and was tended to by two PSWs who provided care and support for the resident.

During separate interviews, PSW #101, registered staff RN #129, RPNs #136, #112, Recreation Assistant #107 and resident #017 verified that they have witnessed resident #009's responsive behavior; sometimes several times during the day. Furthermore, PSW #101 described multiple encounters with resident #009 while displaying the behavior.

PSW #101, RN #129, RPN #136 and RPN #102 verified that resident #009's behavior was witnessed by multiple resident, staff, and family members who visited other residents on the unit.

During separate interviews PSW #101, RN #129, ADOC #118, DOC #100 and BSO Manager #131 verified that resident #009's display of responsive behavior in the presence of others showed a lack of privacy and dignity.

Therefore, the home failed to ensure that residents #009, #015, #016, #017 were fully respected and promoted the residents' rights to be treated with courtesy and respect and in a way that fully recognized their individuality and respects their dignity. [s. 3. (1) 1.] (535)

Additional Required Actions:

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

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that anyone who had reasonable grounds to suspect the abuse of a resident may have occurred, should immediately report

the suspicion and the information upon which it was based to the Director.

The Ministry of Long-Term Care received a complaint on an identified date, related to verbal abuse of residents.

Record review of the complaint and an interview with the complainant who was also a resident in the home (resident #008), indicated that on an identified date, resident #008 visited the unit were resident #009 resided and both residents were verbally abused by a third resident #010.

During an interview, Recreational Assistant (RA) #107 recalled the incident since they transported resident #008 to visit with resident #009 on their unit. The RA described the presence of co-resident #010 who was using multiple unkind words directed at residents #008 and #009. The RA reported the incident to registered staff RN #129.

During an interview, RN #129 stated that they were aware that resident #008 came to visit with resident #009, and verified that they 'heard an argument out there'. The RN stated that they did not see what happened, and they did not hear what resident #010 had said. The RPN verified that they had witnessed resident #010 being verbally abusive to others in the past; however, they denied that resident #010 verbally abused resident #008 and resident #009 during this incident. The RN stated that they did not report the incident which occurred during the shift to management since it was the week-end. The RN stated that they documented the incident; and they might have told staff on the next shift.

During an interview, ADOC #118 stated that they were not aware of the incident until the initiation of this inspection. The ADOC stated that they did not receive a message from the RN working the shift that weekend; but acknowledged that they should have been notified of the incident for reporting purposes. The ADOC verified that verbal abuse should be reported to the Director immediately, and that this incident was not reported since they were not aware the incident had occurred. During an interview, DOC #100 also stated that they were not aware of the incident and it should have been reported to the Director immediately. During separate interviews, the ADOC and DOC commented that staff seemed to have normalized resident's responsive behaviors on the units.

b) The MLTC received a CIS report on an identified date, related to an incident for which the resident was transferred to hospital with an unknown injury.

Record review of the critical incident report and the home's investigation notes indicated that on an identified date, resident #007 was transferred by PSW #138, and the resident sustained an injury which resulted in their transfer to hospital on a later identified date.

The home was informed later that day by the resident's SDM, that the resident sustained an identified injury as a result of the incident, however the critical incident was reported to the Director on a later identified date. During an interview, DOC #100 acknowledged that the incident should have been reported to the Director as soon as the home became aware of the resident's injury and the circumstances related to the resident's injury.

c) A CIS report was submitted to the MLTC on an identified date, by ADOC#118 related to an incident that occurred to resident #002.

Record review of the CIS report indicated that a PSW reported to the nurse that resident #002 had an injury to an identified body part. Physician and family were notified. Resident #002 was transferred to the hospital for assessment. The cause of injury was unknown, and an investigation was initiated.

The amended CIS report was submitted to the MLTC on another identified date. Review of the amended CIS report indicated that resident #002 received a diagnosed injury, had a scheduled procedure, and returned to the home on an identified date. Further review of the amended report indicated that the home had reviewed the surveillance video footage and became aware of the cause of injury. Detailed information regarding actions the home took were not provided.

In an interview, DOC #100 confirmed that the incident occurred to resident #002 on the identified date as shown in the surveillance video footage. The DOC stated that during the investigation, they reviewed the surveillance video footage and discovered that resident #002 sustained an injury the day before the resident was transferred to hospital. The DOC stated that the nurse did not complete the appropriate assessments because the PSW told the nurse that they had guarded the resident from being injured.

In an interview, RPN #102 acknowledged that they did not direct the PSW to monitor resident #002 after the incident which caused their injury, they did not notify the family regarding the incident, they did not document the incident and

they did not inform the staff on the following shift that an incident had occurred during shift report. RPN #102 confirmed that they left the resident sitting in the television room after the incident occurred. RPN #102 acknowledged that the way they managed resident #002's fall incident on that identified date, would constitute neglect. RPN #102 stated that during the home's investigation interview, the management staff said that the incident would constitute neglect, and they agreed with management staff.

In an interview, ADOC #118 stated that they should have reported the incident to the MLTC at the time when they identified neglect of resident #002 by the staff during the investigation.

Therefore, the home failed to ensure that anyone who had reasonable grounds to suspect the abuse of residents #002, #007, #008 and #009, immediately report the suspicion and the information upon which it was based to the Director. [s. 24. (1)] (535)

Additional Required Actions:

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

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure behavioral triggers were identified for the resident demonstrating responsive behaviors where possible.

On an identified date, while conducting an inspection in the home, Inspectors #535 and #762 observed resident #015 displaying a responsive behavior. Approximately 20 - 30 minutes later, the inspectors heard a co-resident calling loudly outside the door of the same consultant room where they were working. Inspector #535 opened the door and observed that co-resident #016 appeared to be affected when they saw resident #015 displaying responsive behavior.

Record review indicated resident #015 was admitted to the home on an identified date and was assessed using the home's RAI-MDS assessment tool.

During an interview, BSO Manager #131 stated they could not recall the resident being referred to an external Behavior Support Outreach Team (BSOT) related to their responsive behavior to support identifying possible triggers for the behavior. The BSO Manager stated that the staff who worked on the unit seemed to have 'normalized the resident's behavior' as a result of witnessing the behavior frequently and since the resident was admitted to the home. Furthermore, the BSO Manager verified that the physician recently wrote a few orders to try to identify the trigger for the resident's responsive behavior. [s. 53. (4) (a)] (535)

2. The Ministry of Long-Term Care received a complaint on an identified date, related to verbal abuse of a resident.

Record review indicated that resident #010 was admitted to the home on an identified date and was assessed using the home's RAI-MDS assessment tool.

Record review of the complaint report indicated that resident #010 was involved in an altercation with residents #008 and #009 on an identified date. A review of the complaint record and staff interviews indicated that resident #010 frequently displayed responsive behaviors and engaged in altercations with other residents on the unit.

During an interview, PSW #101 verified resident #010's involvement in the specific incident with resident #009 and #008, which affected both residents. PSW #101 stated resident #010 had multiple identified responsive behaviors and 'was hard to deal with'.

A review of resident #010's written care plan indicated a list of responsive behaviors; however, there were no known identified triggers.
During separate interviews, DOC #100, RN #129, ADOC #118, RAI Coordinator #130 verified that resident #010 displayed responsive behaviors and engaged in behavioral altercations with other residents and staff on the unit. During an interview, BSO Manager #131 also verified that the resident engaged in multiple altercations as a result of their responsive behaviors. According to the BSO Manager, they had multiple discussions with this resident about respecting residents' rights and respecting all residents personal space. The BSO Manager verified that the resident refused to be seen by members of the BSO team and therefore, behavior triggers were not identified. [s. 53. (4) (a)] (535)

3. The MLTC received a CIS report on an identified date, related to an incident for which the resident was transferred to hospital.

Record review indicated that resident #006 experienced recent bouts of responsive behaviors on the unit.

During separate interviews, PSWs #105 and #106 stated that recently resident #006 started displaying new responsive behaviors.

During an interview, registered staff RN #104, BSO Manager #131 and ADOC #118 stated they were not aware that the resident was displaying those behaviors.

During an interview, BSO Manager #131, verified that the resident was assessed and referred to the external BSO team after an unrelated incident had occurred on the unit; however, they were not aware that the resident was displaying new behaviors. The BSO manager acknowledged that these behavior triggers were not yet identified, and there were no strategies in place to address those behaviors.

Therefore, the home failed to ensure behavioral triggers were identified for residents #006, #010 and #015 who were demonstrating responsive behaviors. [s. 53. (4) (a)] (535)

4. The licensee has failed to ensure that actions were taken to meet the needs of the resident with responsive behaviors included documentation of the resident's responses to the intervention.

The Ministry of Long-Term Care received a complaint on an identified date, related to verbal abuse of a resident.

Record review of the complaint and an interview with the complainant who was also a resident in the home (resident #008), indicated that on an identified date, resident #008 visited the unit were resident #009 resided. During the visit on the second-floor, resident #010 displayed responsive behaviors towards residents #008 and #009.

During an interview, Recreational Assistant (RA) #107 verified that they witnessed the altercation by resident #010 towards resident #008 and #009 on the unit. The RA stated that they immediately went into the nursing office, which was near the location of the incident, and informed registered staff RN #129. The RA also stated that resident #008 was affected by the incident.

During an interview, RN #129 stated that they did not see what had happened during the identified incident. The RN verified that they had witnessed resident #010 engaging in altercations with residents on the unit in the past; but denied that resident #010 verbally abused resident #008 and #009 during this incident.

Record review of the progress notes indicated there was documentation of the incident by the recreation assistant; however, there was no documentation in PCC

from RN #129 on that date related to an incident involving all three residents.

During an interview, ADOC #118 verified that the registered staff did not document the incident in PCC, and stated that their expectation was that the registered staff should inform the ADOC when such incidents occur; and that RN #129 should have documented the incident in PCC along with the outcome of their actions and the status of all residents involved.

Therefore, the home failed to ensure that actions were taken to meet the needs of resident #010 with responsive behaviors including documentation of the resident's responses to interventions as applicable. [s. 53. (4) (c)] (535)

Additional Required Actions:

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

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 003

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

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan had not been effective.

The MLTC received a complaint related to the provision of recreational activities for the residents in the home during an identified period. Resident #004 was one of the three residents who were selected for review.

The resident was assessed using the home’s RAI-MDS assessment tool on an identified date, and had multiple diagnoses listed.

Record review of the Medication Administration Record during an identified period, indicated that resident #004 was fed by an alternative method.

Review of resident #004’s care plan indicated under the focus of psychosocial/activities multiple interventions.
.
In an interview, resident #004’s SDM stated that the resident used to participate in multiple activities; however, SDM had not seen any increase in activities provided

for resident #004 although they had requested specific activities to be provided.

In an interview, Recreational Assistant #115 acknowledged that they had not done a re-assessment for resident #004; and that they were aware of the family's request for specific activities.

In an interview, the Resident Programs Manager (RPM) #116 stated the staff should have brought the request from resident #004's family forward to them. RPM #116 reviewed resident #004s recent activity participation reports and their care plan, then acknowledged that most of the interventions/activities written in resident #004s care plan were no longer effective and the recreation staff should have reassessed the resident's needs, and review and revised the resident's care plan accordingly.

Therefore, the home failed to ensure that resident #004 was reassessed and the plan of care reviewed and revised when the care set out in the plan had not been effective. [s. 6. (10) (c)] (726)

2. The licensee has failed to ensure that if a resident was being reassessed and the plan of care was being revised because the care set out in the plan of care had not been effective, a different approach had been considered in the revision of the plan of care.

The Ministry of Long-Term Care received a complaint on an identified date, related to verbal abuse and neglect of a resident.

Record review of the complaint and an interview with the complainant who was also a resident in the home (resident #008), indicated that on an identified date, resident #008 visited the unit were resident #009 resided. Upon entry to the unit, resident #008 observed that resident #009 was displaying responsive behavior in an open area between the dining room and the nursing station.

During an interview, PSW #101 stated that they find resident #009 displaying that behavior a lot; and that the intervention listed in the resident's care plan was not effective since the resident continued to display the behavior even when the intervention was put in place.

During an interview, registered staff RPN #129 verified that the interventions listed in the care plan should be reviewed and revised since those strategies were not

effective.

During an interview, ADOC #118 acknowledged that the interventions in the resident care plan were not effective; and verified that the resident's plan of care should be reviewed and updated with new approaches and strategies to manage the resident's responsive behavior. [s. 6. (11) (b)] (535)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan has not been effective, and
that if the plan of care is being revised because care set out in the plan has not been effective, different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by resident #004 at all times.

The MLTC received a complaint related to shortage of staff, inconsistent staffing and provision of recreational activities for the residents in the home during an identified time period. Resident #004 was one of the three residents who were selected for review.

The resident was assessed using the home's RAI-MDS assessment tool.

Review of resident #004's kardex indicated an intervention to check call bell on every shift. A review of resident #004's care plan indicated that one intervention listed was to promote the use of the call bell.

On an identified date and time, the inspector observed resident #004 sitting their room watching television. The inspector observed the call bell was placed on the resident's bed (close to the head of the bed). The call bell could not be easily accessed by resident #004 as the resident was sitting in a chair which was a few feet away from the bed.

In interviews, PSW #108 and RPN #109 acknowledged that the staff should have placed the call bell within reach of resident #004 when the resident was sitting in the chair away from their bed.

In an interview, the DOC (#100) acknowledged that the call bell should be placed within reach for every resident at any time regardless of their ability or risks. [s. 17. (1) (a)] (726)

2. As a result of non-compliance related to resident #004, residents #012 and #013 were selected to increase the sample size.

Resident #012 was assessed using the home's RAI-MDS assessment tool. A review of the resident's clinical records in the Point Click Care (PCC) indicated multiple diagnosis.

On an identified date and time, the inspector observed resident #012 sleeping in bed and the call bell was not within reach of the resident as it was on the floor beside the head board of the bed.

During interviews, PSW #124 and RPN #125 acknowledged that the call bell should have been placed within reach of resident #012.

In an interview, the DOC (#100) acknowledged that the call bell should be placed within reach for every resident at any time regardless of their ability or risks. [s. 17. (1) (a)] (726)

3. Resident #013 was also assessed using the home's RAI-MDS assessment tool on an identified date. A review of the resident's clinical records in the Point Click Care, indicated that the resident had multiple diagnoses.

Review of resident #013's care plan indicated an intervention which includes placing the call bell in proximity. On an identified date and time, the inspector observed resident #013 sitting up in bed watching the television. The inspector observed the call bell was not within reach of the resident as it was hanging in front of the head board of the bed behind the resident's back. The call bell could not be seen or accessed by resident #013.

During interviews, PSW #124 and RPN #125 acknowledged that the call bell should have been placed within reach of resident #013.

In an interview, DOC #100 acknowledged that the call bell should be placed within reach for every resident at any time regardless of their ability or risks.

Therefore, the home failed to ensure the resident-staff communication and response system could be easily seen, accessed and used by resident #004, #012 and #013 at all times. [s. 17. (1) (a)]

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 home is equipped with a resident-staff communication and response system that could be easily seen, access and use by the resident at all times, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations.

Record review and staff interviews with PSW #101, registered staff RN #129, RPN #112, RPN #102, ADOC #118, and BSO Manager #131 verified that resident #010 was involved in multiple altercations with co-residents in their home unit. A review of the resident's progress notes in the PCC documentation system revealed multiple potentially harmful interactions/altercations with other residents on identified dates.

During an interview, BSO #131 verified that the resident refused to be assessed by the home's BSO team. A review of the resident's written care plan included a behavior focus with interventions, however within the care plan there were no identified behavior triggers.

During separate interviews, PSW #101, RN #129, RPN #112, RPN #102, ADOC #118, and BSO Manager #131 verified that resident #010 had identified responsive behaviors; and that the resident engaged in multiple altercations with other residents on the unit which could be considered potentially harmful interactions.

Therefore, the home failed to ensure steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations. [s. 54. (a)] (535)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations, to be implemented voluntarily.

Issued on this 25th day of May, 2020 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by VERON ASH (535) - (A2)
Inspection No. / No de l'inspection :	2019_808535_0017 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	009571-19, 010689-19 (A2)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	May 25, 2020(A2)
Licensee / Titulaire de permis :	West Park Healthcare Centre 82 Buttonwood Avenue, TORONTO, ON, M6M-2J5
LTC Home / Foyer de SLD :	West Park Long Term Care Centre 82 Buttonwood Avenue, TORONTO, ON, M6M-2J5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Matt Lamb

To West Park Healthcare Centre, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

The licensee must be compliant with the LTCHA, 2007, c. 8, s. 3. (1).

Specifically, the licensee shall ensure all residents are fully respected and afforded the right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity by completing the following:

1. Provide additional education and training to all staff working in the home including management, related to respecting and promoting Residents' rights to be treated with courtesy, respect and dignity. Education should address staff awareness that the long-term care home is the residents' home and not just a place of employment. Maintain documentation of training records including names of those attended, dates, who provided the education and training materials.

2. Provide psychosocial support to residents #008, #009, #015, #016, #017, and all other residents as applicable to ensure their well-being and protection related to their experiences, as evidenced by the grounds in this report. Maintain documentation of the support provided to all residents.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #017 and #009's rights to be treated with courtesy and respect and in a way that fully recognized their individuality and respects their dignity, were fully respected and promoted.

The Ministry of Long-Term Care (MLTC) received a complaint on an identified date, related to neglect of a resident.

Record review indicated that resident #017 was admitted to the home on an identified date and was assessed using the home's Resident Assessment Instrument - Minimum Data Set (RAI-MDS).

On an identified date, while sitting in their wheelchair in their room, Inspector #535 approached and communicated with resident #017 regarding resident #009's responsive behaviors. Resident #017 responded immediately and was visibly affected negatively by witnessing the behavior.

During the interview, resident #017 stated that they reported how they felt about the situation to staff numerous times, but nothing happened in the end.

During separate interviews, PSW #101 and registered staff RPN #129 verified that resident #009 displayed that responsive behavior sometimes once or multiple times each day. According to PSWs, registered staff and housekeeping staff working on the unit, the resident displayed this behavior spontaneously and sporadically.

During an interview, BSO Manager #131 verified that resident #009 was assessed by the appropriate BSO team, and that the resident was referred to an external BSO team and was waiting for an appointment to be transferred to an external facility for further assessment and treatment.

During an interview, ADOC #118 verified that they have witnessed resident #009's display responsive behavior; and agreed that there was a breach in privacy, dignity and respect related to resident #009 and #017 who were subjected to this behavior repeatedly. The ADOC acknowledged that resident #009's behavior would have a negative impact on other residents and visitors in the home as well, although they might not have complained about it. The staff seem to have accepted resident #009's behavior because they have normalized the behavior and were looking to management to provide new ways of managing the resident's responsive behavior. [s. 3. (1) 1.] (535)

2. On an identified date, while conducting an inspection in the home, Inspectors #535 and #762 observed resident #015 displaying a responsive behavior outside the consultant room where the inspectors were working.

Approximately 20 - 30 minutes later, the inspectors heard another resident calling loudly outside the door of the consultant room where they were working. Inspector #535 observed that resident #016 was visibly affected by resident #015's displayed responsive behavior which prompted them to calling for help.

Record review indicated resident #015 was admitted to the home on an identified date; and was assessed using the RAI-MDS tool.

During an interview, the resident's family member and substitute decision-maker (SDM) stated that they had never seen their family member displaying the responsive behavior; and that they would not want to witness the behavior. Furthermore, they commented that staff, residents and other people visiting the home would see them displaying the behavior, and the SDM stated the lack of dignity witnessing the behavior.

During an interview, PSW #101 and RPN #133 verified the resident's responsive behavior. RPN #133 stated that since their admission to the home, the resident displayed the behavior at times. The RPN verified that visitors have also seen the resident's displayed responsive behavior. [s. 3. (1) 1.] (535)

3. The Ministry of Long-Term Care received a complaint on an identified date, related to verbal abuse and neglect.

Record review indicated that resident #009 was admitted to the home on an identified date and was assessed using the home's RAI-MDS tool.

Record review of the complaint and an interview with the complainant who was also a resident in the home (resident #008), indicated that on an identified date, resident #008 visited the unit were resident #009 resided. Upon entry to the unit, resident #008 observed that resident #009 was displaying a responsive behavior close to the dining room and the nursing station.

Record review indicated that resident #009 had an identified responsive behavior

which occurred almost daily and often multiple times each day. According to multiple staff and the complainant, this identified behavior was displayed because of a possible trigger.

On an identified date, the inspector visited the resident's room with the intent to speak with the resident. Upon initial entry to the room, the inspector observed that the resident was displaying a responsive behavior; and was tended to by two PSWs who provided care and support for the resident.

During separate interviews, PSW #101, registered staff RN #129, RPNs #136, #112, Recreation Assistant #107 and resident #017 verified that they have witnessed resident #009's responsive behavior; sometimes several times during the day. Furthermore, PSW #101 described multiple encounters with resident #009 while displaying the behavior.

PSW #101, RN #129, RPN #136 and RPN #102 verified that resident #009's behavior was witnessed by multiple resident, staff, and family members who visited other residents on the unit.

During separate interviews PSW #101, RN #129, ADOC #118, DOC #100 and BSO Manager #131 verified that resident #009's display of responsive behavior in the presence of others showed a lack of privacy and dignity.

Therefore, the home failed to ensure that residents #009, #015, #016, #017 were fully respected and promoted the residents' rights to be treated with courtesy and respect and in a way that fully recognized their individuality and respects their dignity. [s. 3. (1) 1.]

The severity of this issue was determined as minimum harm or minimum risk to residents. The scope of the issue was widespread as it relates to three out of three residents. The home had ongoing history of non-compliance in this same subsection including:
- a Written Notification, inspection #2017_654605_0011 issued on September 26, 2017,
- a Voluntary Plan of Correction, inspection #2018_524500_0001 issued on February

28, 2018,
- a Voluntary Plan of Correction, inspection #2018_759502_0018 issued on November 19, 2018,
- a Written Notification, inspection #2019_526645_0004 issued on June 13, 2019.
As such, a compliance order (CO) is warranted. (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 24, 2020(A2)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with the LTCHA, 2007, c. 8, s. 24. (1).

Specifically, the licensee shall ensure that anyone who has reasonable grounds to suspect the abuse of a resident may have occurred, must immediately report the suspicion and the information upon which it is based to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that anyone who had reasonable grounds to suspect the abuse of a resident may have occurred, should immediately report the suspicion and the information upon which it was based to the Director.

The Ministry of Long-Term Care received a complaint on an identified date, related to verbal abuse of residents.

Record review of the complaint and an interview with the complainant who was also

a resident in the home (resident #008), indicated that on an identified date, resident #008 visited the unit were resident #009 resided and both residents were verbally abused by a third resident #010.

During an interview, Recreational Assistant (RA) #107 recalled the incident since they transported resident #008 to visit with resident #009 on their unit. The RA described the presence of co-resident #010 who was using multiple unkind words directed at residents #008 and #009. The RA reported the incident to registered staff RN #129.

During an interview, RN #129 stated that they were aware that resident #008 came to visit with resident #009, and verified that they 'heard an argument out there'. The RN stated that they did not see what happened, and they did not hear what resident #010 had said. The RPN verified that they had witnessed resident #010 being verbally abusive to others in the past; however, they denied that resident #010 verbally abused resident #008 and resident #009 during this incident. The RN stated that they did not report the incident which occurred during the shift to management since it was the week-end. The RN stated that they documented the incident; and they might have told staff on the next shift.

During an interview, ADOC #118 stated that they were not aware of the incident until the initiation of this inspection. The ADOC stated that they did not receive a message from the RN working the shift that weekend; but acknowledged that they should have been notified of the incident for reporting purposes. The ADOC verified that verbal abuse should be reported to the Director immediately, and that this incident was not reported since they were not aware the incident had occurred. During an interview, DOC #100 also stated that they were not aware of the incident and it should have been reported to the Director immediately. During separate interviews, the ADOC and DOC commented that staff seemed to have normalized resident's responsive behaviors on the units.

b) The MLTC received a CIS report on an identified date, related to an incident for which the resident was transferred to hospital with an unknown injury.

Record review of the critical incident report and the home's investigation notes indicated that on an identified date, resident #007 was transferred by PSW #138, and

the resident sustained an injury which resulted in their transfer to hospital on a later identified date.

The home was informed later that day by the resident's SDM, that the resident sustained an identified injury as a result of the incident, however the critical incident was reported to the Director on a later identified date. During an interview, DOC #100 acknowledged that the incident should have been reported to the Director as soon as the home became aware of the resident's injury and the circumstances related to the resident's injury.

c) A CIS report was submitted to the MLTC on an identified date, by ADOC#118 related to an incident that occurred to resident #002.

Record review of the CIS report indicated that a PSW reported to the nurse that resident #002 had an injury to an identified body part. Physician and family were notified. Resident #002 was transferred to the hospital for assessment. The cause of injury was unknown, and an investigation was initiated.

The amended CIS report was submitted to the MLTC on another identified date. Review of the amended CIS report indicated that resident #002 received a diagnosed injury, had a scheduled procedure, and returned to the home on an identified date. Further review of the amended report indicated that the home had reviewed the surveillance video footage and became aware of the cause of injury. Detailed information regarding actions the home took were not provided.

In an interview, DOC #100 confirmed that the incident occurred to resident #002 on the identified date as shown in the surveillance video footage. The DOC stated that during the investigation, they reviewed the surveillance video footage and discovered that resident #002 sustained an injury the day before the resident was transferred to hospital. The DOC stated that the nurse did not complete the appropriate assessments because the PSW told the nurse that they had guarded the resident from being injured.

In an interview, RPN #102 acknowledged that they did not direct the PSW to monitor resident #002 after the incident which caused their injury, they did not notify the family regarding the incident, they did not document the incident and they did not

inform the staff on the following shift that an incident had occurred during shift report. RPN #102 confirmed that they left the resident sitting in the television room after the incident occurred. RPN #102 acknowledged that the way they managed resident #002's fall incident on that identified date, would constitute neglect. RPN #102 stated that during the home's investigation interview, the management staff said that the incident would constitute neglect, and they agreed with management staff.

In an interview, ADOC #118 stated that they should have reported the incident to the MLTC at the time when they identified neglect of resident #002 by the staff during the investigation.

Therefore, the home failed to ensure that anyone who had reasonable grounds to suspect the abuse of residents #002, #007, #008 and #009, immediately report the suspicion and the information upon which it was based to the Director. [s. 24. (1)] (535)

The severity of this issue was determined as minimum harm or minimum risk to residents. The scope of the issue was widespread as it relates to three out of three residents. The home had ongoing history of non-compliance in this same subsection including:
- a Written Notification, inspection #2019_526645_0005 issued on June 24, 2019. As such, a compliance order (CO) is warranted. (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 24, 2020(A2)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(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).

Order / Ordre :

The licensee must be compliant with the O. Reg. 79/10, s. 53 (4).

Specifically, the licensee shall ensure that responsive behavior triggers are identified in the plan of care for residents #006, #009, #010 and #015's and any other residents, and that staff take action to respond to the needs of the residents, and complete appropriate assessments, reassessments, interventions and documentation of residents' responses to all interventions as required.

Grounds / Motifs :

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

1. The licensee has failed to ensure behavioral triggers were identified for the resident demonstrating responsive behaviors where possible.

On an identified date, while conducting an inspection in the home, Inspectors #535 and #762 observed resident #015 displaying a responsive behavior. Approximately 20 - 30 minutes later, the inspectors heard a co-resident calling loudly outside the door of the same consultant room where they were working. Inspector #535 opened the door and observed that co-resident #016 appeared to be affected when they saw resident #015 displaying responsive behavior.

Record review indicated resident #015 was admitted to the home on an identified date and was assessed using the home’s RAI-MDS assessment tool.

During an interview, BSO Manager #131 stated they could not recall the resident being referred to an external Behavior Support Outreach Team (BSOT) related to their responsive behavior to support identifying possible triggers for the behavior. The BSO Manager stated that the staff who worked on the unit seemed to have ‘normalized the resident’s behavior’ as a result of witnessing the behavior frequently and since the resident was admitted to the home. Furthermore, the BSO Manager verified that the physician recently wrote a few orders to try to identify the trigger for the resident’s responsive behavior. [s. 53. (4) (a)] (535) (535)

2. The Ministry of Long-Term Care received a complaint on an identified date, related to verbal abuse of a resident.

Record review indicated that resident #010 was admitted to the home on an identified date and was assessed using the home's RAI-MDS assessment tool.

Record review of the complaint report indicated that resident #010 was involved in an altercation with residents #008 and #009 on an identified date. A review of the complaint record and staff interviews indicated that resident #010 frequently displayed responsive behaviors and engaged in altercations with other residents on the unit.

During an interview, PSW #101 verified resident #010's involvement in the specific incident with resident #009 and #008, which affected both residents. PSW #101 stated resident #010 had multiple identified responsive behaviors and 'was hard to deal with'.

A review of resident #010's written care plan indicated a list of responsive behaviors; however, there were no known identified triggers.

During separate interviews, DOC #100, RN #129, ADOC #118, RAI Coordinator #130 verified that resident #010 displayed responsive behaviors and engaged in behavioral altercations with other residents and staff on the unit. During an interview, BSO Manager #131 also verified that the resident engaged in multiple altercations as a result of their responsive behaviors. According to the BSO Manager, they had multiple discussions with this resident about respecting residents' rights and respecting all residents personal space. The BSO Manager verified that the resident refused to be seen by members of the BSO team and therefore, behavior triggers were not identified. [s. 53. (4) (a)] (535) (535)

3. The MLTC received a CIS report on an identified date, related to an incident for which the resident was transferred to hospital.

Record review indicated that resident #006 experienced recent bouts of responsive behaviors on the unit.

During separate interviews, PSWs #105 and #106 stated that recently resident #006 started displaying new responsive behaviors.

During an interview, registered staff RN #104, BSO Manager #131 and ADOC #118 stated they were not aware that the resident was displaying those behaviors.

During an interview, BSO Manager #131, verified that the resident was assessed and referred to the external BSO team after an unrelated incident had occurred on the unit; however, they were not aware that the resident was displaying new behaviors. The BSO manager acknowledged that these behavior triggers were not yet identified, and there were no strategies in place to address those behaviors.
Therefore, the home failed to ensure behavioral triggers were identified for residents #006, #010 and #015 who were demonstrating responsive behaviors. [s. 53. (4) (a)] (535)
(535)

4. The licensee has failed to ensure that actions were taken to meet the needs of the resident with responsive behaviors included documentation of the resident's responses to the intervention.

The Ministry of Long-Term Care received a complaint on an identified date, related to verbal abuse of a resident.

Record review of the complaint and an interview with the complainant who was also a resident in the home (resident #008), indicated that on an identified date, resident #008 visited the unit were resident #009 resided. During the visit on the second-floor, resident #010 displayed responsive behaviors towards residents #008 and #009.

During an interview, Recreational Assistant (RA) #107 verified that they witnessed the altercation by resident #010 towards resident #008 and #009 on the unit. The RA stated that they immediately went into the nursing office, which was near the location

of the incident, and informed registered staff RN #129. The RA also stated that resident #008 was affected by the incident.

During an interview, RN #129 stated that they did not see what had happened during the identified incident. The RN verified that they had witnessed resident #010 engaging in altercations with residents on the unit in the past; but denied that resident #010 verbally abused resident #008 and #009 during this incident.

Record review of the progress notes indicated there was documentation of the incident by the recreation assistant; however, there was no documentation in PCC from RN #129 on that date related to an incident involving all three residents.

During an interview, ADOC #118 verified that the registered staff did not document the incident in PCC, and stated that their expectation was that the registered staff should inform the ADOC when such incidents occur; and that RN #129 should have documented the incident in PCC along with the outcome of their actions and the status of all residents involved.

Therefore, the home failed to ensure that actions were taken to meet the needs of resident #010 with responsive behaviors including documentation of the resident's responses to interventions as applicable. [s. 53. (4) (c)] (535)

The severity of this issue was determined as minimum harm or minimum risk to residents. The scope of the issue was widespread as it relates to three out of three residents. The home had ongoing history of non-compliance in this same subsection including:
- a Voluntary Plan of Correction, inspection #2017_642606_0011 issued on September 26, 2017. As such, a compliance order (CO) is warranted. (535) (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 24, 2020(A2)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

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

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

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

Issued on this 25th day of May, 2020 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by VERON ASH (535) - (A2)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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