Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue 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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

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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
Dec 4, 2018	2018_687607_0009	024935-17, 008992-18, 025244-18	Follow up

Licensee/Titulaire de permis

The Regional Municipality of York
17250 Yonge Street NEWMARKET ON L3Y 6Z1

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

York Region Newmarket Health Centre
194 Eagle Street NEWMARKET ON L3Y 1J6

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

JULIET MANDERSON-GRAY (607)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 30, May 1 and 2, 2018

During this Follow-up inspection, the following intakes were reviewed and inspected.

Summary of Follow Up Intakes:
#021329-17: Compliance Order (CO) #001 issued on October 12, 2017, within inspection report #2017_524500_0002 under LTCHA, 2007. c. 8. s. 19 (1) resident to resident abuse.
#025244-18: Compliance Order #002 issued on October 12, 2017, within inspection report #2017_524500_0002 under O. Reg 79/10, s. 36 safe transferring and positioning techniques.
During this Follow-Up inspection, intake #008992-18, Critical Incident (CIR) related to a suspected resident to resident abuse, was also inspected.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Manager of Support Service (MSS), Food and Service Supervisor (FSS), Physiotherapist (PT), Registered Nurse Supervisor (RNS), registered nurses (RN), registered practical nurses (RPN), food and service workers (FSW), housekeeping staff (HSKP), and personal support workers (PSW).

During the course of the inspection, the inspector observed staff to resident interactions, reviewed clinical health records, staff training records and home specific policies related to responsive behaviours and prevention of abuse and neglect.

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

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

5 WN(s)
2 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2017_524500_0002	607
O.Reg 79/10 s. 36.	CO #002	2017_524500_0002	607

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

On October 12, 2017, the licensee was issued an order #001 under s. 19 (1) from inspection #2017_524500_0002, with a compliance due date of January 31, 2018. The licensee was ordered to:
1). Prepare, develop, and implement a plan to protect all residents on the unit from resident #010's identified responsive behaviours.
2). Manage resident #008, and #012's behavioral issues which may trigger resident #010's identified responsive behaviours.
3). Conduct weekly meetings with all staff working on the unit including all departments, and supervisors/managers of those departments to identify all possible triggers which can exhibit resident #010's identified responsive behaviours.
4). Provide opportunity to the above mentioned staff to participate in the discussion to identify triggers, and in the development and implementation of strategies to manage those triggers.
5). Keep a record of all possible triggers and strategies identified in the above mentioned meetings in regards to resident #010's responsive behaviors.
6). Keep records of minutes of the above mentioned meetings and a list of staff who attended those meetings.
7). Conduct weekly audits by the lead of the Responsive Behaviour Program to evaluate the implementation of the identified strategies to manage resident #010's identified responsive behaviours.
8). Have interdisciplinary team meetings to discuss the outcome identified during the above mentioned audits and an action plan for each outcome. The licensee to ensure to keep minutes of these meetings.
9). Educate all staff working on the unit by creating a case study scenario for incidents involving resident #010, due to the resident's identified responsive behaviors.
10). Include resident to resident abuse case scenarios in the home's mandatory training education.

The home successfully complied with items 1-10 in CO #001.

During the course of the follow up inspection, the inspector inspected intake #008992-18 related to a CIR.

The home submitted a Critical Incident Report (CIR) to the Director on an identified date and time, for an incident of a suspected resident to resident abuse that occurred on an identified date. The CIR indicated that when staff were completing rounds resident #001 was found with resident #008, while in another resident's identified area.

A review of the clinical health records indicated resident #001 had several identified diagnoses and had an identified cognitive performance score. Resident #008 also had several identified diagnoses and had an identified cognitive performance scale.

A review of resident #001's progress notes with an identified date, indicated that when staff were completing rounds, they found resident #001 and #008 in another resident's identified area. Both resident #001 and #008 were noted to be exhibiting an identified responsive behaviour, the staff member who found the residents, went to inform the nurse in charge.

A review of resident #001 and #008's written plan of care had no interventions related to an identified responsive behaviours in place, prior to the above identified incident. There were several interventions put in place on an identified date related to the identified responsive behaviour.

During an interview on an identified date and time, Personal Support Worker (PSW) #114 indicated to the inspector that on an identified date, the PSW went to find resident #001 and was unable to locate the resident. The PSW indicated they then found resident #001 and #008 in an identified area exhibiting an identified responsive behaviour. The PSW indicated they left to get RN #109 for assistance.

During an interview on an identified date and time, via telephone, Registered Nurse (RN) #109 indicated to the inspector that on an identified date, PSW #114 had indicated to the RN that they had found resident #001 and #008 in resident #005's identified area, exhibiting an identified responsive behaviour. The RN indicated that upon arrival to the identified area, resident #001 was standing in a specific area and resident #008 was in another identified area. RN #109 also indicated that resident #001 has impaired decision making ability, would lack the capability to consent to the identified responsive behaviour, and further indicated that resident #008 is also cognitively aware of the identified responsive behaviours. RN #109 indicated they did not report the incident to a supervisor as there was no harm to both residents. The RN also indicated that if there was no harm to both residents, there is no urgency to report, and further indicated if there was no harm to either resident, then the incident is not considered abuse. The RN also indicated that as there was no abuse or harm identified, the physician was also not notified of the incident.

During an interview on an identified date, RN #107 Supervisor of Care indicated to the

inspector that on an identified date, they became aware of the incident involving resident #001 and #008, that occurred the prior day. RN #107 also indicated that both family members were notified of the incident and did not want an investigation completed. The RN indicated that at the time they became aware of the incident, they had looked at the abuse decision tree and thought that both residents had consented to the identified responsive behaviour, but did not ask any of the residents if they had consented. The RN #107 also indicated not being of aware of both residents having a capacity assessment completed to determine capability to consent to the identified responsive behaviour, and was not aware if resident #001 had any prior responsive behaviours. RN #107 also indicated not being aware of resident #001's capability to consent to the identified responsive behaviour, and further indicated that the Director of Care (DOC) and resident #001's family member was not notified of the incident until later, on the day the RN became aware of the incident. RN #107 also indicated that this was the only incident that occurred related to the identified responsive behaviours involving resident #001 and #008. A review of the progress notes by the inspector, for an identified period, for both resident #001 and #008, verified the same.

During an interview on an identified date, RN #123 indicated that resident #001 is pleasantly confused and was not aware of any other incident, involving resident #001 and #008 related to the identified responsive behaviours.

During an interview on an identified date and time, the Director of Care (DOC) indicated to the inspector that both resident #001 and #008, were separated at the time of the incident, and indicated the abuse decision tree was used at the time of the incident, to determine if an internal investigation was needed or a report was to be completed to the Director. The DOC further indicated that at the time of the incident, it was determined that both residents had consented to the identified responsive behaviours. However, the DOC further indicated that a capacity assessment had not been completed for either resident, and therefore could not confirm whether consent had been granted.

The licensee failed to ensure that resident #001 and resident #008 had been protected from abuse which occurred on an identified date. [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. 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 has failed to ensure that, every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (1) abuse of a resident by anyone.

This area of non-compliance was identified during a Follow-up inspection Log #021329-17, related to c.8, s 19 (1) Duty to protect.

A Critical Incident Report (CIR) was submitted to the Director on an identified date and time, for an incident of a suspected resident to resident abuse that occurred on an identified date. The CIR indicated that when staff were completing rounds resident #001 was found with resident #008, while in another resident's identified area.

Review of the clinical health records for resident #001 and resident #008, indicated there was one incident of resident to resident abuse, involving resident #001 and #008 and there was no indication that the incident was investigated.

During an interview with RN #109 on an identified date and time via telephone, the RN indicated to inspector #607 that resident #008 exhibited an identified responsive behaviours towards resident #001. RN #109 indicated not reporting the above identified incident to anyone.

During an interview on an identified date, RN #123 indicated to the inspector remembering having a discussion with RN #107 about the incident and they both discussed that resident #008's family member had no problem with the incident and did not want an investigation completed.

During an interview on an identified date, RN #107 indicated to the inspector that on an identified date, the RN found out about the incident involving resident #001 and #008. RN #107 also indicated that both family members were notified of the incident and did not want an investigation completed.

During an interview on an identified date, the DOC verified with the inspector that RN #109 was in charge of the long-term care home at the time of the incident and did not complete an investigation, and further indicated that RN #107 also did not complete an investigation the following day, related to the incident. The DOC also verified that an investigation was not completed by the DOC, as RN #107 had indicated to the DOC on an identified date, that the RN had followed up with families and staff in regards to the incident. Upon conclusion of the inspection, the DOC had not yet completed an investigation into the incident between the two residents.

The licensee failed to ensure that, every alleged, suspected or witnessed incident abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated. Specifically, when RN #109, RN #107, RN #123 and the DOC became aware of a suspected incident of abuse involving resident #001 and #008, the incident was not investigated. [s. 23. (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 ensuring that 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, to be implemented voluntarily.

WN #3: 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 a person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone.

This area of non-compliance was identified during a Follow-up inspection Log #021329-17, related to c.8, s 19 (1) Duty to protect.

A review of resident #001's progress notes with an identified date, indicated that when staff were completing rounds, they found resident #001 and #008 in another resident's identified space, the staff member who found the residents, went to inform the nurse in charge.

During an interview on an identified date via telephone, RN #109 indicated to the inspector being aware of when to report an incident related to abuse to the Director. The RN further indicated that the incident involving resident #001 and #008, which occurred on an identified date, when both residents were found in another resident's identified space, was not urgent. The RN also indicated that both residents have impaired decision making abilities and were not in any distress after the incident occurred and therefore did not see any point in reporting the incident. The RN further indicated not reporting the incident to a supervisor or the DOC.

During an interview with the DOC on an identified date, the DOC verified with the inspector that RN #109 was in charge of the long-term care home at the time of the incident and did not report the incident to an on-call supervisor or the DOC. The DOC also indicated they became of aware of the incident by RN #107 on an identified date, and further indicated that a Critical Incident Report (CIR) was not submitted to the Director at the time of the incident.

The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director. Specifically, when there was a suspected incident of resident to resident abuse involving resident #001 and #008. A CIR was not submitted to the Director immediately, the CIR was only submitted as a result of the inspection, after the inspector brought it to the DOC's attention, several days, later. [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 ensuring the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone, 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 has failed to ensure that its written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

A review of the licensee's Zero Tolerance of Abuse and Neglect Program Policy, Part B: Procedure with date of July 2014, page 11-12/43 directs:

Section Three: Investigating and Responding to Alleged, Suspected or Witnessed Abuse and Neglect of Residents.

Staff who are reporting a suspected, alleged or witnessed incident of resident abuse or neglect:

-Report the incident immediately to a supervisor or manager on-call.

Senior Manager investigating the incident:

- All reports of abuse or neglect must be immediately investigated in accordance with the investigation procedures set out in this document. LTCHA s. 23 (1).

-A charge nurse who receives a report after hours must contact the on-call nursing supervisor and receive direction.

During the investigation the following must be considered:

Fully investigate the incident, and complete the documentation of all know details of the reported incident.

Clinical staff responsible for care of the Resident (s) by the abuse or neglect:

-Conduct a head to toe assessment on the alleged victim and document findings if abuse is alleged.

-Contact the physician if necessary, or other health practitioners for further assessment, treatment and follow-up.

This area of non-compliance was identified during a Follow-up inspection Log #021329-17, related to c.8, s 19 (1) Duty to protect.

A review of resident #001's progress notes with an identified date, indicated that when staff were completing rounds, they found resident #001 and #008 in a resident's identified area, the staff member who found the residents, went to inform the nurse in charge.

During an interview with RN #109 via telephone on an identified date, the RN indicated to the inspector that they did not report the above identified incident to a supervisor as there was no harm to both residents. The RN further indicated that if there was no harm to both residents, there is no urgency to report, and also indicated if there was no harm to the either resident, then incident is not considered abuse. The RN also indicated that as there was no abuse or harm identified, the physician was also not notified of the incident.

During an interview on an identified date, RN #123 indicated remembering having a discussion with the RN #107 about the above identified incident and they both discussed that resident #008's family member had no problem with the incident and did not want an

investigation completed.

During an interview on an identified date and time, RN #107 indicated to the inspector that on an identified date, the RN found out about the incident involving resident #001 and #008. RN #107 also indicated that both family members were notified of the incident and did not want an investigation completed.

During an interview on an identified date and time, the DOC verified with the inspector that RN #109 was in charge of the long-term care home at the time of the incident and did not complete an investigation, and further indicated that RN #107 also did not complete an investigation the following day, related to the incident. The DOC verified that an investigation was not completed by the DOC, as RN #107 had indicated that the RN had followed up with family members and staff in regards to the incident.

The licensee failed to ensure that its written policy that promotes zero tolerance of abuse and neglect of residents is complied with. When RN #109 became aware of the above identified incident, the RN did not notify a supervisor on-call and did not notify the physician. When RN #107 also became aware of the incident, the RN did not fully investigate the incident, and complete the documentation of all know details of the reported incident. [s. 20. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, 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.

This area of non-compliance was identified during a Follow-up inspection Log #021329-17, related to c.8, s 19 (1) Duty to protect.

A review of resident #001's progress notes with an identified date indicated that when staff were completing rounds, they found resident #001 and #008 in another resident's identified space, exhibiting an identified responsive behaviour, the staff member who found the residents, went to inform the nurse in charge. Further review of the progress notes indicated there was documented evidence that resident #008's who was involved in a suspected resident to resident abuse, SDM was not notified of the incident until later.

During an interview on an identified date via telephone, RN #109 who was in charge of the building and discovered the incident, indicated that resident #008's SDM was not notified of the incident on the date it occurred. Both RN #109 and RN #123 indicated that resident #008's SDM was not notified of the incident involving resident #001 and #008 until later, the following day.

During an interview on an identified date, the DOC indicated to the inspector that RN #107 had indicated following up with the family members in regards to the incident and was not aware that resident #008's family member was not notified within the allotted time frame. The DOC indicated the expectation is family members are to be notified within the designated time frame.

The licensee failed to ensure that resident #001's substitute decision-maker, was notified within a designated time frame, upon the licensee becoming aware of a suspected incident of abuse involving resident #001 and #008. Specifically, when RN #109, RN #123 and RN #107 became aware of the above identified incident, resident #008's SDM was not notified of the incident involving resident #001 and #008, until the next day, several hours later. [s. 97. (1) (a)]

Issued on this 7th day of December, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIET MANDERSON-GRAY (607)
Inspection No. / No de l'inspection :	2018_687607_0009
Log No. / No de registre :	024935-17, 008992-18, 025244-18
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Dec 4, 2018
Licensee / Titulaire de permis :	The Regional Municipality of York 17250 Yonge Street, NEWMARKET, ON, L3Y-6Z1
LTC Home / Foyer de SLD :	York Region Newmarket Health Centre 194 Eagle Street, NEWMARKET, ON, L3Y-1J6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lisa Salonen MacKay

To The Regional Municipality of York, 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 s. 19 (1) of the LTCHA.

Specifically the licensee must:

1. Review and revise its Zero Tolerance of Abuse and Neglect Program policy:

A) To provide guidance to staff to ensure that capacity is assessed in residents, including resident #001 and #008, and any other residents with cognitive impairment;
B) To support good decision-making in staff interventions and on-going monitoring;
C) To support appropriate mandatory reporting under s. 24 (1) of the LTCHA, 2007;
D) To ensure only consensual activity is occurring between residents, and;
E) To further ensure that residents are not vulnerable to abuse.

2. The licensee shall develop, implement and keep record of a process to ensure:
A) That the capacity of all residents, including residents with cognitive impairment who demonstrate an identified responsive behaviours are being assessed and;
B) That interventions put in place to manage identified responsive behaviours, such as defined monitoring, are being consistently implemented.

3. Educate all staff including registered staff and management on any changes made to the home's policy and the process indicated above, including but not limited to the requirements related to investigating an abuse incident, reporting to the Director and the SDM notification.

4. Retain records of changes made to the policy, the process put in place, education provided to all staff, and staff training records, so that these records are available to the inspector upon follow up.

Grounds / Motifs :

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

On October 12, 2017, the licensee was issued an order #001 under s. 19 (1) from inspection #2017_524500_0002, with a compliance due date of January 31, 2018.
The licensee was ordered to:
1). Prepare, develop, and implement a plan to protect all residents on the unit from resident #010's identified responsive behaviours.
2). Manage resident #008, and #012's behavioral issues which may trigger resident #010's identified responsive behaviours.
3). Conduct weekly meetings with all staff working on the unit including all departments, and supervisors/managers of those departments to identify all possible triggers which can exhibit resident #010's identified responsive behaviours.
4). Provide opportunity to the above mentioned staff to participate in the discussion to identify triggers, and in the development and implementation of strategies to manage those triggers.
5). Keep a record of all possible triggers and strategies identified in the above mentioned meetings in regards to resident #010's responsive behaviors.
6). Keep records of minutes of the above mentioned meetings and a list of staff who attended those meetings.
7). Conduct weekly audits by the lead of the Responsive Behaviour Program to evaluate the implementation of the identified strategies to manage resident #010's identified responsive behaviours.
8). Have interdisciplinary team meetings to discuss the outcome identified during the above mentioned audits and an action plan for each outcome. The licensee to ensure to keep minutes of these meetings.
9). Educate all staff working on the unit by creating a case study scenario for incidents involving resident #010, due to the resident's identified responsive behaviors.
10). Include resident to resident abuse case scenarios in the home's mandatory training education.

The home successfully complied with items 1-10 in CO #001.

During the course of the follow up inspection, the inspector inspected intake #008992-18 related to a CIR.

The home submitted a Critical Incident Report (CIR) to the Director on an

identified date and time, for an incident of a suspected resident to resident abuse that occurred on an identified date. The CIR indicated that when staff were completing rounds resident #001 was found with resident #008, while in another resident's identified area.

A review of the clinical health records indicated resident #001 had several identified diagnoses and had an identified cognitive performance score. Resident #008 also had several identified diagnoses and had an identified cognitive performance scale.

A review of resident #001's progress notes with an identified date, indicated that when staff were completing rounds, they found resident #001 and #008 in another resident's identified area. Both resident #001 and #008 were noted to be exhibiting an identified responsive behaviour, the staff member who found the residents, went to inform the nurse in charge.

A review of resident #001 and #008's written plan of care had no interventions related to an identified responsive behaviours in place, prior to the above identified incident. There were several interventions put in place on an identified date related to the identified responsive behaviour.

During an interview on an identified date and time, Personal Support Worker (PSW) #114 indicated to the inspector that on an identified date, the PSW went to find resident #001 and was unable to locate the resident. The PSW indicated they then found resident #001 and #008 in an identified area exhibiting an identified responsive behaviour. The PSW indicated they left to get RN #109 for assistance.

During an interview on an identified date and time, via telephone, Registered Nurse (RN) #109 indicated to the inspector that on an identified date, PSW #114 had indicated to the RN that they had found resident #001 and #008 in resident #005's identified area, exhibiting an identified responsive behaviour. The RN indicated that upon arrival to the identified area, resident #001 was standing in a specific area and resident #008 was in another identified area. RN #109 also indicated that resident #001 has impaired decision making ability, would lack the capability to consent to the identified responsive behaviour, and further indicated that resident #008 is also cognitively aware of the identified responsive

behaviours. RN #109 indicated they did not report the incident to a supervisor as there was no harm to both residents. The RN also indicated that if there was no harm to both residents, there is no urgency to report, and further indicated if there was no harm to either resident, then the incident is not considered abuse. The RN also indicated that as there was no abuse or harm identified, the physician was also not notified of the incident.

During an interview on an identified date, RN #107 Supervisor of Care indicated to the inspector that on an identified date, they became aware of the incident involving resident #001 and #008, that occurred the prior day. RN #107 also indicated that both family members were notified of the incident and did not want an investigation completed. The RN indicated that at the time they became aware of the incident, they had looked at the abuse decision tree and thought that both residents had consented to the identified responsive behaviour, but did not ask any of the residents if they had consented. The RN #107 also indicated not being of aware of both residents having a capacity assessment completed to determine capability to consent to the identified responsive behaviour, and was not aware if resident #001 had any prior responsive behaviours. RN #107 also indicated not being aware of resident #001's capability to consent to the identified responsive behaviour, and further indicated that the Director of Care (DOC) and resident #001's family member was not notified of the incident until later, on the day the RN became aware of the incident. RN #107 also indicated that this was the only incident that occurred related to the identified responsive behaviours involving resident #001 and #008. A review of the progress notes by the inspector, for an identified period, for both resident #001 and #008, verified the same.

During an interview on an identified date, RN #123 indicated that resident #001 is pleasantly confused and was not aware of any other incident, involving resident #001 and #008 related to the identified responsive behaviours.

During an interview on an identified date and time, the Director of Care (DOC) indicated to the inspector that both resident #001 and #008, were separated at the time of the incident, and indicated the abuse decision tree was used at the time of the incident, to determine if an internal investigation was needed or a report was to be completed to the Director. The DOC further indicated that at the time of the incident, it was determined that both residents had consented to the

identified responsive behaviours. However, the DOC further indicated that a capacity assessment had not been completed for either resident, and therefore could not confirm whether consent had been granted.

The licensee failed to ensure that resident #001 and resident #008 had been protected from abuse which occurred on an identified date. [s. 19. (1)]

The severity of this issue was determined to be a level 2 as there was potential harm to the residents. The scope of the issue was a level 1 as it was related to one incident involving two residents. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA that included:

-Compliance Order (CO) #001 issued October 12, 2017 (2017_524500_0002), with a compliance due date of January 31, 2018.
-Compliance Order (CO) #001 issued on January 30, 2017, (2016_168202_0022), with a compliance due date of May 31, 2017.
(607)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 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 4th day of December, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Juliet Manderson-Gray

Service Area Office /
Bureau régional de services : Central East Service Area Office