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 sous la Loi de 2007 sur les foyers de soins de longue durée

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 16, 2018	2018_712665_0003	020937-17, 022378-17, 022721-17	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Woodbridge Vista Care Community
5400 Steeles Avenue West Woodbridge ON L4L 9S1

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

JOY IERACI (665)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 28, March 1, 2, 5, 6, 7, 8, 13, 14 and 15, 2018. Off site interviews were conducted on March 16, 18 and 28, 2018.

The following Critical Incident System (CIS) reports were inspected:
Log #020937-17, CIS #2945-000028-17 related to resident to resident abuse
Log #022378-17, CIS #2945-000031-17 related to resident to resident abuse
Log #022721-17, CIS #2945-000032-17 related to resident to resident abuse

PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, c.8, s. 6 (7), s. 6 (11) (b) and s.19(1), identified in a concurrent complaint inspection #2018_712665_0002 (Log #024222-17, Log #021306-17, CIS #2945-000029 -17 and CIS #2945-000034-17), were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Nursing (ADOC), Resident Relations Coordinator (RRC), Registered Nurses (RNs), Behavioural Support Ontario (BSO) Registered Practical Nurse (RPN), Registered Practical Nurses (RPNs), Resident Programs Team Member, Personal Support Workers (PSWs), residents and family members.

The inspector also conducted medication administration observations, provision of care observations, staff and resident interactions, reviewed clinical health records, reviewed relevant home policies and procedures and other pertinent documents.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 :

The licensee has failed to ensure that the plan of care was provided as specified in the plan.

The home submitted three critical incident system (CIS) reports, #2945000028-17, #2945000031-17 and #2945000032-17 to the Ministry of Health and Long Term Care (MOHLTC) for resident to resident altercations involving resident #003 over a period of 28 days on three identified dates in 2017.

Review of resident #003's clinical records indicated the resident had been admitted to an identified facility to manage their responsive behaviour on an identified date in 2018, and had returned to the home eight weeks later.

During observations on an identified date in 2018, at 1145 hours (hrs), the substitute decision maker (SDM) of resident #003 informed the Inspector of their concern regarding medication administration for the resident since returning from the identified facility. The SDM indicated they were concerned that the recommendations from the identified facility were not being followed regarding administering medications to the resident. The SDM stated they found medications in the resident's mouth on an identified date in 2018, during their visit with the resident.

Record review of the care tips from the identified facility, indicated that resident #003 had responsive behaviours when taking their medications. The care tips had four identified interventions related to medication administration. Review of the current written plan of care reflected the above recommendations for medication administration for resident

#003.

Interviews with Registered Practical Nurses (RPNs) #121 and #127 indicated the resident had a history of two identified responsive behaviours towards other residents and exhibited another identified responsive behaviour towards staff. The RPNs stated they were aware of resident #003's responsive behaviours when taking medications. Both RPNs also indicated that they did not follow one of the identified interventions when the medications had been administered as per the plan of care. The RPNs stated that it is important to follow the plan of care for the resident to ensure their responsive behaviour did not continue and worsen.

Interview with RPN #124 who worked when the SDM visited the resident noted above, confirmed the resident had two identified responsive behaviour towards other residents. The RPN confirmed they had not followed two of the four interventions when they administered medications to resident #003 on the identified date in 2018. The RPN indicated it is important to follow the plan of care to ensure that resident #003's behaviour was managed and did not worsen. The RPN said they had not followed the plan of care as specified in the plan for resident #003.

Interview with the Associate Director of Care (ADOC) on an identified date in 2018, indicated they had followed up with the registered staff regarding the interventions for medication administration for the resident at the request of the Executive Director (ED) the day prior. The ADOC said they had met with the registered staff and reviewed the interventions for medication administration in the plan of care plan since the resident's return from the identified facility. The ADOC said the expectation was that registered staff follow the plan of care regarding medication administration for resident #003 and RPNs #121, #124 and #127 had not provided the care as specified in the plan for resident #003.

2. The responsive behaviour inspection protocol (IP) was initiated as the home notified the MOHLTC after-hours pager on an identified date in 2017, and submitted a CIS report #2945-000031-17 to the MOHLTC the next day, regarding resident to resident abuse. The CIS report indicated residents #003 and #004 had an altercation with one another.

Record review of resident #004's clinical record indicated resident had a history of two identified responsive behaviours toward other residents and exhibited another identified responsive behaviour.

Record review of the resident's current plan of care identified an intervention to manage the resident's responsive behaviour under two different focus areas.The plan of care directed staff when to implement the identified intervention.

Interviews with RPNs #121 and #124 and Personal Support Workers (PSWs) #122 and #123 indicated resident #004 had a history of two identified responsive behaviours toward other residents and exhibited another identified responsive behaviour. The staff indicated the identified intervention noted above managed resident #004's responsive behaviour.

Observation conducted on an identified date in 2018, at 1330 hrs indicated the resident was seated in an identified area of the unit without the identified intervention in place.

Interview with PSW #125 indicated they had been aware that the identified intervention managed resident #004's responsive behaviour. When asked why the intervention was not in place, the PSW indicated they had been too busy after the lunch meal service. The PSW said they had not followed the plan of care as specified in the plan for resident #004.

3. The Ministry of Health and Long Term Care (MOHLTC) received a complaint, through the ACTIONline on an identified date in 2017. The complainant alleged that resident #001 was abused on a specified date in 2017, by another resident, who entered resident #001's room, sustaining injury to an identified area of resident #001's body. The home submitted a CIS report #2945-000029-17 to the MOHLTC of the incident five days after the specified date in 2017, regarding the allegation of abuse towards resident #001 by resident #002.

One month after the complaint above was received by the MOHLTC, a complaint response was received from the home on an identified date, regarding an incident between residents #001 and #002, which had occurred 10 days prior. The complainant provided a written complaint to the home via email regarding an altercation between residents #001 and #002.

After two weeks of receiving the complaint response from the home, the MOHLTC after-hours pager was notified and a CIS report #2945-000034-17 related to a mandatory report of resident to resident abuse between residents #001 and #002 was submitted by the home on an identified date. The CIS report indicated two altercations between residents #001 and #002 on the same day.

The first incident occurred at an identified time. A PSW witnessed resident #002 had exhibited an identified responsive behaviour towards resident #001 with an identified object, resulting in injury to two different areas of the body on resident #001. The second incident occurred 25 minutes later in the hallway outside of each of the residents' rooms where residents #001 and #002 had an altercation with each other.

A review of resident #001's clinical records indicated the resident had two identified responsive behaviours toward other residents and exhibited another specified responsive behaviour. A review of resident #001's current plan of care indicated a specific intervention to prevent triggering resident #001's responsive behaviour.

Observations conducted on two different dates in March 2018, indicated the specific intervention had not been implemented.

Interview with resident #001 indicated they were aware of the specific intervention and indicated the intervention had to be in place.

Interview with PSW #103 indicated resident #001 had two identified responsive behaviours and a trigger had been identified. The PSW indicated they were aware that the plan of care for the resident included the specific intervention. The PSW said they had forgotten to put in place the specific intervention on the identified date in March 2018. The PSW stated it is the home's expectation for the plan of care to be followed and they had not followed the plan of care for resident #001.

Interview with RPN #114 indicated the plan of care for resident #001 included the specific intervention to prevent resident #001 from being triggered. The RPN stated that the resident had told them it was their preference to have the intervention in place. The RPN said it is the home's expectation for the plan of care to be followed. The RPN stated the intervention was effective and it was important for the plan of care to be followed to prevent the resident from exhibiting responsive behaviours.

Interview with the ADOC indicated it is the home's expectation for the plan of care to be followed as specified in the plan. The ADOC acknowledged the specific intervention was to be implemented to prevent the resident from exhibiting responsive behaviours.

4. The licensee failed to ensure when a resident was reassessed and the plan of care reviewed and revised because care set out in the plan has not been effective, the

licensee shall ensure that different approaches were considered in the revision of the plan of care.

The home submitted three CIS reports, #2945000028-17, #2945000031-17 and #2945000032-17 to the MOHLTC for resident to resident altercations involving resident #003 over a period of 28 days on three identified dates in 2017. The first incident occurred with resident #005, 22 days later with resident #004 and six days later with resident #006.

Review of resident #003's clinical records indicated the resident had been admitted to an identified facility to manage their responsive behaviour on an identified date in 2018, and had returned to the home eight weeks later. The resident's clinical records also indicated the resident had a history of two identified responsive behaviours toward others and a trigger was identified.

Review of the written responsive behaviour plan of care to manage resident #003's responsive behaviour indicated nine interventions which were implemented five months prior to the critical incident (CI) with resident #005. Four months after the interventions were implemented and one month prior to the CI with resident #005, a review of resident #003's progress notes indicated three documented incidents related to responsive behaviours towards co-residents. The incidents had occurred within a period of 10 days on two identified dates in 2017. Staff separated the residents and no injury occurred from the incidents.

Resident #003's written responsive behaviour plan of care was reviewed and revised the same month when the three documented incidents occurred noted above. An identified intervention was added to the written plan of care.

One month after the documented incidents noted above, further review of resident #003's progress notes indicated another three incidents had occurred over a period of 22 days with co-residents as follows:
1) Resident #003 had an altercation with resident #005 in an identified area of the unit. A CIS #2945000032-17 report was submitted noted above and resident #003 sustained injury to an identified area of the body.
2) Residents #003 and #005 had an altercation with each other in an identified area of the unit. No injuries noted and residents were separated.
3) Resident #003 had altercation with resident #004 in front of resident #003's door resulting in injury to resident #004. A CIS report #2945000031-17 was submitted noted

above.

Resident #003's responsive behaviour referral and assessment dated one day after the CI with resident #004, directed staff to follow the interventions in the care plan and enhance one of the nine interventions noted earlier with identified residents, intervene and remove these residents away from the resident #003's room.

Four days after the responsive behaviour referral and assessment was completed, resident #003 exhibited an identified responsive behaviour towards resident #004. Staff separated the residents. One day later, resident #003 had an altercation with resident #006 resulting in injury to resident #003 as per CIS #2945000032-17 noted above.

The plan of care had been updated 13 days after the altercation resident #003 had with resident #006, with an identified intervention. The care team was directed to intervene accordingly and night staff was to enhance one of the nine interventions noted earlier as much as possible.

Twenty-five days after resident #003's altercation with resident #006, there was another incident when resident #003 exhibited two identified behaviours toward an unidentified resident in an identified area of the unit. Resident #003 exhibited an identified responsive behaviour with the co-resident who attempted to sit on an empty chair next to them. Staff separated the residents. Nineteen days later, resident #003 had an identified altercation with resident #004 in front of their room. Resident #003 was observed to have exhibited an identified responsive behaviour and swinging an identified object at resident #004. Staff separated the residents and no injury noted.

A review of resident #003's BSO assessment dated the day of the altercation with resident #004 noted above, directed staff to continue to enhance one of the nine interventions mentioned earlier and intervene to prevent further escalation in the event of altercations.

Resident #003's plan of care was updated 11 days later with a new intervention to ward off identified residents.

Interviews with RPNs #121 and #124 indicated that resident #003 had a history of responsive behaviour towards other residents. They indicated resident had an identified responsive behaviour and identified three triggers for the responsive behaviour.

PSW #130 and RPNs #121 and #124 indicated the interventions that were in place to manage resident #003's responsive behaviour were one of the nine interventions mentioned earlier, and two other identified interventions to prevent other residents from triggering resident #003. When asked what one of the nine interventions entailed, the staff indicated the intervention was implemented when staff were documenting in an identified area of the unit, monitor an identified common area, and staff were to be in the identified common area when an identified trigger was present.

Further interviews with PSWs #131 and #132 and RPNs #133, #134 indicated resident #003 had responsive behaviours towards co-residents. The staff indicated resident #003 exhibited an identified responsive behaviour by an identified trigger, and another identified trigger. The staff identified four interventions that had been in place to manage resident's responsive behaviour. One of these interventions included one of the nine interventions noted earlier. When asked what one of the nine interventions entailed, staff indicated they implement the intervention when they were near the resident. This would include times they were documenting, or when near the resident's room. Staff indicated there was no set time when the identified intervention was implemented, but would do it when it was convenient.

Interviews with RPNs #133 and #134 indicated the one of the nine intervention noted for resident #003 had not been effective in preventing altercations with other residents. RPN #134 indicated two family members raised concern regarding resident #003's behaviour and preferred for their loved ones living in the home not to be in the same room with resident #003.

Interview with the BSO RPN who assessed resident #003 and provided interventions to staff over a two month period in 2017, indicated the resident had been on their caseload since admission on an identified date in 2017. When asked what one of the nine interventions entailed, the BSO RPN indicated that staff would implement the intervention when the residents were in a common area and separate the residents to prevent altercations and when documenting. The BSO RPN indicated the intervention had not been effective and another identified intervention was implemented on an identified date in 2017. When asked if these interventions were effective in managing altercations between resident #003 and other residents, the BSO RPN indicated that the intervention may not have been the most appropriate intervention as it had not worked to prevent altercations and had not been effective. The BSO RPN said no new approaches had been identified when the plan of care was reviewed and revised for resident #003 until after seven documented altercations with other residents.

5. The MOHLTC received notification from the home on an identified date in 2017, through the after-hours pager and a CIS #2945000028-17 report was submitted by the home two days later, regarding resident to resident abuse between residents #003 and #005. The CIS report indicated resident #003 was observed to have injury to an identified area of the body. As per CIS report, resident #005 exhibited an identified responsive behaviour towards resident #003.

Review of resident #005's behavioural progress notes and responsive behaviour assessments indicated the resident had a history four identified responsive behaviours toward other residents and exhibited a specified responsive behaviour. The written responsive behaviour plan of care reflected the resident's responsive behaviours.

Review of the written responsive behaviour plan of care for resident #005 had interventions that were implemented on an identified date in 2017, five months prior to the CI. The plan of care directed staff to follow two identified interventions. The written plan of care was reviewed on three identified dates over a period of three months, with no changes made.

Review of resident #005's progress notes indicated two documented incidents related to responsive behaviours on an identified month in 2017, with resident #003. The two incidents occurred within a period of two weeks. One of the incidents resulted in injury to #003 by resident #005 and the submission of the critical incident.

Review of resident #005's progress notes and responsive behaviour assessments indicated that the resident had been followed and assessed by the BSO RPN and provided interventions for staff to follow on three identified dates over a period of three months, with the same interventions noted above. The staff were also directed to be more vigilant, with an identified intervention whenever the resident presented with the responsive behaviour. Resident was referred to an external consultant two days after the altercation with resident #003 for an assessment. The progress notes and assessments were dated prior to and after the CI had occurred.

Two weeks after the altercations with resident #003 noted above, further review of resident #005's progress notes indicated another two incidents on identified dates occurred with a co-resident and with resident #003.

A review of resident #005's clinical record indicated a BSO assessment was completed one month after the last altercation with resident #003 noted above. The assessment directed staff to continue with an identified intervention and intervene in a timely manner.

Over a five month period after the last documented incident between resident #005 and #003, another three documented incidents occurred when resident #005 exhibited responsive behaviour towards resident #004 and other residents.

Interview with RPN #128 indicated resident #005 had a history of an identified responsive behaviours towards other residents. The RPN stated an identified intervention was implemented to manage their responsive behaviours. When asked what the intervention entailed, the RPN indicated it was implemented when they are documenting in an identified area of the unit and would ask the PSW staff to implement the intervention when they were in two identified areas of the unit.

Interviews with PSWs #122 and #125 and RPNs #124 and #121 indicated resident #005 had identified responsive behaviours towards other residents and they identified resident #005's triggers. The staff stated the resident had an identified intervention to manage their responsive behaviour and to prevent altercations with other residents. When asked what the identified intervention entailed, PSW #125 and RPNs #124 and #121 indicated it was implemented when the resident was in an identified area of the unit and when they were documenting in two identified areas of the unit. The RPNs indicated the PSW staff are to be mindful of where the resident was located when the identified intervention was implemented.

Interview with the BSO RPN indicated resident #005 exhibited three identified responsive behaviours toward other residents and identified two triggers. The BSO RPN indicated the intervention to manage resident #005's responsive behaviour included two identified interventions. When asked what one of the identified intervention entailed, the BSO RPN indicated, when staff were documenting and when staff were in an identified area of the unit to prevent altercations with other residents. The BSO RPN indicated that the identified intervention may not have been the most appropriate intervention, as it was not working to prevent altercations and that the plan of care had not been effective. The BSO RPN acknowledged no new interventions or approaches had been identified when the plan of care was reviewed and revised for resident #005.

6. The Ministry of Health and Long Term Care (MOHLTC) received a complaint, through the ACTIONline on an identified date in 2017. The complainant alleged that resident

#001 was abused on a specified date in 2017, by resident #002. The home submitted a CIS report #2945-000029-17 to the MOHLTC of the incident regarding the allegation the day after the complaint was received.

One month after the complaint above was received by the MOHLTC, a complaint response was received from the home on an identified date in 2017, regarding a written complaint for an incident that occurred between residents #001 and #002. The incident occurred 10 days prior to receiving the complaint response.

Within one month of receiving the complaint response from the home, the MOHLTC after-hours pager was notified and another CIS report #2945-000034-17 related to a mandatory report of resident to resident abuse between residents #001 and #002 was submitted by the home on an identified date. The CIS report indicated two altercations between residents #001 and #002 on the same day.

A review of resident #001's clinical records indicated the resident had two identified responsive behaviours toward other residents and exhibited a specified responsive behaviour. Review of the written responsive behaviour plan of care, included five identified interventions to manage the resident's responsive behaviours and had been implemented four months prior to the CIS #2945-000029-17 on two identified dates in 2017.

The written responsive behaviour plan of care was reviewed and revised on three identified dates over a period of two months with identified interventions to manage the resident's responsive behaviour after the CIS #2945-000029-17 had occurred.

Review of resident #001's progress notes and responsive behaviour assessments indicated that the resident had been followed and assessed by the BSO nurse and provided interventions for staff to follow on five identified dates over a period of six months.

Review of resident #001's progress notes indicated two documented incidents between residents #001 and #002 prior to the CI #2945-000029-17 that was submitted. After the CI noted above, there were another five documented incidents between residents #001 and #002 over a period of two months.

Review of resident #001's BSO assessments dated four days prior to the CIS #2945-000034-17, it directed staff to continue to implement an identified intervention, which had

been in for place six months in the plan of care.

Interviews with PSW #116 and RPNs #102, #105 and #119 indicated residents #001 and #002 would trigger each other. The staff indicated there had been altercations between the two residents. The staff indicated resident #001 had identified responsive behaviours and identified their triggers. RPN #102 indicated the identified interventions for resident #001 had been in the plan of care for six months prior to CIS #2945-000034.

Interview with the BSO RPN #104 indicated resident #002 had been on their caseload since an identified date in 2016, to manage their responsive behaviours towards other residents. The BSO RPN stated residents #001 and #002 had been triggers for each other and had altercations with one another. The interventions that had been in place to minimize altercations between the two residents included two identified interventions. When asked what one of the identified intervention entailed, the RPN indicated that staff would implement the intervention when the residents were in identified areas of the unit and separate the residents to prevent altercations. The identified intervention was also implemented when staff were documenting. The BSO RPN indicated the two identified interventions may not have been the most appropriate interventions as there were seven incidents of altercations between residents #001 and #002 over a period of three months. The interventions were not working in preventing the altercations between the residents and that the plan of care had not been effective. The BSO RPN acknowledged no new approaches had been identified when the plan of care was reviewed and revised for resident #001.

7. The Ministry of Health and Long Term Care (MOHLTC) received a complaint, through the ACTIONline on an identified date in 2017. The complainant alleged that resident #001 was abused on a specified date in 2017, by resident #002. The home submitted a CIS report #2945-000029-17 to the MOHLTC of the incident regarding the allegation the day after the complaint was received.

One month after the complaint above was received by the MOHLTC, a complaint response was received from the home on an identified date in 2017, regarding a written complaint for an incident that occurred between residents #001 and #002. The incident occurred 10 days prior to receiving the complaint response.

Within one month of receiving the complaint response from the home, the MOHLTC after-hours pager was notified and another CIS report #2945-000034-17 related to a mandatory report of resident to resident abuse between residents #001 and #002 was

submitted by the home on an identified date. The CIS report indicated two altercations between residents #001 and #002 on the same day.

A review of resident #002's clinical records indicated the resident exhibited two identified responsive behaviours toward other residents and another specified responsive behaviour. Review of the written responsive behaviour plan of care, included six identified interventions which had been implemented seven months prior to the CIS #2945-000029-17, on an identified date in 2017.

Review of resident #002's progress notes and responsive behaviour assessments indicated that resident had been followed and assessed by the BSO RPN and had provided interventions for staff to follow on five identified dates in 2017, over a period of two months. The BSO RPN directed staff to continue to review the care plan and kardex and follow the interventions outlined in the care plan.

Review of the written responsive behaviour plans of care for resident #002 indicated the plan of care was updated with two new interventions over a period of two months, on two identified dates in 2017, and had been in place for three months prior to CIS #2945-000029-17.

Review of resident #002's progress notes indicated two documented incidents between residents #001 and #002 prior to CIS #2945-000029-17 that was submitted. After the CI, there were another two documented incidents between residents #001 and #002 which had occurred over a period of one month.

Review of resident #002's BSO assessment completed after CIS #2945-000029-17, the staff was directed to continue to review the interventions outlined in the care plan and team to continue to implement an identified intervention.

Review of the written responsive behaviour plan of care for resident #002 indicated a new intervention was added on an identified date in 2017, in response to one of the incidents that occurred with resident #001.

Further review of resident #002's progress notes, prior to CIS #2945-000034-17, indicated five additional incidents between residents #001 and #002 over a one month period.

Review of the BSO assessment dated 20 days after CIS #2945-000029-17, it directed

staff that interventions to address the resident #002's responsive behaviour were outlined in the care plan. After CIS #2945-000034-17, resident #002's written responsive behaviour plan of care was updated to include an identified intervention.

Interviews with PSW #116 and RPNs #102, #105 and #119 indicated residents #001 and #002 had been triggers for each other. The staff indicated there had been altercations between the two residents. The staff indicated resident #002 had responsive behaviours towards other residents. The staff stated resident #002 exhibited a specified responsive behaviour at all times.

Interview with RPN #107 indicated three identified interventions had been in place for resident #002. When asked what an identified intervention entailed, the RPN indicated it had been implemented when staff were documenting or when staff are in an area where resident #002 was located.

Interview with the BSO RPN #104 indicated resident #002 had been on their caseload since an identified date in 2016, to manage their responsive behaviours toward other residents. The BSO RPN stated residents #001 and #002 had been triggers for each other and had altercations with one another. The interventions that had been in place to minimize altercations between the two residents included two identified interventions. When asked what one of the identified intervention entailed, the RPN indicated that staff would implement the intervention when the residents were in identified areas of the unit and separate the residents to prevent altercations. The identified intervention was also implemented when staff were documenting. The BSO RPN indicated the two identified interventions may not have been the most appropriate interventions as there were seven incidents of altercations between residents #001 and #002 over a period of three months. The interventions were not working in preventing the altercations between the residents and that the plan of care had not been effective. The BSO RPN acknowledged no new approaches had been identified when the plan of care was reviewed and revised for resident #002.

Additional Required Actions:

CO # - 001, 002 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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The MOHLTC received notification from the home on an identified date in 2017, through the after-hours pager and a CIS report, #2945-000031-17 was submitted by the home one day later, regarding resident to resident abuse between residents #003 and #004. As per CIS report, RPN #124 heard a noise and saw resident #004 standing at the doorway of resident #003's room. Resident #004 was holding an identified object in an attempt to exhibit an identified responsive behaviour towards resident #003. Resident #003 was standing at their doorway waving an identified object and exhibited an identified responsive behaviour towards resident #004. Resident #004 sustained injury to an identified area of the body.

Review of resident #003's clinical records indicated the resident had been admitted to an identified facility to manage their responsive behaviour on an identified date in 2018, and had returned to the home eight weeks later. The resident's clinical records also indicated the resident had a history of two identified responsive behaviours toward others and was triggered by other residents going into their room.

Interview with PSW #130 stated resident #003 had a history of two identified responsive behaviours toward other residents and had altercations with other residents.

Review of resident #003's progress notes indicated that two months prior to CI #2945-

000031-17, there were three documented incidents where residents triggered resident #003 in the same month on identified dates in 2017. The incidents resulted in resident #003 to have exhibited an identified responsive behaviour towards the other residents.

Six days after the critical incident, a progress note, indicated resident #006 exhibited an identified responsive behaviour towards resident #003 which resulted in an altercation. Resident #003 sustained injury and another CIS report #2945-000032-17 was submitted to the MOHLTC.

Record review of resident #004's clinical record indicated the resident had a history of two identified responsive behaviours toward other residents and exhibited a specified behaviour.

Interviews with RPNs #121 and #124 and PSWs #122 and #123 indicated resident #004 had a history of two identified responsive behaviours toward other residents and exhibited a specified behaviour. The staff indicated resident #004 exhibited the specified behaviour in identified areas of the unit, especially during an identified time of the day. There were two identified interventions to manage resident's #004's responsive behaviours. When asked what one of the identified intervention entailed, the staff indicated they had to be mindful where resident #004 was in the unit, and staff to implement the intervention they were in identified areas of the unit to prevent altercations.

Review of the written responsive behaviour plan of care to manage resident #003's responsive behaviour indicated nine interventions which were implemented six months prior to CIS #2945-000031-17.

Within two months prior to CIS #2945-000031-17, there were three documented incidents of residents triggering resident #003 resulting in altercations.

Review of the written plan of care for resident #003 indicated there were no new interventions to manage the identified residents from triggering resident #003.

Interview with RPN #124 indicated resident #003 had a history of two identified responsive behaviours toward other residents. The resident had a specified responsive behaviour and the RPN identified the triggers for the resident. The RPN indicated on the day of CIS #2945-000031-17 had occurred, they heard a noise in the area of resident #003's room and observed residents #003 and #004 in front of resident #003's room.

Resident #003 was waving an identified object at resident #004 and the RPN separated the residents. The RPN indicated resident #004 sustained injury to an identified area of the body. The intervention that had been in place to prevent identified residents from tiggering resident #003 was an identified intervention. When asked what the identified intervention entailed, the RPN indicated the staff were constantly making sure where resident #003 was in the unit to prevent altercations. RPN #124 considered the incident to be physical abuse by resident #003 to resident #004.

Interview with the BSO RPN indicated resident #004 exhibited an identified responsive behaviour. The BSO RPN stated resident #003 had a history of identified responsive behaviours. The BSO RPN indicated the intervention that had been in place to manage resident #003's specified behaviour were two identified interventions that had been in place six months prior to the CI on an identified date in 2017. One of the identified intervention that had been in place, had not been effective. The BSO RPN stated there were no new interventions implemented until after the CI occurred on an identified date in 2017. The BSO RPN considered the incident between residents #003 and #004 to be abuse towards resident #004.

Interview with the ADOC indicated resident #003 exhibited a specified responsive behaviour. The resident would exhibit two identified responsive behaviours toward other residents who had triggered them. An identified intervention that had in place for six months prior to the CI, was not an effective intervention to manage the resident's specified responsive behaviour. The ADOC indicated no new interventions had been put in place until after the CI had occurred at the end of an identified month in 2017. The ADOC stated it took so long to implement new interventions as the home struggled to find an effective intervention to manage resident #003's identified responsive behaviour and prevent altercations with identified residents.

2. The MOHLTC received notification from the home on an identified date in 2017, through the after-hours pager and a CIS #2945000028-17 report was submitted by the home two days later, regarding resident to resident abuse between residents #003 and #005. The CIS report indicated resident #003 was observed to have injury to an identified area of the body. As per CIS report, resident #005 exhibited an identified responsive behaviour towards resident #003.

Review of resident #005's behavioural progress notes and responsive behaviour assessments indicated the resident had a history four identified responsive behaviour towards other residents and exhibited a specified responsive behaviour. The written

responsive behaviour plan of care reflected the resident's responsive behaviours.

Prior to the CI, a review of resident #005's clinical records indicated, three documented incidents had occurred over a period of one and half months, where resident #005 had altercations with an identified resident and with resident #003. The altercation with resident #003 occurred just over four hours prior to the noted CI.

One month prior to the CI on an identified date, review of the responsive behaviour referral and follow up assessment by the BSO RPN for resident #005 directed staff to continue to follow the interventions outlined in the care plan and to be more vigilant, and implement an identified intervention.

Review of resident #005's written plan of care indicated it had been reviewed and revised just over one month prior to the CI on an identified date in 2017. It directed staff to follow two identified interventions. These interventions were implemented five months prior to the CI.

Two days after the CI, the BSO RPN directed staff to continue to follow the interventions outlined in the care plan and referred the resident to an external consultant, and was assessed on an identified date in 2017.

The written responsive behaviour plan of care for resident #005 was reviewed and revised two months after the CI on an identified date in 2017, which directed staff to enhance an identified intervention and intervene as quickly as possible and implement another identified intervention to avoid altercations.

Interview with RPN #128 who worked the day of the CI, indicated resident #005 had a history of an identified responsive behaviour towards other residents and exhibited two other identified responsive behaviours. On the day of the CI, there was an identified altercation between residents #003 and #005. The RPN indicated while they were in an identified area of the unit, a scream was heard from an identified common area and had observed resident #005 to have exhibited an identified responsive behaviour towards resident #003's personal item and an identified altercation occurred. The two residents were separated and resident #003 indicated to the RPN that resident #005 tried to exhibit an identified responsive behaviour towards them. The RPN assessed resident #003's identified area of the body at the time of the incident and did not observe any injury until 30 minutes later when resident #003 sustained injury to an identified area of the body. Another identified assessment was completed and resident #003 was interviewed and

indicated that resident #005 exhibited an identified responsive behaviour towards them. The RPN stated the staff implemented an identified intervention for resident #005. When asked what the intervention entailed, the RPN indicated it was implemented when documenting in an identified area of the unit and when the resident was in an identified common area. The RPN stated they would ask the PSW staff to implement the intervention if they were in a common area of the unit. At the time of the CI, the RPN indicated the PSW staff were providing nourishment and were not in the identified common area when the CI occurred. The RPN considered the incident to be abuse by resident #005 to resident #003.

Review of resident #003's identified assessment dated the day of the CI, indicated resident #003 sustained injury to an identified area of the body.

Interviews with PSWs #122 and #125 and RPNs #124 and #121 indicated resident #005 had identified responsive behaviours towards other residents and identified their triggers. The staff stated the resident had an identified intervention to manage their responsive behaviour and to prevent altercations with other residents. When asked what the identified entailed, PSW #125 and RPNs #124 and #121 indicated it was implemented when the resident was in an identified area of the unit and when they were documenting in two identified areas of the unit. The RPNs indicated the PSW staff had to be mindful of where the resident was located when the identified intervention was implemented.

Interview with the BSO RPN indicated resident #005 exhibited three identified responsive behaviours towards other residents and identified two triggers of the responsive behaviours. The BSO RPN indicated the intervention to manage resident #005's responsive behaviour included two identified interventions. When asked what one of the identified intervention entailed, the BSO RPN indicated, when staff were documenting and when staff were in an identified area of the unit to prevent altercations with other residents. The BSO RPN indicated that the identified intervention may not have been the most appropriate intervention, as it was not working to prevent altercations and that the plan of care had not been effective. The BSO RPN acknowledged no new interventions or approaches had been identified when the plan of care was reviewed and revised for resident #005. The BSO RPN considered the incident, to be abuse towards resident #003 by resident #005.

3. The MOHLTC received notification from the home on an identified date in 2017, through the after-hours pager and a CIS #2945-000032-17 was submitted by the home two days later, regarding resident to resident abuse between residents #003 and #006.

Resident #006 was observed by staff to leave resident #003's room with an identified object. Resident #003 came out of their room holding an identified object and stated resident #006 exhibited an identified behaviour. Resident #003 sustained injury to an identified area of the body.

Review of resident #006's clinical records indicated resident exhibited identified responsive behaviours. Four days prior to the CI, the progress notes indicated, resident #006 exhibited an identified responsive behaviour towards another resident.

Review of resident #003's incident report dated the day of the CI, indicated resident #003 sustained injury to an identified area of the body.

Interview with PSW #130 indicated resident #006 exhibited an identified responsive behaviour and had an identified responsive behaviour towards staff. On the day of the CI, the PSW indicated they heard resident #003 yelling and observed resident #006 holding the door of resident #003's room. Resident #003 was holding an identified object and sustained injury, but was unable to recall where the injury was located at the time of the interview. The PSW stated resident #003 had a history of two identified responsive behaviours toward other residents and identified the resident's triggers. The PSW indicated staff implemented an identified intervention for resident #006 to manage their identified responsive behaviour. When asked what the identified intervention entailed, the PSW indicated that staff had to keep an eye where the resident was in the unit. PSW #130 considered the incident to be abuse by resident #006 to resident #003.

Review of the written responsive behaviour plan of care at the time of the CI was dated two months prior to the CI, indicated resident #006 exhibited four identified responsive behaviours. There were three identified interventions which were all implemented over two years ago.

Interviews with RPNs #121 and #124 and PSWs #122 and #123, indicated resident #006 exhibited three identified responsive behaviours where one of the behaviours was towards other residents. The staff indicated the intervention to manage one of the resident's responsive behaviour were two identified interventions. When asked what one of the intervention entailed, the staff indicated they allowed the resident to follow staff which made implementing the intervention easier, staff had to be aware where the resident was in the unit and if in an identified area of the unit, staff were to be present in the identified area. There were no other interventions to manage resident's identified responsive behaviour.

Interview with the BSO RPN confirmed that resident #006 exhibited an identified responsive behaviour and identified two interventions to manage their behaviour. The BSO RPN indicated they had informed staff to be more vigilant and proactive in implementing the identified intervention of the resident. When asked what the identified intervention entailed, they indicated for front line staff to constantly check on resident #006, staff should be in an identified area of the unit to monitor the residents to prevent altercations and staff at night to continue their rounds on residents that exhibited the same responsive behaviour. The BSO RPN stated that the identified intervention had not been an effective intervention as there was an altercation between residents #003 and #006 and considered the incident between the residents to be abuse by resident #006.

Interview with the DOC indicated resident #006 exhibited an identified responsive behaviour. Resident #003 and #006 had a history of two identified responsive behaviour towards other residents. The DOC indicated staff were to implement an identified intervention for both residents. When asked what the identified intervention entailed, the DOC stated that staff had to look out for the residents and intervene if resident #006 exhibited the identified responsive behaviour towards resident #003. The DOC stated the identified intervention had not been effective as an altercation occurred between the two residents causing injury. The home should have used interventions that were more effective to manage resident #006's identified responsive behaviour. The DOC considered the CI to be abuse of resident #003 by resident #006.

4. The MOHLTC received notification through the MOHLTC after-hours pager on an identified date in 2017, regarding an incident of resident to resident abuse between residents #001 and #002. The home submitted a CIS report #2945-000034-17, the following day, which indicated two altercations between the residents over a span of 25 minutes.

The first incident, occurred at an identified time, and PSW #101 witnessed resident #002 to have exhibited an identified responsive behaviour towards resident #001 with an identified object in a common area of the unit. Resident #001 sustained injury to an identified area of the body. The second incident occurred 25 minutes later in a common area outside of each of the residents' rooms where resident #001 exhibited an identified responsive behaviour towards resident #002. Resident #002 attempted to exhibit an identified responsive behaviour towards resident #001 but lost their balance and fell. Resident #002 sustained injury from the fall.

Review of resident #001's identified assessment dated the day of the CI, indicated resident sustained injury to an identified area of the body.

Review of resident #002's written responsive behaviour plan of care, indicated resident exhibited an identified responsive behaviour and had a history of two identified responsive behaviours toward other residents.

Review of residents #001 and #002's progress notes indicated six incidents of altercations between the two prior to the CI.

Interviews with RPNs #105 and #119 indicated residents #001 and #002 had been triggers for each other and had numerous altercations with each other. RPN #119 indicated the CI, was considered to be abuse by resident #002 towards resident #001.

Interview with the BSO RPN #104 indicated resident #002 had been on their caseload since an identified date in 2016, to manage their responsive behaviours. The BSO RPN stated residents #001 and #002 had been triggers for each other and had altercations with one another. The interventions in place to minimize altercations between the two residents had been three identified interventions. When asked what one of the interventions entailed, the BSO RPN indicated that staff would implement the intervention when residents are in a common area and separate the residents to prevent altercations. The identified intervention was implemented when documenting and to redirect both residents if they are close to each other. The BSO RPN indicated the interventions were not effective as there were six incidents of altercations between the two residents prior to the CI. The BSO RPN considered the incident to be abuse towards resident #001 by resident #002.

Additional Required Actions:

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

Issued on this 1st day of August, 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

Ministére 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) :	JOY IERACI (665)
Inspection No. / No de l'inspection :	2018_712665_0003
Log No. / No de registre :	020937-17, 022378-17, 022721-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 16, 2018
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Woodbridge Vista Care Community 5400 Steeles Avenue West, Woodbridge, ON, L4L-9S1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lora Monaco

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the Act.

Specifically the licensee must prepare, submit and implement a plan to ensure that the care set out in the plans of care for residents #001, #003 and #004 are provided as specified in the plan. The plan must include, but is not limited to the following:

1) Develop a process to ensure the contents of the plans of care for residents #001, #003 and #004 are communicated to the registered staff and PSWs.

2) Develop an ongoing auditing process to ensure the plans of care for residents #001, #003 and #004 are implemented as specified in the plan. The home is required to maintain a documentation record of the audits, the dates the audits were conducted, who performed the audits and an evaluation of the results.

Please submit the written plan for achieving compliance for, 2018_712665_003 to Joy Ieraci, LTC Homes Inspector, MOHLTC, by email to TorontoSAO.moh@ontario.ca by July 28, 2018.

Grounds / Motifs :

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

The home submitted three critical incident system (CIS) reports, #2945000028-17, #2945000031-17 and #2945000032-17 to the Ministry of Health and Long Term Care (MOHLTC) for resident to resident altercations involving resident #003 over a period of 28 days on three identified dates in 2017.

Review of resident #003's clinical records indicated the resident had been admitted to an identified facility to manage their responsive behaviour on an identified date in 2018, and had returned to the home eight weeks later.

During observations on an identified date in 2018, at 1145 hours (hrs), the substitute decision maker (SDM) of resident #003 informed the Inspector of their concern regarding medication administration for the resident since returning from the identified facility. The SDM indicated they were concerned that the recommendations from the identified facility were not being followed regarding administering medications to the resident. The SDM stated they found medications in the resident's mouth on an identified date in 2018, during their visit with the resident.

Record review of the care tips from the identified facility, indicated that resident #003 had responsive behaviours when taking their medications. The care tips had four identified interventions related to medication administration. Review of the current written plan of care reflected the above recommendations for medication administration for resident #003.

Interviews with Registered Practical Nurses (RPNs) #121 and #127 indicated the resident had a history of two identified responsive behaviours towards other residents and exhibited another identified responsive behaviour towards staff. The RPNs stated they were aware of resident #003's responsive behaviours when taking medications. Both RPNs also indicated that they did not follow one of the identified interventions when the medications had been administered as per the plan of care. The RPNs stated that it is important to follow the plan of care for the resident to ensure their responsive behaviour did not continue and worsen.

Interview with RPN #124 who worked when the SDM visited the resident noted above, confirmed the resident had two identified responsive behaviour towards other residents. The RPN confirmed they had not followed two of the four interventions when they administered medications to resident #003 on the identified date in 2018. The RPN indicated it is important to follow the plan of care to ensure that resident #003's behaviour was managed and did not worsen. The RPN said they had not followed the plan of care as specified in the plan for resident #003.

Interview with the Associate Director of Care (ADOC) on an identified date in 2018, indicated they had followed up with the registered staff regarding the interventions for medication administration for the resident at the request of the Executive Director (ED) the day prior. The ADOC said they had met with the registered staff and reviewed the interventions for medication administration in the plan of care plan since the resident's return from the identified facility. The ADOC said the expectation was that registered staff follow the plan of care regarding medication administration for resident #003 and RPNs #121, #124 and #127 had not provided the care as specified in the plan for resident #003.

2. The responsive behaviour inspection protocol (IP) was initiated as the home notified the MOHLTC after-hours pager on an identified date in 2017, and submitted a CIS report #2945-000031-17 to the MOHLTC the next day, regarding resident to resident abuse. The CIS report indicated residents #003 and #004 had an altercation with one another.

Record review of resident #004's clinical record indicated resident had a history of two identified responsive behaviours toward other residents and exhibited another identified responsive behaviour.

Record review of the resident's current plan of care identified an intervention to manage the resident's responsive behaviour under two different focus areas.The plan of care directed staff when to implement the identified intervention.

Interviews with RPNs #121 and #124 and Personal Support Workers (PSWs) #122 and #123 indicated resident #004 had a history of two identified responsive behaviours toward other residents and exhibited another identified responsive behaviour. The staff indicated the identified intervention noted above managed resident #004's responsive behaviour.

Observation conducted on an identified date in 2018, at 1330 hrs indicated the resident was seated in an identified area of the unit without the identified intervention in place.

Interview with PSW #125 indicated they had been aware that the identified intervention managed resident #004's responsive behaviour. When asked why the intervention was not in place, the PSW indicated they had been too busy after the lunch meal service. The PSW said they had not followed the plan of care as specified in the plan for resident #004.

3. The Ministry of Health and Long Term Care (MOHLTC) received a complaint, through the ACTIONline on an identified date in 2017. The complainant alleged that resident #001 was abused on a specified date in 2017, by another resident, who entered resident #001's room, sustaining injury to an identified area of resident #001's body. The home submitted a CIS report #2945-000029-17 to the MOHLTC of the incident five days after the specified date in 2017, regarding the allegation of abuse towards resident #001 by resident #002.

One month after the complaint above was received by the MOHLTC, a complaint response was received from the home on an identified date, regarding an incident between residents #001 and #002, which had occurred 10 days prior. The complainant provided a written complaint to the home via email regarding an altercation between residents #001 and #002.

After two weeks of receiving the complaint response from the home, the MOHLTC after-hours pager was notified and a CIS report #2945-000034-17 related to a mandatory report of resident to resident abuse between residents #001 and #002 was submitted by the home on an identified date. The CIS report indicated two altercations between residents #001 and #002 on the same day.

The first incident occurred at an identified time. A PSW witnessed resident #002 had exhibited an identified responsive behaviour towards resident #001 with an identified object, resulting in injury to two different areas of the body on resident #001. The second incident occurred 25 minutes later in the hallway outside of each of the residents' rooms where residents #001 and #002 had an altercation with each other.

A review of resident #001's clinical records indicated the resident had two identified responsive behaviours toward other residents and exhibited another specified responsive behaviour. A review of resident #001's current plan of care indicated a specific intervention to prevent triggering resident #001's responsive behaviour.

Observations conducted on two different dates in March 2018, indicated the specific intervention had not been implemented.

Interview with resident #001 indicated they were aware of the specific intervention and indicated the intervention had to be in place.

Interview with PSW #103 indicated resident #001 had two identified responsive behaviours and a trigger had been identified. The PSW indicated they were aware that the plan of care for the resident included the specific intervention. The PSW said they had forgotten to put in place the specific intervention on the identified date in March 2018. The PSW stated it is the home's expectation for the plan of care to be followed and they had not followed the plan of care for resident #001.

Interview with RPN #114 indicated the plan of care for resident #001 included the specific intervention to prevent resident #001 from being triggered. The RPN stated that the resident had told them it was their preference to have the intervention in place. The RPN said it is the home's expectation for the plan of care to be followed. The RPN stated the intervention was effective and it was important for the plan of care to be followed to prevent the resident from exhibiting responsive behaviours.

Interview with the ADOC indicated it is the home's expectation for the plan of care to be followed as specified in the plan. The ADOC acknowledged the specific intervention was to be implemented to prevent the resident from exhibiting responsive behaviours.

The severity of this issue was determined to be a level two as there was a risk or potential for actual harm/risk to residents #001, #003 and #004. The scope of the issue was a pattern as it involved three out of six residents that were reviewed. The home had a history of ongoing non-compliance with VPC or compliance order (CO) in the last 36 months as follows:
- #2017_527665_0012, Resident Quality Inspection (RQI), October 30, 2017 - VPC
- #2016_324535_0009, RQI, December 14, 2016 - VPC
- #2016_405189_0008, Critical Incident System Inspection, June 2, 2016 - CO #001
- #2016_378116_0005, Complaint Inspection, February 10, 2016 – VPC

(665)

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

Ministére 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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 10, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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

(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).

Order / Ordre :

The licensee must be compliant with s. 6 (11) b of the Act.

Specifically, the licensee must prepare, submit and implement a plan to ensure when residents #001, #002, #003 and #005 are reassessed and the plan of care reviewed and revised because the care set out in the plan has not been effective, the licensee must ensure that different approaches are considered in the revision of the plan of care. The plan must include, but is not limited to the following:

1) Identify different approaches to manage the responsive behaviours of residents #001, #002, #003 and #005 and any other resident identified as having responsive behaviours towards co-residents.

2) Update the plans of care with these approaches for residents #001, #002, #003 and #005 and any other resident identified as a result.

3) Develop a plan on how the different approaches and or strategies will be implemented for residents #001, #002, #003 and #005 and other identified residents with responsive behaviours towards co-residents.

4) Develop an on-going audit tool to monitor the plans of care for residents #001, #002, #003 and #005 and any other identified residents for different approaches when the care set out in the plan of care has not been effective. The home is required to maintain a documentation record of the audit, the date the audit is conducted, who completed the audit, the outcome of the audit and an analysis of the results.

Please submit the written plan for achieving compliance for, 2018_712665_003 to Joy Ieraci, LTC Homes Inspector, MOHLTC, by email to TorontoSAO.moh@ontario.ca by July 28, 2018.

Grounds / Motifs :

1. The licensee failed to ensure when a resident was reassessed and the plan of care reviewed and revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches were considered in the revision of the plan of care.

The home submitted three CIS reports, #2945000028-17, #2945000031-17 and #2945000032-17 to the MOHLTC for resident to resident altercations involving

resident #003 over a period of 28 days on three identified dates in 2017. The first incident occurred with resident #005, 22 days later with resident #004 and six days later with resident #006.

Review of resident #003's clinical records indicated the resident had been admitted to an identified facility to manage their responsive behaviour on an identified date in 2018, and had returned to the home eight weeks later. The resident's clinical records also indicated the resident had a history of two identified responsive behaviours toward others and a trigger was identified.

Review of the written responsive behaviour plan of care to manage resident #003's responsive behaviour indicated nine interventions which were implemented five months prior to the critical incident (CI) with resident #005. Four months after the interventions were implemented and one month prior to the CI with resident #005, a review of resident #003's progress notes indicated three documented incidents related to responsive behaviours towards co-residents. The incidents had occurred within a period of 10 days on two identified dates in 2017. Staff separated the residents and no injury occurred from the incidents.

Resident #003's written responsive behaviour plan of care was reviewed and revised the same month when the three documented incidents occurred noted above. An identified intervention was added to the written plan of care.

One month after the documented incidents noted above, further review of resident #003's progress notes indicated another three incidents had occurred over a period of 22 days with co-residents as follows:
1) Resident #003 had an altercation with resident #005 in an identified area of the unit. A CIS #2945000032-17 report was submitted noted above and resident #003 sustained injury to an identified area of the body.
2) Residents #003 and #005 had an altercation with each other in an identified area of the unit. No injuries noted and residents were separated.
3) Resident #003 had altercation with resident #004 in front of resident #003's door resulting in injury to resident #004. A CIS report #2945000031-17 was submitted noted above.

Resident #003's responsive behaviour referral and assessment dated one day after the CI with resident #004, directed staff to follow the interventions in the care plan and enhance one of the nine interventions noted earlier with identified

residents, intervene and remove these residents away from the resident #003's room.

Four days after the responsive behaviour referral and assessment was completed, resident #003 exhibited an identified responsive behaviour towards resident #004. Staff separated the residents. One day later, resident #003 had an altercation with resident #006 resulting in injury to resident #003 as per CIS #2945000032-17 noted above.

The plan of care had been updated 13 days after the altercation resident #003 had with resident #006, with an identified intervention. The care team was directed to intervene accordingly and night staff was to enhance one of the nine interventions noted earlier as much as possible.

Twenty-five days after resident #003's altercation with resident #006, there was another incident when resident #003 exhibited two identified behaviours toward an unidentified resident in an identified area of the unit. Resident #003 exhibited an identified responsive behaviour with the co-resident who attempted to sit on an empty chair next to them. Staff separated the residents. Nineteen days later, resident #003 had an identified altercation with resident #004 in front of their room. Resident #003 was observed to have exhibited an identified responsive behaviour and swinging an identified object at resident #004. Staff separated the residents and no injury noted.

A review of resident #003's BSO assessment dated the day of the altercation with resident #004 noted above, directed staff to continue to enhance one of the nine interventions mentioned earlier and intervene to prevent further escalation in the event of altercations.

Resident #003's plan of care was updated 11 days later with a new intervention to ward off identified residents.

Interviews with RPNs #121 and #124 indicated that resident #003 had a history of responsive behaviour towards other residents. They indicated resident had an identified responsive behaviour and identified three triggers for the responsive behaviour.

PSW #130 and RPNs #121 and #124 indicated the interventions that were in place to manage resident #003's responsive behaviour were one of the nine

interventions mentioned earlier, and two other identified interventions to prevent other residents from triggering resident #003. When asked what one of the nine interventions entailed, the staff indicated the intervention was implemented when staff were documenting in an identified area of the unit, monitor an identified common area, and staff were to be in the identified common area when an identified trigger was present.

Further interviews with PSWs #131 and #132 and RPNs #133, #134 indicated resident #003 had responsive behaviours towards co-residents. The staff indicated resident #003 exhibited an identified responsive behaviour by an identified trigger, and another identified trigger. The staff identified four interventions that had been in place to manage resident's responsive behaviour. One of these interventions included one of the nine interventions noted earlier. When asked what one of the nine interventions entailed, staff indicated they implement the intervention when they were near the resident. This would include times they were documenting, or when near the resident's room. Staff indicated there was no set time when the identified intervention was implemented, but would do it when it was convenient.

Interviews with RPNs #133 and #134 indicated the one of the nine intervention noted for resident #003 had not been effective in preventing altercations with other residents. RPN #134 indicated two family members raised concern regarding resident #003's behaviour and preferred for their loved ones living in the home not to be in the same room with resident #003.

Interview with the BSO RPN who assessed resident #003 and provided interventions to staff over a two month period in 2017, indicated the resident had been on their caseload since admission on an identified date in 2017. When asked what one of the nine interventions entailed, the BSO RPN indicated that staff would implement the intervention when the residents were in a common area and separate the residents to prevent altercations and when documenting. The BSO RPN indicated the intervention had not been effective and another identified intervention was implemented on an identified date in 2017. When asked if these interventions were effective in managing altercations between resident #003 and other residents, the BSO RPN indicated that the intervention may not have been the most appropriate intervention as it had not worked to prevent altercations and had not been effective. The BSO RPN said no new approaches had been identified when the plan of care was reviewed and revised for resident #003 until after seven documented altercations with other residents.

2. The MOHLTC received notification from the home on an identified date in 2017, through the after-hours pager and a CIS #2945000028-17 report was submitted by the home two days later, regarding resident to resident abuse between residents #003 and #005. The CIS report indicated resident #003 was observed to have injury to an identified area of the body. As per CIS report, resident #005 exhibited an identified responsive behaviour towards resident #003.

Review of resident #005's behavioural progress notes and responsive behaviour assessments indicated the resident had a history four identified responsive behaviours toward other residents and exhibited a specified responsive behaviour. The written responsive behaviour plan of care reflected the resident's responsive behaviours.

Review of the written responsive behaviour plan of care for resident #005 had interventions that were implemented on an identified date in 2017, five months prior to the CI. The plan of care directed staff to follow two identified interventions. The written plan of care was reviewed on three identified dates over a period of three months, with no changes made.

Review of resident #005's progress notes indicated two documented incidents related to responsive behaviours on an identified month in 2017, with resident #003. The two incidents occurred within a period of two weeks. One of the incidents resulted in injury to #003 by resident #005 and the submission of the critical incident.

Review of resident #005's progress notes and responsive behaviour assessments indicated that the resident had been followed and assessed by the BSO RPN and provided interventions for staff to follow on three identified dates over a period of three months, with the same interventions noted above. The staff were also directed to be more vigilant, with an identified intervention whenever the resident presented with the responsive behaviour. Resident was referred to an external consultant two days after the altercation with resident #003 for an assessment. The progress notes and assessments were dated prior to and after the CI had occurred.

Two weeks after the altercations with resident #003 noted above, further review

of resident #005's progress notes indicated another two incidents on identified dates occurred with a co-resident and with resident #003.

A review of resident #005's clinical record indicated a BSO assessment was completed one month after the last altercation with resident #003 noted above. The assessment directed staff to continue with an identified intervention and intervene in a timely manner.

Over a five month period after the last documented incident between resident #005 and #003, another three documented incidents occurred when resident #005 exhibited responsive behaviour towards resident #004 and other residents.

Interview with RPN #128 indicated resident #005 had a history of an identified responsive behaviours towards other residents. The RPN stated an identified intervention was implemented to manage their responsive behaviours. When asked what the intervention entailed, the RPN indicated it was implemented when they are documenting in an identified area of the unit and would ask the PSW staff to implement the intervention when they were in two identified areas of the unit.

Interviews with PSWs #122 and #125 and RPNs #124 and #121 indicated resident #005 had identified responsive behaviours towards other residents and they identified resident #005's triggers. The staff stated the resident had an identified intervention to manage their responsive behaviour and to prevent altercations with other residents. When asked what the identified intervention entailed, PSW #125 and RPNs #124 and #121 indicated it was implemented when the resident was in an identified area of the unit and when they were documenting in two identified areas of the unit. The RPNs indicated the PSW staff are to be mindful of where the resident was located when the identified intervention was implemented.

Interview with the BSO RPN indicated resident #005 exhibited three identified responsive behaviours toward other residents and identified two triggers. The BSO RPN indicated the intervention to manage resident #005's responsive behaviour included two identified interventions. When asked what one of the identified intervention entailed, the BSO RPN indicated, when staff were documenting and when staff were in an identified area of the unit to prevent altercations with other residents. The BSO RPN indicated that the identified

intervention may not have been the most appropriate intervention, as it was not working to prevent altercations and that the plan of care had not been effective. The BSO RPN acknowledged no new interventions or approaches had been identified when the plan of care was reviewed and revised for resident #005.

3. The Ministry of Health and Long Term Care (MOHLTC) received a complaint, through the ACTIONline on an identified date in 2017. The complainant alleged that resident #001 was abused on a specified date in 2017, by resident #002. The home submitted a CIS report #2945-000029-17 to the MOHLTC of the incident regarding the allegation the day after the complaint was received.

One month after the complaint above was received by the MOHLTC, a complaint response was received from the home on an identified date in 2017, regarding a written complaint for an incident that occurred between residents #001 and #002. The incident occurred 10 days prior to receiving the complaint response.

Within one month of receiving the complaint response from the home, the MOHLTC after-hours pager was notified and another CIS report #2945-000034-17 related to a mandatory report of resident to resident abuse between residents #001 and #002 was submitted by the home on an identified date. The CIS report indicated two altercations between residents #001 and #002 on the same day.

A review of resident #001's clinical records indicated the resident had two identified responsive behaviours toward other residents and exhibited a specified responsive behaviour. Review of the written responsive behaviour plan of care, included five identified interventions to manage the resident's responsive behaviours and had been implemented four months prior to the CIS #2945-000029-17 on two identified dates in 2017.

The written responsive behaviour plan of care was reviewed and revised on three identified dates over a period of two months with identified interventions to manage the resident's responsive behaviour after the CIS #2945-000029-17 had occurred.

Review of resident #001's progress notes and responsive behaviour assessments indicated that the resident had been followed and assessed by the BSO nurse and provided interventions for staff to follow on five identified dates over a period of six months.

Review of resident #001's progress notes indicated two documented incidents between residents #001 and #002 prior to the CI #2945-000029-17 that was submitted. After the CI noted above, there were another five documented incidents between residents #001 and #002 over a period of two months.

Review of resident #001's BSO assessments dated four days prior to the CIS #2945-000034-17, it directed staff to continue to implement an identified intervention, which had been in for place six months in the plan of care.

Interviews with PSW #116 and RPNs #102, #105 and #119 indicated residents #001 and #002 would trigger each other. The staff indicated there had been altercations between the two residents. The staff indicated resident #001 had identified responsive behaviours and identified their triggers. RPN #102 indicated the identified interventions for resident #001 had been in the plan of care for six months prior to CIS #2945-000034.

Interview with the BSO RPN #104 indicated resident #002 had been on their caseload since an identified date in 2016, to manage their responsive behaviours towards other residents. The BSO RPN stated residents #001 and #002 had been triggers for each other and had altercations with one another. The interventions that had been in place to minimize altercations between the two residents included two identified interventions. When asked what one of the identified intervention entailed, the RPN indicated that staff would implement the intervention when the residents were in identified areas of the unit and separate the residents to prevent altercations. The identified intervention was also implemented when staff were documenting. The BSO RPN indicated the two identified interventions may not have been the most appropriate interventions as there were seven incidents of altercations between residents #001 and #002 over a period of three months. The interventions were not working in preventing the altercations between the residents and that the plan of care had not been effective. The BSO RPN acknowledged no new approaches had been identified when the plan of care was reviewed and revised for resident #001.

4. The Ministry of Health and Long Term Care (MOHLTC) received a complaint, through the ACTIONline on an identified date in 2017. The complainant alleged that resident #001 was abused on a specified date in 2017, by resident #002. The home submitted a CIS report #2945-000029-17 to the MOHLTC of the incident regarding the allegation the day after the complaint was received.

One month after the complaint above was received by the MOHLTC, a complaint response was received from the home on an identified date in 2017, regarding a written complaint for an incident that occurred between residents #001 and #002. The incident occurred 10 days prior to receiving the complaint response.

Within one month of receiving the complaint response from the home, the MOHLTC after-hours pager was notified and another CIS report #2945-000034-17 related to a mandatory report of resident to resident abuse between residents #001 and #002 was submitted by the home on an identified date. The CIS report indicated two altercations between residents #001 and #002 on the same day.

A review of resident #002's clinical records indicated the resident exhibited two identified responsive behaviours toward other residents and another specified responsive behaviour. Review of the written responsive behaviour plan of care, included six identified interventions which had been implemented seven months prior to the CIS #2945-000029-17, on an identified date in 2017.

Review of resident #002's progress notes and responsive behaviour assessments indicated that resident had been followed and assessed by the BSO RPN and had provided interventions for staff to follow on five identified dates in 2017, over a period of two months. The BSO RPN directed staff to continue to review the care plan and kardex and follow the interventions outlined in the care plan.

Review of the written responsive behaviour plans of care for resident #002 indicated the plan of care was updated with two new interventions over a period of two months, on two identified dates in 2017, and had been in place for three months prior to CIS #2945-000029-17.

Review of resident #002's progress notes indicated two documented incidents between residents #001 and #002 prior to CIS #2945-000029-17 that was submitted. After the CI, there were another two documented incidents between residents #001 and #002 which had occurred over a period of one month.

Review of resident #002's BSO assessment completed after CIS #2945-000029-17, the staff was directed to continue to review the interventions outlined in the care plan and team to continue to implement an identified intervention.

Review of the written responsive behaviour plan of care for resident #002

indicated a new intervention was added on an identified date in 2017, in response to one of the incidents that occurred with resident #001.

Further review of resident #002's progress notes, prior to CIS #2945-000034-17, indicated five additional incidents between residents #001 and #002 over a one month period.

Review of the BSO assessment dated 20 days after CIS #2945-000029-17, it directed staff that interventions to address the resident #002's responsive behaviour were outlined in the care plan. After CIS #2945-000034-17, resident #002's written responsive behaviour plan of care was updated to include an identified intervention.

Interviews with PSW #116 and RPNs #102, #105 and #119 indicated residents #001 and #002 had been triggers for each other. The staff indicated there had been altercations between the two residents. The staff indicated resident #002 had responsive behaviours towards other residents. The staff stated resident #002 exhibited a specified responsive behaviour at all times.

Interview with RPN #107 indicated three identified interventions had been in place for resident #002. When asked what an identified intervention entailed, the RPN indicated it had been implemented when staff were documenting or when staff are in an area where resident #002 was located.

Interview with the BSO RPN #104 indicated resident #002 had been on their caseload since an identified date in 2016, to manage their responsive behaviours toward other residents. The BSO RPN stated residents #001 and #002 had been triggers for each other and had altercations with one another. The interventions that had been in place to minimize altercations between the two residents included two identified interventions. When asked what one of the identified intervention entailed, the RPN indicated that staff would implement the intervention when the residents were in identified areas of the unit and separate the residents to prevent altercations. The identified intervention was also implemented when staff were documenting. The BSO RPN indicated the two identified interventions may not have been the most appropriate interventions as there were seven incidents of altercations between residents #001 and #002 over a period of three months. The interventions were not working in preventing the altercations between the residents and that the plan of care had not been effective. The BSO RPN acknowledged no new approaches had been identified

when the plan of care was reviewed and revised for resident #002.

The severity of this issue was determined to be a level two as there was a risk or potential for actual harm/risk to residents #001, #002, #003 and #005. The scope of the issue was a pattern as it affected four out of six residents that were reviewed. The home had a history of ongoing non-compliance with VPC or compliance order (CO) in the last 36 months in inspection #2017_527665_0012, Resident Quality Inspection (RQI), October 30, 2017, with VPC issued.
(665)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 10, 2018

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

Ministére 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

Order # / Ordre no : 003

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

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 Act.

Specifically, the licensee must prepare, submit and implement a plan to ensure that:
- resident #001 is protected from abuse by resident #002
- resident #003 is protected from abuse by residents #005 and #006
- resident #004 is protected from abuse by resident #003.

In addition, residents #001, #003 and #004 are to be protected from abuse by other co-residents who exhibits responsive behaviours. The plan must include, but is not limited, to the following:

1) Update the plan of care for resident #001 and resident #002, to include interventions and/or strategies to protect resident #001 from abuse by resident #002 and any other resident.

2) Update the plan of care for resident #003 and residents #005 and #006, to include interventions and/or strategies to protect resident #003 from abuse by residents #005 and #006 and any other resident.

3) Update the plan of care for resident #004 and resident #003, to include interventions and/or strategies to protect resident #004 from abuse by resident #003 and any other resident.

4) Develop a process to monitor residents who exhibit wandering behaviours to prevent altercations with co-residents.

5) Provide education to registered staff and PSWs that will enable them to identify strategies and or interventions to prevent resident to resident abuse. The home is required to maintain a documentation record of the material taught, education dates,
attendance records and the educator.

Please submit the written plan for achieving compliance for, 2018_712665_003 to Joy Ieraci, LTC Homes Inspector, MOHLTC, by email to TorontoSAO.moh@ontario.ca by July 28, 2018.

Grounds / Motifs :

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

anyone.

The MOHLTC received notification from the home on an identified date in 2017, through the after-hours pager and a CIS report, #2945-000031-17 was submitted by the home one day later, regarding resident to resident abuse between residents #003 and #004. As per CIS report, RPN #124 heard a noise and saw resident #004 standing at the doorway of resident #003's room. Resident #004 was holding an identified object in an attempt to exhibit an identified responsive behaviour towards resident #003. Resident #003 was standing at their doorway waving an identified object and exhibited an identified responsive behaviour towards resident #004. Resident #004 sustained injury to an identified area of the body.

Review of resident #003's clinical records indicated the resident had been admitted to an identified facility to manage their responsive behaviour on an identified date in 2018, and had returned to the home eight weeks later. The resident's clinical records also indicated the resident had a history of two identified responsive behaviours toward others and was triggered by other residents going into their room.

Interview with PSW #130 stated resident #003 had a history of two identified responsive behaviours toward other residents and had altercations with other residents.

Review of resident #003's progress notes indicated that two months prior to CI #2945-000031-17, there were three documented incidents where residents triggered resident #003 in the same month on identified dates in 2017. The incidents resulted in resident #003 to have exhibited an identified responsive behaviour towards the other residents.

Six days after the critical incident, a progress note, indicated resident #006 exhibited an identified responsive behaviour towards resident #003 which resulted in an altercation. Resident #003 sustained injury and another CIS report #2945-000032-17 was submitted to the MOHLTC.

Record review of resident #004's clinical record indicated the resident had a history of two identified responsive behaviours toward other residents and exhibited a specified behaviour.

Interviews with RPNs #121 and #124 and PSWs #122 and #123 indicated resident #004 had a history of two identified responsive behaviours toward other residents and exhibited a specified behaviour. The staff indicated resident #004 exhibited the specified behaviour in identified areas of the unit, especially during an identified time of the day. There were two identified interventions to manage resident's #004's responsive behaviours. When asked what one of the identified intervention entailed, the staff indicated they had to be mindful where resident #004 was in the unit, and staff to implement the intervention they were in identified areas of the unit to prevent altercations.

Review of the written responsive behaviour plan of care to manage resident #003's responsive behaviour indicated nine interventions which were implemented six months prior to CIS #2945-000031-17.

Within two months prior to CIS #2945-000031-17, there were three documented incidents of residents triggering resident #003 resulting in altercations.

Review of the written plan of care for resident #003 indicated there were no new interventions to manage the identified residents from triggering resident #003.

Interview with RPN #124 indicated resident #003 had a history of two identified responsive behaviours toward other residents. The resident had a specified responsive behaviour and the RPN identified the triggers for the resident. The RPN indicated on the day of CIS #2945-000031-17 had occurred, they heard a noise in the area of resident #003's room and observed residents #003 and #004 in front of resident #003's room. Resident #003 was waving an identified object at resident #004 and the RPN separated the residents. The RPN indicated resident #004 sustained injury to an identified area of the body. The intervention that had been in place to prevent identified residents from tiggering resident #003 was an identified intervention. When asked what the identified intervention entailed, the RPN indicated the staff were constantly making sure where resident #003 was in the unit to prevent altercations. RPN #124 considered the incident to be physical abuse by resident #003 to resident #004.

Interview with the BSO RPN indicated resident #004 exhibited an identified responsive behaviour. The BSO RPN stated resident #003 had a history of identified responsive behaviours. The BSO RPN indicated the intervention that had been in place to manage resident #003's specified behaviour were two identified interventions that had been in place six months prior to the CI on an

identified date in 2017. One of the identified intervention that had been in place, had not been effective. The BSO RPN stated there were no new interventions implemented until after the CI occurred on an identified date in 2017. The BSO RPN considered the incident between residents #003 and #004 to be abuse towards resident #004.

Interview with the ADOC indicated resident #003 exhibited a specified responsive behaviour. The resident would exhibit two identified responsive behaviours toward other residents who had triggered them. An identified intervention that had in place for six months prior to the CI, was not an effective intervention to manage the resident's specified responsive behaviour. The ADOC indicated no new interventions had been put in place until after the CI had occurred at the end of an identified month in 2017. The ADOC stated it took so long to implement new interventions as the home struggled to find an effective intervention to manage resident #003's identified responsive behaviour and prevent altercations with identified residents.

2. The MOHLTC received notification from the home on an identified date in 2017, through the after-hours pager and a CIS #2945000028-17 report was submitted by the home two days later, regarding resident to resident abuse between residents #003 and #005. The CIS report indicated resident #003 was observed to have injury to an identified area of the body. As per CIS report, resident #005 exhibited an identified responsive behaviour towards resident #003.

Review of resident #005's behavioural progress notes and responsive behaviour assessments indicated the resident had a history four identified responsive behaviour towards other residents and exhibited a specified responsive behaviour. The written responsive behaviour plan of care reflected the resident's responsive behaviours.

Prior to the CI, a review of resident #005's clinical records indicated, three documented incidents had occurred over a period of one and half months, where resident #005 had altercations with an identified resident and with resident #003. The altercation with resident #003 occurred just over four hours prior to the noted CI.

One month prior to the CI on an identified date, review of the responsive behaviour referral and follow up assessment by the BSO RPN for resident #005

directed staff to continue to follow the interventions outlined in the care plan and to be more vigilant, and implement an identified intervention.

Review of resident #005's written plan of care indicated it had been reviewed and revised just over one month prior to the CI on an identified date in 2017. It directed staff to follow two identified interventions. These interventions were implemented five months prior to the CI.

Two days after the CI, the BSO RPN directed staff to continue to follow the interventions outlined in the care plan and referred the resident to an external consultant, and was assessed on an identified date in 2017.

The written responsive behaviour plan of care for resident #005 was reviewed and revised two months after the CI on an identified date in 2017, which directed staff to enhance an identified intervention and intervene as quickly as possible and implement another identified intervention to avoid altercations.

Interview with RPN #128 who worked the day of the CI, indicated resident #005 had a history of an identified responsive behaviour towards other residents and exhibited two other identified responsive behaviours. On the day of the CI, there was an identified altercation between residents #003 and #005. The RPN indicated while they were in an identified area of the unit, a scream was heard from an identified common area and had observed resident #005 to have exhibited an identified responsive behaviour towards resident #003's personal item and an identified altercation occurred. The two residents were separated and resident #003 indicated to the RPN that resident #005 tried to exhibit an identified responsive behaviour towards them. The RPN assessed resident #003's identified area of the body at the time of the incident and did not observe any injury until 30 minutes later when resident #003 sustained injury to an identified area of the body. Another identified assessment was completed and resident #003 was interviewed and indicated that resident #005 exhibited an identified responsive behaviour towards them. The RPN stated the staff implemented an identified intervention for resident #005. When asked what the intervention entailed, the RPN indicated it was implemented when documenting in an identified area of the unit and when the resident was in an identified common area. The RPN stated they would ask the PSW staff to implement the intervention if they were in a common area of the unit. At the time of the CI, the RPN indicated the PSW staff were providing nourishment and were not in the identified common area when the CI occurred. The RPN considered the incident

to be abuse by resident #005 to resident #003.

Review of resident #003's identified assessment dated the day of the CI, indicated resident #003 sustained injury to an identified area of the body.

Interviews with PSWs #122 and #125 and RPNs #124 and #121 indicated resident #005 had identified responsive behaviours towards other residents and identified their triggers. The staff stated the resident had an identified intervention to manage their responsive behaviour and to prevent altercations with other residents. When asked what the identified entailed, PSW #125 and RPNs #124 and #121 indicated it was implemented when the resident was in an identified area of the unit and when they were documenting in two identified areas of the unit. The RPNs indicated the PSW staff had to be mindful of where the resident was located when the identified intervention was implemented.

Interview with the BSO RPN indicated resident #005 exhibited three identified responsive behaviours towards other residents and identified two triggers of the responsive behaviours. The BSO RPN indicated the intervention to manage resident #005's responsive behaviour included two identified interventions. When asked what one of the identified intervention entailed, the BSO RPN indicated, when staff were documenting and when staff were in an identified area of the unit to prevent altercations with other residents. The BSO RPN indicated that the identified intervention may not have been the most appropriate intervention, as it was not working to prevent altercations and that the plan of care had not been effective. The BSO RPN acknowledged no new interventions or approaches had been identified when the plan of care was reviewed and revised for resident #005. The BSO RPN considered the incident, to be abuse towards resident #003 by resident #005.

3. The MOHLTC received notification from the home on an identified date in 2017, through the after-hours pager and a CIS #2945-000032-17 was submitted by the home two days later, regarding resident to resident abuse between residents #003 and #006. Resident #006 was observed by staff to leave resident #003's room with an identified object. Resident #003 came out of their room holding an identified object and stated resident #006 exhibited an identified behaviour. Resident #003 sustained injury to an identified area of the body.

Review of resident #006's clinical records indicated resident exhibited identified responsive behaviours. Four days prior to the CI, the progress notes indicated,

resident #006 exhibited an identified responsive behaviour towards another resident.

Review of resident #003's incident report dated the day of the CI, indicated resident #003 sustained injury to an identified area of the body.

Interview with PSW #130 indicated resident #006 exhibited an identified responsive behaviour and had an identified responsive behaviour towards staff. On the day of the CI, the PSW indicated they heard resident #003 yelling and observed resident #006 holding the door of resident #003's room. Resident #003 was holding an identified object and sustained injury, but was unable to recall where the injury was located at the time of the interview. The PSW stated resident #003 had a history of two identified responsive behaviours toward other residents and identified the resident's triggers. The PSW indicated staff implemented an identified intervention for resident #006 to manage their identified responsive behaviour. When asked what the identified intervention entailed, the PSW indicated that staff had to keep an eye where the resident was in the unit. PSW #130 considered the incident to be abuse by resident #006 to resident #003.

Review of the written responsive behaviour plan of care at the time of the CI was dated two months prior to the CI, indicated resident #006 exhibited four identified responsive behaviours. There were three identified interventions which were all implemented over two years ago.

Interviews with RPNs #121 and #124 and PSWs #122 and #123, indicated resident #006 exhibited three identified responsive behaviours where one of the behaviours was towards other residents. The staff indicated the intervention to manage one of the resident's responsive behaviour were two identified interventions. When asked what one of the intervention entailed, the staff indicated they allowed the resident to follow staff which made implementing the intervention easier, staff had to be aware where the resident was in the unit and if in an identified area of the unit, staff were to be present in the identified area. There were no other interventions to manage resident's identified responsive behaviour.

Interview with the BSO RPN confirmed that resident #006 exhibited an identified responsive behaviour and identified two interventions to manage their behaviour. The BSO RPN indicated they had informed staff to be more vigilant and

proactive in implementing the identified intervention of the resident. When asked what the identified intervention entailed, they indicated for front line staff to constantly check on resident #006, staff should be in an identified area of the unit to monitor the residents to prevent altercations and staff at night to continue their rounds on residents that exhibited the same responsive behaviour. The BSO RPN stated that the identified intervention had not been an effective intervention as there was an altercation between residents #003 and #006 and considered the incident between the residents to be abuse by resident #006.

Interview with the DOC indicated resident #006 exhibited an identified responsive behaviour. Resident #003 and #006 had a history of two identified responsive behaviour towards other residents. The DOC indicated staff were to implement an identified intervention for both residents. When asked what the identified intervention entailed, the DOC stated that staff had to look out for the residents and intervene if resident #006 exhibited the identified responsive behaviour towards resident #003. The DOC stated the identified intervention had not been effective as an altercation occurred between the two residents causing injury. The home should have used interventions that were more effective to manage resident #006's identified responsive behaviour. The DOC considered the CI to be abuse of resident #003 by resident #006.

4. The MOHLTC received notification through the MOHLTC after-hours pager on an identified date in 2017, regarding an incident of resident to resident abuse between residents #001 and #002. The home submitted a CIS report #2945-000034-17, the following day, which indicated two altercations between the residents over a span of 25 minutes.

The first incident, occurred at an identified time, and PSW #101 witnessed resident #002 to have exhibited an identified responsive behaviour towards resident #001 with an identified object in a common area of the unit. Resident #001 sustained injury to an identified area of the body. The second incident occurred 25 minutes later in a common area outside of each of the residents' rooms where resident #001 exhibited an identified responsive behaviour towards resident #002. Resident #002 attempted to exhibit an identified responsive behaviour towards resident #001 but lost their balance and fell. Resident #002 sustained injury from the fall.

Review of resident #001's identified assessment dated the day of the CI, indicated resident sustained injury to an identified area of the body.

Review of resident #002's written responsive behaviour plan of care, indicated resident exhibited an identified responsive behaviour and had a history of two identified responsive behaviours toward other residents.

Review of residents #001 and #002's progress notes indicated six incidents of altercations between the two prior to the CI.

Interviews with RPNs #105 and #119 indicated residents #001 and #002 had been triggers for each other and had numerous altercations with each other. RPN #119 indicated the CI, was considered to be abuse by resident #002 towards resident #001.

Interview with the BSO RPN #104 indicated resident #002 had been on their caseload since an identified date in 2016, to manage their responsive behaviours. The BSO RPN stated residents #001 and #002 had been triggers for each other and had altercations with one another. The interventions in place to minimize altercations between the two residents had been three identified interventions. When asked what one of the interventions entailed, the BSO RPN indicated that staff would implement the intervention when residents are in a common area and separate the residents to prevent altercations. The identified intervention was implemented when documenting and to redirect both residents if they are close to each other. The BSO RPN indicated the interventions were not effective as there were six incidents of altercations between the two residents prior to the CI. The BSO RPN considered the incident to be abuse towards resident #001 by resident #002.
(665)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 10, 2018

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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

RENSEIGNEMENTS 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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 16th day of July, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Ministére 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

Name of Inspector /
Nom de l'inspecteur : Joy Ieraci

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