Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 26, 2019	2019_530726_0005	008758-19, 009101-19	Complaint

Licensee/Titulaire de permis

Villa Colombo Seniors Centre (Vaughan) Inc.
10443 Highway 27, Kleinburg VAUGHAN ON L0J 1C0

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

Villa Colombo Seniors Centre (Vaughan)
10443 Highway 27, Kleinburg VAUGHAN ON L0J 1C0

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

REBECCA LEUNG (726)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 22, 23 and 27, 2019, and off-site on May 29, 31, June 3-7 and 13, 2019

The following Complaint intake was inspected during this inspection:
Log #009101-19 related to plan of care

The following Critical Incident System related intake was inspected during this Complaint inspection:
Log #:008758-19 - related to unexpected death

PLEASE NOTE: A Written Notification and a Compliance Order related to LTCHA, 2007, c.8, s. 19 (1), identified in a concurrent inspection #2019_530726_0003 (Complaint log #007237-19 and related CIS log #006697-19, CIS #2969-000013-19) were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (Administrative), Medical Director, Coroner, Paramedics, Police Officer, On-call Manager (RAI-MDS Coordinator), Food Services Manager, Registered Dietitian, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents, family member and substitute decision-maker (SDM).

During the course of the inspection, the inspector reviewed resident's health records, relevant policies and procedures, lunch menu, home's investigation notes, and paramedics' incident reports.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

- **2 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #008 was not neglected by the licensee or staff.

For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. O. Reg. 79/10, s. 5.

Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC), related to an unexpected death involving resident #008. Review of the CIS report indicated that at the time of the incident, a personal support worker (PSW) observed resident #008 was unable to respond, and the registered nurse's (RN) was called to assess the resident. The RN assessed resident #008 and found the resident responded to an identified verbal command. The CIS report further indicated that a specified first-aid procedure was started by the RAI-MDS Coordinator (#118) with no effect. Emergency 911 and Code Blue were called. Resident #008 was identified with a specified level of advanced care directive. Resident #008 was then transported to an identified location, monitoring and a specified procedure and therapy were initiated. Police and Paramedics arrived, and the Coroner was called. Resident #008's family member was called and came to the home later.

The MOHLTC received a complaint from the coroner (#116). In an interview, coroner #116 stated that when they asked if emergency care was initiated, the staff told them that resident #008 was identified with a specified level of advanced care directive, and some staff said they did the specified first-aid procedure for the resident, but when the coroner arrived, they found resident #008 remained in an identified position in the mobility assistive device in the identified location. Coroner #116 then indicated that in their

professional opinion, resident #008 should have received emergency care based on the specified level of advanced care directive consented by resident's family, because the resident suffered from an identified "reversible" acute medical condition, but not a chronic disease condition. The staff were expected to initiate first-aid and emergency care for resident #008 and continue until the paramedics arrived. Coroner #116 also indicated that the staff should have kept resident #008 at the scene as it was an emergency situation.

The MOHLTC also received complaints from two paramedics (#117 and #123). Paramedic #117 stated they were concerned that when they interviewed the staff members with the police officers about the incident, all of the information obtained from the staff involved was conflicted and the staff then all began changing their stories on what happened. Paramedic #117 and the police officers concluded that there were no attempts made to help relieve resident #008 from the identified acute reversible medical condition and the resident was just taken back to the identified location. Paramedic #117 also indicated that the specified first-aid procedure and emergency care should have been performed for resident #008.

In the interviews, paramedic #117 and #123 stated that the staff did not know resident #008's specified level of advanced care directive at the beginning when they found the resident first presenting the identified reversible acute medical condition in the identified location, however, there was no sign that the staff had performed the emergency care for the resident. Paramedic #117 stated that based on resident #008's body size, the staff would not be able to perform the specified first-aid procedure effectively with the resident remained in an identified position in their mobility assistive device.

Review of the specified incident reports completed on the date of incident confirmed the information reported by paramedics #117 and #123 during the interviews. Paramedic #117 reported that the staff stated that resident #008 was not moved from their mobility assistive device during the entire incident and remained in the identified position the entire time.

Review of the specified consent form related to advanced care directives last signed by resident #008's SDM on an identified date, indicated that specified level of advanced care directive was consented by the SDM.

Review of the home's specified policy related to advanced care directives, indicated that the home's policy did not provide any instruction to direct the registered staff on how to

manage "reversible" acute medical conditions for residents who consented for the specified level of advanced care directive.

In an interview, resident #009 stated that they sat with resident #008 at the same table at the time of incident. Resident #009 stated they did not see any staff at the table assisting resident #008. Resident #009 stated that they saw resident #008 present the identified reversible acute medical conditions and the staff came to help resident #008 right away, but they did not see anyone perform the specified first-aid procedure for resident #008.

In an interview, PSW #121 stated that on the date of incident, resident #008 was doing an identified activity of daily living (ADL) in an identified location and they were standing beside the resident. PSW #121 said that they saw resident #008 present an identified symptom but they did not perform the specified first-aid procedure for resident #008. PSW #121 called RN #124 over to check the resident. PSW #121 saw RN #124 start the specified first-aid procedure for resident #008, then the on-call manager (#118, who also worked as the RAI/MDS Coordinator/RPN in the home) came. PSW #121 said they did not know what the on-call manager (#118) did for resident #008 as they were observing other residents at that time. PSW #121 stated that someone instructed them to bring resident #008 to an identified location, they then took the resident in their mobility assistive device to the identified location.

Review of progress note entered on an identified date and time, RN #124 documented that resident #008 was a specified level of advanced care directive. Emergency care was not started.

In an interview, RN #124 stated that PSW #121 called them at an identified time to check resident #008. Resident #008 did not respond to verbal command. RN #124 then started the specified first-aid procedures for resident #008 for a few times with no effect. RN #124 stated based on their emergency care training, when the specified first-aid procedure had no effect, they could try performing an alternate specified first-aid procedure to help the resident. However, RN #124 indicated that they did not perform the alternate specified first-aid procedure for resident #008 as they were panicking. Instead, they left resident #008 with PSW #121 and went to call 911 and code blue. RN #124 stated that they were unsure of resident #008's status and they did not check the resident's vital signs before leaving the resident with PSW #121. RN #124 stated they were aware that the resident's condition could get worse quickly if the acute medical condition was not reversed. RN #124 acknowledged that as the RN in-charge of the identified unit and the entire building, they were the most qualified registered staff to

assist resident #008 during the incident before the paramedics arrived. RN #124 confirmed that they were the lead for the code blue, however, when they saw the staff was moving resident #008 from the scene to the identified location, they did not stop the staff from doing it. They did not know who made that decision and they did not ask their colleagues. RN #124 stated that after calling 911, they went to the identified location and resident #008 was in a specified level of consciousness (LOC) and their vital signs were at a specified status as informed by the staff. RN #124 believed the nurses looked at resident #008's chart and found out that the resident was a specified level of advanced care directive. The team then decided not to initiate emergency care for resident #008. RN #124 indicated that although they did not make the decision, they did not question the other nurses' decision. That happened before the paramedic arrived. RN #124 confirmed that they understood that the specified first-aid procedure and emergency care were considered "active care" in the management of the identified reversible acute medical condition. RN #124 also indicated that when they attended the emergency care training, they were taught to initiate emergency care when an adult suffered from the identified reversible acute medical condition changed to the specified LOC. However, it was unclear to them whether this situation applied to resident who consented for the specified level of advanced care directive. It was not outlined in the specified consent form for advanced care directives. It was nowhere stated that the registered staff could change the decision for emergency care in a situation like this. RN #124 stated that this situation never came up at the training and they were never in a situation like that before.

In an interview, PSW #122 stated that they heard PSW #121 screaming and went to the identified unit and location to help. PSW #122 said they saw on-call manager #118 arrive and performed the specified first-aid procedure for resident #008 many times, but they did not see on-call manager #118 perform the alternate specified first-aid procedure for resident #008. PSW #122 stated when on-call manager #118 came, resident #008 was at an identified LOC. PSW #122 stated that they were with on-call manager #118 and PSW #121 when resident #008 changed to a specified LOC. PSW #122 was then told by on-call manager #118 to take resident #008 to an identified location from the scene in their mobile assistive device, and PSW #121 went with them. PSW #122 said after bringing resident #008 to the identified location, they checked the vital signs for resident #008 and their vital signs were at a specified status. PSW #122 then assisted on-call manager #118 to perform a specified procedure for resident #008, RPN #129 and RPN #114 came later. PSW #122 heard on-call manager #118 ask for resident #008's chart. After someone brought resident #008's chart to the room, on-call manager #118 read the chart and said that resident #008 was a specified level of advanced care directive and

asked the staff to stop the emergency care. PSW #122 indicated that all the staff did for resident #008 was the specified first-aid procedure and a specified procedure, and a specified therapy was not initiated, but the on-call manager #118 said to stop the emergency care. PSW #122 stated that the paramedics were upset about why they moved resident #008 from the scene to the identified location, and why they did not place resident #008 in a specified position on a specified surface area and start the emergency care for them. At the end of the interview, PSW #122 said they were disappointed and were wondering where the emergency care was, and stated that they should have done more for the resident when their LOC deteriorated to the specified status.

Review of progress note written by on-call manager #118 on an identified date, indicated that at an identified time, on-call manager #118 responded to PSW's call for help and PSW said someone was presenting an identified reversible acute medical condition. On-call manager went to the identified unit and location to help and found resident #008 in a specified position and in a specified acute condition. On-call manager #118 performed a specified first-aid procedure for resident #008 for a few times. Staff helped to take the resident to the identified location. Specified procedure and therapy were started. Resident #008's vital sign was at a specified status. Resident's code status was a specified level of advanced care directive.

In the first interview, on-call manager #118 indicated when they went to the identified location to help as PSW #121 said resident #008 was suffering from the identified reversible acute medical condition and needed help. On-call manager #118 stated that when they first saw resident #008, the resident vital sign was at a specified status and they performed a specified first-aid procedure for resident #008 while the resident remained in an identified position on their mobile assistive device and it was unsuccessful. On-call manager #118 and other staff then moved resident #008 from the scene to the identified location as the other residents started to get emotional. On-call manager #118 indicated that when they were transporting resident #008 from the scene to the identified location, somebody brought resident's chart and on-call manager #118 read the chart and confirmed resident #008's level of care was the specified level advanced directive. The team then decided not to initiate emergency care for resident #008. In the second interview, when on-call manager #118 was questioned about their response to resident #008 when they first found the resident was at the specified LOC and before they knew that the resident was a specified level advanced directive, on-call manager #118 did not initiate emergency care immediately. On-call manager #118 did not respond to the inspector's inquiry.

In an interview, MD #128 (Medical Director and on-call physician) agreed that the identified condition suffered by resident #008 was a reversible acute medical condition, therefore, when resident #008 changed to the specified LOC after suffering from the above-mentioned condition, the staff should have started the specified first-aid procedure for the resident and when the resident's LOC and vital signs deteriorated to a specified status, the staff needed to initiate emergency care. MD #128 also stated that in consideration of resident #008's body size, it made sense for the staff to place the resident in a specified position on a specified surface area in order for the specified first-aid procedure to be done effectively, and the procedure should be done at the scene. In regard to the situation that the resident (#008) involved in the critical incident, the family had consented for a specified level of advanced care directive, MD #128 confirmed that the staff needed to do the specified first-aid procedure and when the resident's LOC and vital signs deteriorated to a specified status, then start emergency care as well, the staff needed to keep on doing emergency care until the paramedics arrived. MD #128 further clarified that the specified level of advanced care directive (consented by resident #008's family) means to provide "active care". MD #128 indicated that the situation was different from someone just passing away, the identified condition suffered by resident #008 was a totally different issue, and it should be managed immediately until the paramedics arrived.

Review of home's specified policy related to emergency procedures and first-aid indicated that nursing and personal staff were trained in emergency first aid procedures; registered nurses, registered practical nurses and attendant staff (both personal support workers and other departmental staff) were certified annually in basic rescuer skills, all staff were offered training in emergency care and all staff should be trained in emergency care, the home maintained a supply of first aid and emergency equipment, and the nursing and personal care staff of the home would provide emergency first aid care.

In an interview, PSW #122 stated that before the incident occurred, they last attended the training on emergency care for an identified period prior as the home had stopped offering them training on emergency care for an identified period of time. Review of the copy of emergency care training certificates of the staff involved, indicated that the on-call manager #118, RPN #114 and PSW #121 did not attend the emergency care training either annually or 12 months prior. In the reply email message for an identified date, on-call manager #118 confirmed that the home had not maintained the record of the staff's annual emergency care training certificate renewal date to ensure that all staff were attending the emergency care training annually as required by the home's policy.

In summary, the home has failed to protect resident #008 from neglect. The resident suffered from an identified reversible acute medical condition on an identified date to which they died at the home before paramedics arrived. All staff from the on-call manager who was in the highest leadership position in the home at the time of the incident, through to the PSW's on the unit, did not afford resident #008 with the emergency care. There was no emergency care provided as the staff believed that the specified advanced care directive meant that they were not expected to do any emergency care for the resident suffering from the identified reversible acute medical condition. The licensee did not keep their staff properly certified and trained in emergency care procedures. The home's policies for emergency care did not provide direction to the staff as to what to do in the event of a reversible emergency situation. A compliance order is warranted.

PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, c.8, s. 19 (1), identified in a concurrent inspection #2019_530726_0003 (Complaint log #007237-19 and related CIS log #006697-19, CIS #2969-000013-19) was issued in this report. Please see the findings written below:

2. The licensee has failed to ensure that resident #002 was protected from abuse by resident #001.

Under O. Reg. 79/10, s.2 (1), for the purpose of the definition, resident to resident "physical abuse" means the use of physical force by a resident that causes physical injury to another resident.

Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to a resident to resident physical abuse incident involving resident #001 and resident #002. Review of the CIS report indicated that on the date of the incident, a personal support worker (PSW) witnessed an altercation between resident #001 and resident #002, resulted in resident #002 sustaining a specified physical injury. Resident #001 was removed from the scene. Intensive monitoring and an identified monitoring tool was initiated for resident #001. Referral were made to the specified specialty team and the specialist for resident #001. Physician was notified and resident #002 was sent to the hospital for assessment. The police were contacted regarding this

incident.

Review of the CIS report indicated that resident #001 was assessed with specified functional issues. Resident #001 did not require assistance for mobility and had exhibited identified responsive behaviours prior to the date of incident.

Further review of the CIS report indicated that resident #002 used an assistive device for mobility and was assessed with specified functional issues.

The MOHLTC also received a complaint from resident #002's SDM (#131) regarding resident #002 having sustained a physical injury from an altercation with resident #001. SDM #131 was very concerned about the safety of resident #002 and other residents as resident #001 continued to exhibit the same identified responsive behaviours unsupervised in the unit.

Review of progress notes on file, indicated that resident #002 underwent a specified treatment and returned from the hospital on an identified date. Review of physiotherapist's (PT) note for an identified date, indicated that resident #002 sustained a specified physical injury. The resident was referred for procurement of a mobility assistive device. A therapy program was initiated.

Review of resident #002's last Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment, PT's note on an identified date and the interview note with PSW #101, indicated that resident #002 had a significant decrease in their functional abilities related to the activity of daily living after they returned from the hospital.

In an interview, resident #003 stated that resident #001 had exhibited the identified responsive behaviours before the incident occurred. Resident #003 stated that on the day of incident, they witnessed the altercation between resident #001 and resident #002 resulted in resident #002 sustaining a physical injury.

In an interview, PSW #101 stated that on the day of incident, they witnessed the altercation between resident #001 and resident #002 which resulted in resident #002 sustaining a physical injury. PSW #101 called RPN #102 and they came right away to help. PSW #101 then accompanied resident #001 back to their room immediately.

Review of the progress note written by RPN #109 on an identified date, indicated that resident #001 had exhibited the identified responsive behaviours for an identified period

of time and initial specified interventions were implemented prior. Review of follow-up progress note written by RPN #109 on an identified date after the initial specified interventions were implemented for an identified period of time, indicated that the interventions were effective in managing resident #001's identified responsive behaviours.

Review of resident #001's care plan, indicated that before the critical incident occurred, the interventions implemented for managing one of resident #001's identified responsive behaviours remained the same as the initial interventions implemented by RPN #109 as mentioned above. Further review of resident #001's care plan, indicated no specific intervention was implemented for managing the other identified responsive behaviours exhibited by resident #001 prior to the date of incident.

A review of resident #001's progress notes for a specified period of time prior to the incident, indicated there were repeated documentations by the registered staff that resident #001 continued to exhibit the identified responsive behaviours sometimes after the initial interventions were put in place by RPN #109. The registered staff also documented difficulty with managing resident #001's identified responsive behaviours sometimes. The inspector was unable to find any documentation regarding resident #001's identified responsive behaviours being reassessed by the team to identify triggers where possible, and to consider alternate approaches to manage resident #001's identified responsive behaviours.

A review of resident #001's progress notes for a specified period of time prior to the incident, indicated there were repeated documentations by the registered staff that resident #001 exhibited another set of identified responsive behaviours towards the staff during provision of care.

Review of a specialist consultation note for an identified date, indicated that resident #001 was referred because of the identified responsive behaviours exhibited towards the staff during provision of care. No assessment or recommendation was provided regarding management of resident #001's initial identified responsive behaviours which led to the harmful altercation between resident #001 and #002.

Review of resident #001's progress note entered by RPN #109 at an identified time on the day before the incident occurred, indicated that RPN #109 met with the staff from the specified external resource teams, PSW #101 and RPN #102 to discuss resident #001's identified responsive behaviours. Resident #001 was seen by the specialist and the

changes in medication had no effect on resident #001's identified responsive behaviours. Resident #001 exhibited the same identified responsive behaviours towards the staff during provision of care. The action plan developed by the team did not include any specific intervention for managing resident #001's initial identified responsive behaviours.

In an interview, resident #001's SDM (#127) stated that if resident #001 believed they were in a specified situation, they would exhibit the identified responsive behaviours. Review of progress note for an identified date written by physician #128, indicated that resident #001's SDM (#127) was concerned that resident #001 might present risk to others especially when they were in a specified situation. The SDM was aware that resident #001 had exhibited the identified responsive behaviours towards the caregivers and their behaviours were very difficult to manage.

In an interview, resident #001's primary PSW (#101) stated that the other capable residents would stay away from resident #001 to protect themselves. PSW #101 stated that before the incident occurred, resident #001 had exhibited the initial identified responsive behaviours repeatedly and the other identified responsive behaviours towards the staff. PSW #101 stated that the external specialist referral was initiated for resident #001's identified responsive behaviours related a specified personal need, but not related to their initial identified responsive behaviours.

In an interview, RPN #109 stated that before the incident occurred, they were not aware that resident #001 had continued to exhibit the same initial identified responsive behaviours after the initial interventions were implemented (despite the fact that the registered staff had documented these behavioural incidents repeatedly on file). RPN #109 stated that they focused on resident #001's specified personal need and they were not concerned with resident #001's initial identified responsive behaviours as they did not feel that resident #001 would have an altercation with other residents unless they were triggered. RPN #109 stated they were involved in the investigation of the critical incident and had identified the triggers for the critical incident. RPN #109 acknowledged they could not control the location where resident #001 would exhibit their initial identified responsive behaviours that if resident #001 was in a specified situation with another resident, an altercation could happen, and the risk was there.

In summary, before the critical incident occurred, there were repeated documentations that resident #001 had exhibited the initial identified responsive behaviours. The home had not implemented strategies to minimize the risk of resident #001's identified

responsive behaviours leading to the harmful interaction between resident #001 and resident #002. As such, the home has failed to ensure that resident #002 was protected from abuse by resident #001 and a compliance order is warranted. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to provide clear directions to staff and others who provide direct care to resident #008 in relation to offering specified assistance for an identified activity of daily living (ADL) when certain types of food were served.

Review of a specified assessment for an identified date, indicated that resident #008 was recommended to continue with their current food texture.

Review of clinical record in Point Click Care (PCC) indicated that resident #008's food texture was changed before they passed away.

Review of RD #125's assessment for an identified date prior to the incident, indicated resident #008 was referred and nursing staff requested assessment for possible change in diet texture, in addition to the follow-up of a specified issue related to weight monitoring triggered in that month. RD #125 observed resident #008 at an identified time and the resident was given identified food items. RD #125 observed resident #008 able to perform the specified functions related to the identified ADL activity with no difficulty, but the resident would need some specified reminders and supervision. RD #125 then recommended resident #008's diet texture to be changed to a specified food texture.

Review of the physician order form indicated that the registered dietitian (RD #125) recommended a new diet order of a specified food texture for resident #008 on an identified date before the incident occurred.

Review of the clinical record between the date when the new diet order was implemented and the date of incident, no documentation was found related to specific monitoring of resident #008's tolerance of the new specified food texture after the change was implemented.

In an interview, SDM #126 indicated that resident #008 required specified assistance with performing the identified ADL activity as resident #008 had difficulty with performing specified functions related to the identified ADL activity for certain types of food.

In an interview, PSW #121 stated that on the date of the incident, they first served resident #008 with a plate of food as requested by the resident, they then went to serve the other residents in the identified location. Resident #008 then asked PSW #121 later for a plate with another food item. PSW #121 stated they had offered resident #008 the specified assistance for the identified ADL activity, but the resident refused. PSW #121 stated they then stood beside resident #008 and watched them perform the identified ADL activity. PSW #121 could not recall if they had reported the issue to RN #124, who was the nurse in-charge of the unit on the date of incident. In an interview, RN #124 stated they did not receive any report from PSW #121 that resident #008 had refused PSW's offer of the specified assistance for the identified ADL activity on the date of incident.

In an interview, resident #009 stated that they sat with resident #008 at the same table on the day of incident. Resident #009 indicated they did not see any staff at the table assisting resident #008 with the identified ADL activity, and did not see any staff offering resident #008 with the specified assistance.

A review of resident #008's care plan, the inspector was unable to identify any intervention related to offering resident #008 with the specified assistance when performing the identified ADL activity on each specified situation.

In an interview, RD #125 confirmed that prior to changing to the new specified food texture, resident #008 was on a specified food texture for a long period of time. RD #125 stated that they observed resident #008 had difficulty with performing the specified functions related to the identified ADL activity when certain types of food were served in the past, and acknowledged that they should have written clear instructions in the care plan to direct the staff to offer resident #008 with specified assistance for performing the identified ADL activity when certain types of food were served. [s. 6. (1) (c)]

2. The licensee has failed to ensure that resident #008's substitute decision-maker (SDM) was consulted or informed before resident #008's diet texture was changed.

In an interview, SDM #126 stated that they were in the long-term care home most of the evenings assisting resident #008 performing the identified ADL activity. SDM #126 stated that they were away when resident #008's diet texture was changed to a specified food texture. When SDM #126 returned, a visitor called them and informed that resident #008 had started getting food of a different food texture. SDM #126 confirmed that the staff did not consult or inform them before resident #008's diet texture was changed to a specified food texture.

In an interview, RD #125 stated that they assumed the nursing staff had already spoken with the family before initiating the referral to them and had also communicated with the family before implementing the change of food texture for resident #008.

Review of clinical records on file, no documentation was found to support that resident #008's SDM was consulted or informed regarding the potential risks of changing resident #008's diet texture to the specified food texture before the new dietary order was implemented. As such, the licensee has failed to ensure that the SDM was given an opportunity to participate fully in the development and implementation of resident #008's plan of care. [s. 6. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance - to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, and
- to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

Issued on this 9th day of July, 2019

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	REBECCA LEUNG (726)
Inspection No. / No de l'inspection :	2019_530726_0005
Log No. / No de registre :	008758-19, 009101-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 26, 2019
Licensee / Titulaire de permis :	Villa Colombo Seniors Centre (Vaughan) Inc. 10443 Highway 27, Kleinburg, VAUGHAN, ON, L0J-1C0
LTC Home / Foyer de SLD :	Villa Colombo Seniors Centre (Vaughan) 10443 Highway 27, Kleinburg, VAUGHAN, ON, L0J-1C0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Monica Klein-Nouri

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

Order / Ordre :

The licensee must be compliant with LTCHA, 2007, s. 19. (1).

Specifically, the licensee shall ensure that resident #002 and all other residents are protected from abuse by resident #001, and all residents are not neglected by the licensee or staff.

Upon receipt of this report the licensee shall prepare a plan to include but not limited to:

1. Providing additional training to all nursing staff on prevention of neglect related to the management of reversible acute medical conditions. Maintaining the related training records and training materials.

2. Ensuring the staff identified in home's specified policy related to emergency procedures and first-aid are certified annually in emergency care skills. Maintaining the related training records and training materials.

3. Implementing timely and appropriate monitoring to manage resident #001's identified responsive behaviours.

4. Ensuring resident #002 and all other residents are protected from abuse from resident #001 and any resident exhibiting responsive behaviours that put others at risk of harm.

5. Developing and implementing an on-going auditing process to ensure that resident #001 specifically, and any resident exhibiting responsive behaviours that put others at risk of harm, is reassessed, new interventions initiated and

plan of care reviewed and revised to minimize risk of harm to other residents. Include who will be responsible for doing the audits and evaluating the results.

6. Maintaining a written record of the above-mentioned auditing process. Include the frequency of the audits, who will be responsible for doing the audits and evaluating the results. The written record must include the date and location of the audit, the resident's name, staff members audited, the name of the person completing the audit, the outcome and follow-up of the audit.

Please submit the written plan for achieving compliance for inspection #: 2019_530726_0003 and 2019_530726_0005 to Rebecca Leung, LTC Homes Inspector, MOHLTC, by email to TorontoSAO.MOH@ontario.ca by July 16, 2019. Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #008 was not neglected by the licensee or staff.

For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. O. Reg. 79/10, s. 5.

Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC), related to an unexpected death involving resident #008. Review of the CIS report indicated that at the time of the incident, a personal support worker (PSW) observed resident #008 was unable to respond, and the registered nurse's (RN) was called to assess the resident. The RN assessed resident #008 and found the resident responded to an identified verbal command. The CIS report further indicated that a specified first-aid procedure was started by the RAI-MDS Coordinator (#118) with no effect. Emergency 911 and Code Blue were called. Resident #008 was identified with a specified level of advanced care directive. Resident #008 was then transported to an identified location, monitoring and a specified procedure and therapy were initiated. Police

and Paramedics arrived, and the Coroner was called. Resident #008's family member was called and came to the home later.

The MOHLTC received a complaint from the coroner (#116). In an interview, coroner #116 stated that when they asked if emergency care was initiated, the staff told them that resident #008 was identified with a specified level of advanced care directive, and some staff said they did the specified first-aid procedure for the resident, but when the coroner arrived, they found resident #008 remained in an identified position in the mobility assistive device in the identified location. Coroner #116 then indicated that in their professional opinion, resident #008 should have received emergency care based on the specified level of advanced care directive consented by resident's family, because the resident suffered from an identified "reversible" acute medical condition, but not a chronic disease condition. The staff were expected to initiate first-aid and emergency care for resident #008 and continue until the paramedics arrived. Coroner #116 also indicated that the staff should have kept resident #008 at the scene as it was an emergency situation.

The MOHLTC also received complaints from two paramedics (#117 and #123). Paramedic #117 stated they were concerned that when they interviewed the staff members with the police officers about the incident, all of the information obtained from the staff involved was conflicted and the staff then all began changing their stories on what happened. Paramedic #117 and the police officers concluded that there were no attempts made to help relieve resident #008 from the identified acute reversible medical condition and the resident was just taken back to the identified location. Paramedic #117 also indicated that the specified first-aid procedure and emergency care should have been performed for resident #008.

In the interviews, paramedic #117 and #123 stated that the staff did not know resident #008's specified level of advanced care directive at the beginning when they found the resident first presenting the identified reversible acute medical condition in the identified location, however, there was no sign that the staff had performed the emergency care for the resident. Paramedic #117 stated that based on resident #008's body size, the staff would not be able to perform the specified first-aid procedure effectively with the resident remained in an identified position in their mobility assistive device.

Review of the specified incident reports completed on the date of incident confirmed the information reported by paramedics #117 and #123 during the interviews. Paramedic #117 reported that the staff stated that resident #008 was not moved from their mobility assistive device during the entire incident and remained in the identified position the entire time.

Review of the specified consent form related to advanced care directives last signed by resident #008's SDM on an identified date, indicated that specified level of advanced care directive was consented by the SDM.

Review of the home's specified policy related to advanced care directives, indicated that the home's policy did not provide any instruction to direct the registered staff on how to manage "reversible" acute medical conditions for residents who consented for the specified level of advanced care directive.

In an interview, resident #009 stated that they sat with resident #008 at the same table at the time of incident. Resident #009 stated they did not see any staff at the table assisting resident #008. Resident #009 stated that they saw resident #008 present the identified reversible acute medical conditions and the staff came to help resident #008 right away, but they did not see anyone perform the specified first-aid procedure for resident #008.

In an interview, PSW #121 stated that on the date of incident, resident #008 was doing an identified activity of daily living (ADL) in an identified location and they were standing beside the resident. PSW #121 said that they saw resident #008 present an identified symptom but they did not perform the specified first-aid procedure for resident #008. PSW #121 called RN #124 over to check the resident. PSW #121 saw RN #124 start the specified first-aid procedure for resident #008, then the on-call manager (#118, who also worked as the RAI/MDS Coordinator/RPN in the home) came. PSW #121 said they did not know what the on-call manager (#118) did for resident #008 as they were observing other residents at that time. PSW #121 stated that someone instructed them to bring resident #008 to an identified location, they then took the resident in their mobility assistive device to the identified location.

Review of progress note entered on an identified date and time, RN #124

documented that resident #008 was a specified level of advanced care directive. Emergency care was not started.

In an interview, RN #124 stated that PSW #121 called them at an identified time to check resident #008. Resident #008 did not respond to verbal command. RN #124 then started the specified first-aid procedures for resident #008 for a few times with no effect. RN #124 stated based on their emergency care training, when the specified first-aid procedure had no effect, they could try performing an alternate specified first-aid procedure to help the resident. However, RN #124 indicated that they did not perform the alternate specified first-aid procedure for resident #008 as they were panicking. Instead, they left resident #008 with PSW #121 and went to call 911 and code blue. RN #124 stated that they were unsure of resident #008's status and they did not check the resident's vital signs before leaving the resident with PSW #121. RN #124 stated they were aware that the resident's condition could get worse quickly if the acute medical condition was not reversed. RN #124 acknowledged that as the RN in-charge of the identified unit and the entire building, they were the most qualified registered staff to assist resident #008 during the incident before the paramedics arrived. RN #124 confirmed that they were the lead for the code blue, however, when they saw the staff was moving resident #008 from the scene to the identified location, they did not stop the staff from doing it. They did not know who made that decision and they did not ask their colleagues. RN #124 stated that after calling 911, they went to the identified location and resident #008 was in a specified level of consciousness (LOC) and their vital signs were at a specified status as informed by the staff. RN #124 believed the nurses looked at resident #008's chart and found out that the resident was a specified level of advanced care directive. The team then decided not to initiate emergency care for resident #008. RN #124 indicated that although they did not make the decision, they did not question the other nurses' decision. That happened before the paramedic arrived. RN #124 confirmed that they understood that the specified first-aid procedure and emergency care were considered "active care" in the management of the identified reversible acute medical condition. RN #124 also indicated that when they attended the emergency care training, they were taught to initiate emergency care when an adult suffered from the identified reversible acute medical condition changed to the specified LOC. However, it was unclear to them whether this situation applied to resident who consented for the specified level of advanced care directive. It was not outlined in the specified consent form

for advanced care directives. It was nowhere stated that the registered staff could change the decision for emergency care in a situation like this. RN #124 stated that this situation never came up at the training and they were never in a situation like that before.

In an interview, PSW #122 stated that they heard PSW #121 screaming and went to the identified unit and location to help. PSW #122 said they saw on-call manager #118 arrive and performed the specified first-aid procedure for resident #008 many times, but they did not see on-call manager #118 perform the alternate specified first-aid procedure for resident #008. PSW #122 stated when on-call manager #118 came, resident #008 was at an identified LOC. PSW #122 stated that they were with on-call manager #118 and PSW #121 when resident #008 changed to a specified LOC. PSW #122 was then told by on-call manager #118 to take resident #008 to an identified location from the scene in their mobile assistive device, and PSW #121 went with them. PSW #122 said after bringing resident #008 to the identified location, they checked the vital signs for resident #008 and their vital signs were at a specified status. PSW #122 then assisted on-call manager #118 to perform a specified procedure for resident #008, RPN #129 and RPN #114 came later. PSW #122 heard on-call manager #118 ask for resident #008's chart. After someone brought resident #008's chart to the room, on-call manager #118 read the chart and said that resident #008 was a specified level of advanced care directive and asked the staff to stop the emergency care. PSW #122 indicated that all the staff did for resident #008 was the specified first-aid procedure and a specified procedure, and a specified therapy was not initiated, but the on-call manager #118 said to stop the emergency care. PSW #122 stated that the paramedics were upset about why they moved resident #008 from the scene to the identified location, and why they did not place resident #008 in a specified position on a specified surface area and start the emergency care for them. At the end of the interview, PSW #122 said they were disappointed and were wondering where the emergency care was, and stated that they should have done more for the resident when their LOC deteriorated to the specified status.

Review of progress note written by on-call manager #118 on an identified date, indicated that at an identified time, on-call manager #118 responded to PSW's call for help and PSW said someone was presenting an identified reversible acute medical condition. On-call manager went to the identified unit and location

to help and found resident #008 in a specified position and in a specified acute condition. On-call manager #118 performed a specified first-aid procedure for resident #008 for a few times. Staff helped to take the resident to the identified location. Specified procedure and therapy were started. Resident #008's vital sign was at a specified status. Resident's code status was a specified level of advanced care directive.

In the first interview, on-call manager #118 indicated when they went to the identified location to help as PSW #121 said resident #008 was suffering from the identified reversible acute medical condition and needed help. On-call manager #118 stated that when they first saw resident #008, the resident vital sign was at a specified status and they performed a specified first-aid procedure for resident #008 while the resident remained in an identified position on their mobile assistive device and it was unsuccessful. On-call manager #118 and other staff then moved resident #008 from the scene to the identified location as the other residents started to get emotional. On-call manager #118 indicated that when they were transporting resident #008 from the scene to the identified location, somebody brought resident's chart and on-call manager #118 read the chart and confirmed resident #008's level of care was the specified level advanced directive. The team then decided not to initiate emergency care for resident #008. In the second interview, when on-call manager #118 was questioned about their response to resident #008 when they first found the resident was at the specified LOC and before they knew that the resident was a specified level advanced directive, on-call manager #118 did not initiate emergency care immediately. On-call manager #118 did not respond to the inspector's inquiry.

In an interview, MD #128 (Medical Director and on-call physician) agreed that the identified condition suffered by resident #008 was a reversible acute medical condition, therefore, when resident #008 changed to the specified LOC after suffering from the above-mentioned condition, the staff should have started the specified first-aid procedure for the resident and when the resident's LOC and vital signs deteriorated to a specified status, the staff needed to initiate emergency care. MD #128 also stated that in consideration of resident #008's body size, it made sense for the staff to place the resident in a specified position on a specified surface area in order for the specified first-aid procedure to be done effectively, and the procedure should be done at the scene. In regard to

the situation that the resident (#008) involved in the critical incident, the family had consented for a specified level of advanced care directive, MD #128 confirmed that the staff needed to do the specified first-aid procedure and when the resident's LOC and vital signs deteriorated to a specified status, then start emergency care as well, the staff needed to keep on doing emergency care until the paramedics arrived. MD #128 further clarified that the specified level of advanced care directive (consented by resident #008's family) means to provide "active care". MD #128 indicated that the situation was different from someone just passing away, the identified condition suffered by resident #008 was a totally different issue, and it should be managed immediately until the paramedics arrived.

Review of home's specified policy related to emergency procedures and first-aid indicated that nursing and personal staff were trained in emergency first aid procedures; registered nurses, registered practical nurses and attendant staff (both personal support workers and other departmental staff) were certified annually in basic rescuer skills, all staff were offered training in emergency care and all staff should be trained in emergency care, the home maintained a supply of first aid and emergency equipment, and the nursing and personal care staff of the home would provide emergency first aid care.

In an interview, PSW #122 stated that before the incident occurred, they last attended the training on emergency care for an identified period prior as the home had stopped offering them training on emergency care for an identified period of time. Review of the copy of emergency care training certificates of the staff involved, indicated that the on-call manager #118, RPN #114 and PSW #121 did not attend the emergency care training either annually or 12 months prior. In the reply email message for an identified date, on-call manager #118 confirmed that the home had not maintained the record of the staff's annual emergency care training certificate renewal date to ensure that all staff were attending the emergency care training annually as required by the home's policy.

In summary, the home has failed to protect resident #008 from neglect. The resident suffered from an identified reversible acute medical condition on an identified date to which they died at the home before paramedics arrived. All staff from the on-call manager who was in the highest leadership position in the home at the time of the incident, through to the PSW's on the unit, did not afford

resident #008 with the emergency care. There was no emergency care provided as the staff believed that the specified advanced care directive meant that they were not expected to do any emergency care for the resident suffering from the identified reversible acute medical condition. The licensee did not keep their staff properly certified and trained in emergency care procedures. The home's policies for emergency care did not provide direction to the staff as to what to do in the event of a reversible emergency situation. A compliance order is warranted.

The severity of this issue was determined to be a level 4 as there was serious harm to resident #008. The scope of the issue was a level 2 as it related to two of four residents reviewed. The home had a level 3 compliance history as they had previous non-compliance to the same subsection of the LTCHA that included:
- Voluntary plan of correction (VPC) issued on May 19, 2017 (2017_656596_0004)
- Compliance order (CO) issued Dec 4, 2017 with a compliance due date of Jan 12, 2018 (2017_644507_0015)
- VPC issued Feb 23, 2018 (2018_642606_0002)
- VPC issued Aug 27, 2018 (2018_524500_0009)

PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, c.8, s. 19 (1), identified in a concurrent inspection #2019_530726_0003 (Complaint log #007237-19 and related CIS log #006697-19, CIS #2969-000013 -19) was issued in this report. Please see the findings written below:

2. The licensee has failed to ensure that resident #002 was protected from abuse by resident #001.

Under O. Reg. 79/10, s.2 (1), for the purpose of the definition, resident to resident "physical abuse" means the use of physical force by a resident that causes physical injury to another resident.

Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to a resident to resident physical abuse incident involving resident #001 and resident #002. Review of the CIS report indicated that on the date of the incident, a personal support worker (PSW) witnessed an altercation between resident #001 and resident #002, resulted in resident #002 sustaining a specified physical injury. Resident #001 was removed from the scene. Intensive monitoring and an identified monitoring tool was initiated for resident #001. Referral were made to the specified specialty team and the specialist for resident #001. Physician was notified and resident #002 was sent to the hospital for assessment. The police were contacted regarding this incident.

Review of the CIS report indicated that resident #001 was assessed with specified functional issues. Resident #001 did not require assistance for mobility and had exhibited identified responsive behaviours prior to the date of incident.

Further review of the CIS report indicated that resident #002 used an assistive device for mobility and was assessed with specified functional issues.

The MOHLTC also received a complaint from resident #002's SDM (#131) regarding resident #002 having sustained a physical injury from an altercation with resident #001. SDM #131 was very concerned about the safety of resident #002 and other residents as resident #001 continued to exhibit the same identified responsive behaviours unsupervised in the unit.

Review of progress notes on file, indicated that resident #002 underwent a specified treatment and returned from the hospital on an identified date. Review of
physiotherapist's (PT) note for an identified date, indicated that resident #002 sustained a specified physical injury. The resident was referred for procurement of a mobility assistive device. A therapy program was initiated.

Review of resident #002's last Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment, PT's note on an identified date and the interview note with PSW #101, indicated that resident #002 had a significant decrease in their functional abilities related to the activity of daily living after they returned from the hospital.

In an interview, resident #003 stated that resident #001 had exhibited the identified responsive behaviours before the incident occurred. Resident #003 stated that on the day of incident, they witnessed the altercation between resident #001 and resident #002 resulted in resident #002 sustaining a physical injury.

In an interview, PSW #101 stated that on the day of incident, they witnessed the altercation between resident #001 and resident #002 which resulted in resident #002 sustaining a physical injury. PSW #101 called RPN #102 and they came right away to help. PSW #101 then accompanied resident #001 back to their room immediately.

Review of the progress note written by RPN #109 on an identified date, indicated that resident #001 had exhibited the identified responsive behaviours for an identified period of time and initial specified interventions were implemented prior. Review of follow-up progress note written by RPN #109 on an identified date after the initial specified interventions were implemented for an identified period of time, indicated that the interventions were effective in managing resident #001's identified responsive behaviours.

Review of resident #001's care plan, indicated that before the critical incident occurred, the interventions implemented for managing one of resident #001's identified responsive behaviours remained the same as the initial interventions implemented by RPN #109 as mentioned above. Further review of resident #001's care plan, indicated no specific intervention was implemented for managing the other identified responsive behaviours exhibited by resident #001 prior to the date of incident.

A review of resident #001's progress notes for a specified period of time prior to the incident, indicated there were repeated documentations by the registered staff that resident #001 continued to exhibit the identified responsive behaviours sometimes after the initial interventions were put in place by RPN #109. The registered staff also documented difficulty with managing resident #001's identified responsive behaviours sometimes. The inspector was unable to find any documentation regarding resident #001's identified responsive behaviours being reassessed by the team to identify triggers where possible, and to

consider alternate approaches to manage resident #001's identified responsive behaviours.

A review of resident #001's progress notes for a specified period of time prior to the incident, indicated there were repeated documentations by the registered staff that resident #001 exhibited another set of identified responsive behaviours towards the staff during provision of care.

Review of a specialist consultation note for an identified date, indicated that resident #001 was referred because of the identified responsive behaviours exhibited towards the staff during provision of care. No assessment or recommendation was provided regarding management of resident #001's initial identified responsive behaviours which led to the harmful altercation between resident #001 and #002.

Review of resident #001's progress note entered by RPN #109 at an identified time on the day before the incident occurred, indicated that RPN #109 met with the staff from the specified external resource teams, PSW #101 and RPN #102 to discuss resident #001's identified responsive behaviours. Resident #001 was seen by the specialist and the changes in medication had no effect on resident #001's identified responsive behaviours. Resident #001 exhibited the same identified responsive behaviours towards the staff during provision of care. The action plan developed by the team did not include any specific intervention for managing resident #001's initial identified responsive behaviours.

In an interview, resident #001's SDM (#127) stated that if resident #001 believed they were in a specified situation, they would exhibit the identified responsive behaviours. Review of progress note for an identified date written by physician #128, indicated that resident #001's SDM (#127) was concerned that resident #001 might present risk to others especially when they were in a specified situation. The SDM was aware that resident #001 had exhibited the identified responsive behaviours towards the caregivers and their behaviours were very difficult to manage.

In an interview, resident #001's primary PSW (#101) stated that the other capable residents would stay away from resident #001 to protect themselves. PSW #101 stated that before the incident occurred, resident #001 had exhibited

the initial identified responsive behaviours repeatedly and the other identified responsive behaviours towards the staff. PSW #101 stated that the external specialist referral was initiated for resident #001's identified responsive behaviours related a specified personal need, but not related to their initial identified responsive behaviours.

In an interview, RPN #109 stated that before the incident occurred, they were not aware that resident #001 had continued to exhibit the same initial identified responsive behaviours after the initial interventions were implemented (despite the fact that the registered staff had documented these behavioural incidents repeatedly on file). RPN #109 stated that they focused on resident #001's specified personal need and they were not concerned with resident #001's initial identified responsive behaviours as they did not feel that resident #001 would have an altercation with other residents unless they were triggered. RPN #109 stated they were involved in the investigation of the critical incident and had identified the triggers for the critical incident. RPN #109 acknowledged they could not control the location where resident #001 would exhibit their initial identified responsive behaviours that if resident #001 was in a specified situation with another resident, an altercation could happen, and the risk was there.

In summary, before the critical incident occurred, there were repeated documentations that resident #001 had exhibited the initial identified responsive behaviours. The home had not implemented strategies to minimize the risk of resident #001's identified responsive behaviours leading to the harmful interaction between resident #001 and resident #002. As such, the home has failed to ensure that resident #002 was protected from abuse by resident #001 and a compliance order is warranted. [s. 19. (1)]

The severity of this issue was determined to be a level 3 as there was actual harm to resident #002. The scope of the issue was a level 2 as it related to two of four residents reviewed. The home had a level 3 compliance history as they had previous non-compliance to the same subsection of the LTCHA that included:
- Voluntary plan of correction (VPC) issued on May 19, 2017 (2017_656596_0004)
- Compliance order (CO) issued Dec 4, 2017 with a compliance due date of Jan

12, 2018 (2017_644507_0015)
- VPC issued Feb 23, 2018 (2018_642606_0002)
- VPC issued Aug 27, 2018 (2018_524500_0009)
(726)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 26, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 26th day of June, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Rebecca Leung

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