Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: February 26, 2024

Inspection Number: 2023-1035-0006

Inspection Type:
Complaint
Critical Incident

Licensee: CVH (No. 6) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)

Long Term Care Home and City: Southbridge Cornwall, Cornwall

Lead Inspector	**Inspector Digital Signature**
Kelly Boisclair-Buffam (000724)	Kelly Boisclair-Buffam Digitally signed by Kelly Boisclair-Buffam Date: 2024.03.20 09:07:03 -04'00'

Additional Inspector(s)
Laurie Marshall (742466)
Gabriella Kuilder (000726)
Margaret Beamish (000723)
Severn Brown (740785)

INSPECTION SUMMARY

The inspection occurred on site on the following date(s): January 4, 5, 8, 9, 10, 12, 15, 16, 17, 18, 19, 22, 23, 24, 2024.
The inspection occurred off site on the following date(s): January 11, 2024

The following Critical Incident (CI) intake(s) were inspected:

Intake: #00093381/CI #3063-000022-23, #00094440/CI #3063-000027-23, #00097038/CI #3063-000045-23, #00098843/CI #3063-000054-23,

#00099701/CI #3063-000057-23, #00100247/CI #3063-000059-23, #00100728/CI #3063-000064-23, #00101441/CI #3063-000068-23 related to alleged resident to resident sexual abuse.
Intake: #00094438/CI #3063-000026-23, #00097403/CI #3063-000046-23, #00098572/CI#3063-000051-23, #00098701/CI #3063-000052-23, #00100054/CI #3063-000058-23 related to alleged visitor to resident physical abuse.
Intake: #00094730/CI #3063-000028-23, #00097403/CI #3063-000046-23, #00098397/CI #3063-000049-23, #00100665/CI #3063-000063-23, #00101913/CI# 3063-000070-23, #00102161/CI #3063-000071-23 related to alleged resident to resident physical abuse.
Intake: #00094927/CI #063-000030-23 related to fall with injury.
Intake: #00096967/CI #3063-000044-23 related to alleged resident neglect.
Intake: #00095683/CI #3063-000034-23 related to improper/incompetent treatment .
Intake: #00098546/CI #3063-000050-23 related to alleged staff to resident verbal/emotional abuse.
Intake: #00099606/CI #3063-000056-23, #00102519/CI #3063-000072-23, #00102557/CI #3063-000073-23 related to alleged staff to resident physical abuse.

The following complaint intake(s) were inspected:

Intake: #00091754 related to bed refusal.
Intake: #00092825, #00092865/CI #3063-000019-23, #00098388 #00098687, #00100989 related to staffing and alleged resident neglect.
Intake: #00095683/CI #3063-000034-23 related to improper/incompetent treatment.
Intake: #00102875 related to medication administration.
Intake: #00102973 related to alleged resident to resident abuse.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management
Admission, Absences and Discharge
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Laundry service

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 95 (1) (a) (iv)
Laundry service
s. 95 (1) As part of the organized program of laundry services under clause 19 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(iv) there is a process to report and locate residents' lost clothing and personal items;

The licensee has failed to ensure that the organized program of laundry services were implemented to report and locate the lost clothing for a resident.
Policies to be followed under O.Reg 246/22 s. 11 (1) b identifies that the licensee is required to ensure that the policy, protocol and procedure, is complied with.

Rationale and Summary
Review of the homes' Laundry Policy # HL-06-01-21 (January 2022), identified that there was a process for documenting missing clothing found in Appendix 1 titled Missing Clothing Search Form (Laundry Department).
Appendix 1 relating to Policy for Missing Clothing (Missing Laundry Search Form HL-06-01-21 Appendix 1) was the form laundry staff were required to complete when clothing has been reported missing.
Interview with a staff member reported that they were not informed that the resident was missing clothing until a family member contacted them. The staff member reported that they were not aware of a written process to track missing clothing.
Interview with the homes' Regional Manager, reported that the laundry staff are required to fill out the Missing Clothing Search Form as identified in the policy under the appendix.

Laundry staff failed to implement the licensee's policy for documenting missing clothing for the resident using the Missing Laundry Search Form.

Sources: Laundry Policy # HL-06-01-21, Missing Laundry Search Form HL-06-01-21 Appendix 1, interview with staff member and Regional Manager [742466]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for two residents provided clear directions to staff.

Rationale and Summary
#1
It was observed on two specific dates, that a resident was using a specialized device. The residents' care plan and Kardex indicated special instructions with the use of the specialized device and when and how often the resident was to be monitored.
Interviews with staff members reported that the resident regularly declines the special instructions and that they have been observed using the specialized device in a different manner other than what was instructed.
A further interview with another staff member confirmed that the information from the Kardex and care plan for the resident were not the same and direction to staff was not clear.

By not updating the resident plan of care to include clear direction to staff increased the risk of injury complications for resident .

Sources: Observations, Care plan, Kardex, interview with staff members. [742466]

#2
Review of a residents' care plan indicated that they had safety checks every 15 minutes and every 30 minutes. The safety checks in Point of Care (POC) indicated the 15 minutes and every 30 minutes were initiated and in place during five specific months.
Upon review of the residents' progress notes related to a specific date, indicated that the resident was on every 30 safety minute checks and a couple of months later, indicated that when the resident was found in another resident's room, staff were instructed to do every 10 to 15 minute safety checks.
Interview conducted by Inspector #000723 regarding both residents with Director of Quality and Risk (DQR), confirmed that staff should be documenting safety checks every 15 minutes for the resident .
Interview with Director of Care (DOC) confirmed that the direction in the resident's plan of care regarding safety checks was unclear and that staff were to be doing safety checks every 15 minutes.

Failure to ensure that clear direction was provided to staff regarding safety checks increased the risk that safety checks were not completed for the resident.

Sources: Care plan, progress notes, POC, interviews with DQR and DOC .[742466]

WRITTEN NOTIFICATION: Specific duties re: cleanliness and repair

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,

(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has failed to comply with FLTCA, 2021 s. 19 (2) (c) by not ensuring equipment specifically the laundry chute doors, are maintained in a safe condition and in a good state of repair.

Rationale and Summary

Inspector #000726 observed soiled linen bags stored on the floor in the soiled laundry room on one of the home's floors and the laundry chute door was inoperative.

A staff member indicated to Inspector #000726, concerns with the functionality of the soiled laundry chute, delaying transport of soiled linen to the laundry room to be washed. They stated this delay impacts the supply of clean washcloths and towels being sent to the resident home areas (RHA).

Two staff members further indicated on going issues with the functionality of the laundry chute doors, impacting the timely transport of soiled linens to the laundry area. They indicated this impacts the washing and delivery of linens to the home areas. They indicated the home is waiting for new doors for the laundry chute.

A staff member indicated to Inspector #000726, soiled linen bags will be delayed in being transported for washing when the linen chute doors are inoperative. They indicated this occurs when a chute door does not close appropriately, in turn locking out the chute doors on other floors in the home. They indicated at the start of their shift they observed a minimal amount of soiled laundry bags sent to be processed. They believed this was a result of the linen chute doors malfunctioning.

A staff member indicated ongoing issues with the functionality of linen chutes on each floor since the opening of the new building. They indicated Southbridge

corporate office is aware and is working with the builder of the new facility and the chute manufacturer (Wilkinson) to resolve the issue. The staff member was unable to confirm when laundry chute doors would be repaired. They also indicated when chute doors are inoperative, the soiled linen bags are collected on each floor, and transported to the laundry room using transport bags and a cart for processing. They stated the home's staff will notify when the chute door is inoperative but acknowledge at times there is a delay in being notified.

On a particular day, a staff member indicated the laundry chute door was inoperative at time of interview. However, they were unable to validate if inoperative since the beginning of their shift.
A staff member provided Inspector #000726 with two photos of the soiled linen room on the affected floor of the home. The staff member indicated the date and time of the first photo.
The photo depicted soiled linen room on the affected floor with the laundry chute inoperative, and multiple full soiled linen bags from previous shifts stacked in the room. The staff member indicated the date and time of the second photo which was at the beginning of their shift. Photo depicted soiled linen room on the affected floor with the laundry chute inoperative and full soiled linen bags stacked in the room.

On another specific day, a staff member provided Inspector #000726 with the date and time of one photo taken of the soiled linen room on another floor of the home. Photo depicting laundry chute inoperative and full soiled linen bags stacked.

By failing to ensure the laundry chute doors are in a safe condition and in a good state of repair increases the risk of ensuring the availability of linens, to meet the nursing and personal care of the residents.

Sources: Inspector #000726 observation, multiple staff interviews, photos.[000726]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that multiple staff complied with their policy of zero tolerance of resident abuse, neglect and unlawful conduct.

Rationale and Summary
#1
On a specific day and specific shift, a staff member observed another staff member performing care to a resident they considered abusive but did not report the incident immediately. The staff member stated that they observed the other staff member performing care to a resident that they considered abusive but did not report the incident until two days later. The staff member stated they should have reported the incident to the charge Registered Nurse (RN) immediately. The DOC confirmed that the staff member should have reported the incident of alleged abuse to the charge RN immediately.
The home's policy RC-02-01-02: Zero Tolerance of Resident Abuse, Neglect, and Unlawful Conduct states that anyone who witnesses or suspects abuse that causes risk of harm must report the incident and that staff must report the incident immediately during after-hours to the Nurse on site. A mandatory report was first

submitted to the Director two days after the incident of alleged staff to resident abuse occurred .

By not ensuring that the staff member complied with the home's policy for Zero Tolerance of Resident Abuse, Neglect, and Unlawful Conduct, the resident was put at risk of not having all necessary safety interventions put in place following a witnessed incident of alleged abuse as required by the home's policy for prevention of abuse and neglect.

Sources: Staff interviews; Policy RC-02-01-02: Zero Tolerance of Resident Abuse, Neglect, and Unlawful Conduct last reviewed August 2023; CI 3063-000056-23. [740785]

#2
A review of two residents progress notes, noted that one resident was observed by a staff member to be holding hands, hugging, and touching another resident. The residents were immediately separated by the staff member.
In review of the Critical Incident Reporting System, it was noted that there were no Critical Incident Reports (CIR) reported to the Director for the above incident.
The home's policy to promote zero tolerance of abuse, neglect, and unlawful conduct (RC-02-01-02) last reviewed August 2023, states that anyone who witnesses or suspects abuse that causes risk of harm must immediately report the incident and notify their supervisor.
Director of Quality and Risk (DQR) stated they were not aware of this incident and acknowledged that the staff member should have reported it as per their policy.

Failing to ensure the home's policy to promote zero tolerance of abuse and neglect was complied with, may delay the investigation, placing residents at risk of harm.

Sources: Residents progress notes, policy to promote zero tolerance of abuse, neglect and unlawful conduct (RC-02-01-02) last reviewed August 2023, and interview with DQR [000723].

#3
A review of two residents progress notes, noted that both residents were found hugging and kissing in the activity room by a staff member. The residents were immediately separated.
In a review of the Critical Incident Report System, it was noted that a Critical Incident Report (CIR) related to the incident was submitted to the Director.
The home's policy to promote zero tolerance of abuse, neglect and unlawful conduct (RC-02-01-02) last reviewed August 2023, states that anyone who witnesses or suspects abuse that causes risk of harm must immediately report the incident and notify their supervisor.
Director of Quality and Risk (DQR) stated that the incident was not reported by the staff member as per the home's policy as they did not know if it was considered sexual abuse. DQR stated that they discovered the incident while reading through the 24 hour shift report and acknowledged that it was reported late to the Director.

As such, failing to ensure the home's policy to promote zero tolerance of abuse and neglect was complied with, may delay the investigation, placing residents at risk of harm.

Sources: residents progress notes, CIR #3063-000022-23, policy to promote zero tolerance of abuse, neglect and unlawful conduct (RC-02-01-02), last reviewed August 2023, and interview with DQR. [000723].

#4
The licensee has failed to ensure that that the policy to promote zero tolerance was complied with by registered staff relating to reporting resident to resident sexual behaviour.

On a specific day, a resident was found naked in another resident's room sitting on the bed and the other resident was found sitting on floor.
The Geriatric Outreach Consult assessed resident on a specific day and recommendations as below were identified that one resident seeks comfort and affection and staff are required to manage behaviours by distracting and remove them from the situation if making sexual advances.
Specifically dated progress notes indicated that the resident was determined to find the other resident by asking multiple staff members. Later that day, the resident had a 1:1 and approached the other resident not wanting to leave their side and kissed them with staff present.

Review of the homes Policy for Zero Tolerance Abuse Neglect Policy: RC-02-01-01 August 2023, indicates that anyone who witnesses unlawful conduct that causes risk of harm to resident by another resident must report the incident.
A staff member reported that they were assigned as the 1:1 sitter for the resident on this specific day and time and that the resident walked by co-resident and bent down and kissed them. The staff member reported that they had attempted to redirect the resident and reported that intervening with the resident and co-resident may have caused the first resident to fall as they had bent down to kiss co-resident. The staff member reported that they notified the Registered Staff member of the kiss.

Interview with the DOC confirmed that registered staff should have reported the kissing incident that was documented in the progress notes.
There was a history of sexual abuse by the resident towards co-resident. Registered

staff failed to report the incident of sexual behaviour.

Sources: Progress notes, Geriatric outreach consult, Policy for Zero Tolerance Abuse Neglect Policy: RC-02-01-01 August 2023, interview with staff member and DOC. [742466]

#5
The licensee's policy to promote zero tolerance for abuse, neglect, and unlawful conduct which causes harm or risk of harm to a resident (RC-02-01-02) states, any form of abuse, neglect, or unlawful conduct by any person whether through deliberate acts or negligence will not be tolerated, and policy applies to all staff.

A review of the Critical Incident Report #3063-000050-23, indicated a staff member, entered a resident's room when they heard them screaming. The staff member observed another staff member leaning over resident using verbal and emotional abusive comments. A review of resident's progress notes entered by Registered Nurse (RN) indicated two staff members reported an incident of verbal and emotional abuse by another staff member towards the resident. The staff member was sent home pending investigation. Post incident assessment was completed and no injuries related to alleged incident of abuse were noted.
A review of the staff member's onboarding training indicated, they completed education related to the home's policy (RC-02-01-02) related to promotion of zero tolerance for abuse, neglect, and unlawful conduct which causes harm or risk of harm to a resident.

Home level investigation notes reviewed, and written statement by staff member witness, indicated they were alerted to the resident's room when they heard them screaming. Upon entry to the room, they observed the staff member leaning over the resident using verbal and emotional abusive comments.The staff member alerted another staff member who was in doorway of resident's room.

Both staff members directed the third staff member to leave the resident room and they would take over care.
Interview by Inspector #000726 with a staff member confirmed they were alerted to the resident's room by another staff member to assist in managing the alleged incident of verbal and emotional abuse towards the resident by the third staff member. They confirmed the third staff member was directed to leave the resident. One staff member indicated an assessment was completed and no injuries were sustained in relation to incident of alleged abuse.
Interview conducted by Inspector #000726 with the first staff member, indicated they entered the resident's room when they heard the resident screaming and observed third staff member leaning over the resident using verbal and emotional abusive comments. The first staff member stated they alerted the other staff member and the third staff member was directed to leave the resident's room.
Director of Care (DOC) indicated during an interview the employment of third staff member was terminated due to this incident of verbal and emotional abuse.

As such, failing to ensure that the home's policy to promote zero tolerance of abuse and neglect was complied with, placed the resident at an increased risk of harm and injury.

Sources: Resident progress notes, home level investigation notes, CIR #3063-000050-23, training records , policy to promote zero tolerance of abuse, neglect, and unlawful conduct (RC-02-01-02), last reviewed August 2023, and multiple staff member interviews [000726]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that multiple allegations of abuse were reported to the Director immediately.

Rationale and Summary
#1
A staff member reported an incident of alleged abuse, that was reported to them by a resident . A Registered Practical Nurse (RPN) stated they assessed the resident and then reported the incident to the charge Registered Nurse (RN). The charge RN who was working the following day, read in the 24 hour shift report the allegation of abuse made by the resident. The RN read the report of the incident and stated the incident had not been reported to the Ministry of Long-Term Care as it should have been. The After Hours report related to the alleged incident was first reported to the Director the day after staff in the home were made aware of the allegation. The DOC stated the incident was not reported to the Director immediately.

By not ensuring an allegation of abuse was reported to the Director immediately, the resident involved was placed at risk of not having all regulatory resources provided to them.

Sources: Interviews with staff members and the DOC; After Hours report IL-18962; resident's electronic chart. [740785]

#2
On a specific day, a staff member stated that they observed another staff member performing care to a resident that they considered abusive but did not report the

incident until several days after the alleged incident was witnessed. The staff member who witnessed the alleged incident stated they should have reported the incident to the charge RN immediately. The DOC confirmed that the staff member should have reported the incident of alleged abuse immediately. The CI related to the incident was first submitted to the Director several days after the incident occurred.
By not ensuring that an incident of alleged abuse was reported to the Director immediately, the resident involved was not immediately provided all regulatory resources.

Sources: Interviews with staff member and the DOC; investigation notes into the incident; CI 3063-000056-23. [740785]

#3
A Registered Practical Nurse (RPN) documented being informed by another staff member that a resident was slapped across the face by another resident. The staff member documented that they had informed the charge nurse of the incident. A review of the Critical Incident Report (CIR) showed that the Director had been informed of the incident.
In an interview, the RPN stated they informed the charge nurse of the incident. The Registered Nurse (RN) stated that they could not recall being informed of the incident. The Director of Care (DOC) acknowledged that the incident was not immediately reported to the Director.

Failing to immediately report allegations of abuse to the Director may delay the investigation, placing residents at risk of harm.

Sources: Residents progress notes, CIR #3063-000051-23, interviews with staff members and DOC [000723].

WRITTEN NOTIFICATION: Availability of supplies

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 48
Availability of supplies
s. 48. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents.

The licensee has failed to comply with O. Reg 246/22. s.48. by not ensuring supplies specific to washcloths and towels are readily available at the home to meet the nursing and personal care needs of residents.

Rationale and Summary
On a specific day, Inspector #000726 observed no towels or washcloths available in storage cupboard or towel warmer in the Spa room on a resident home area (RHA).
Two days later, Inspector #000726 observed in the laundry cart holding area on the first floor, linen carts awaiting transport to RHA. It was observed three linen carts not fully stocked with washcloths. The inspector also observed a shortage of towels available on laundry cart on another RHA.

A staff member indicated to Inspector #000726, ongoing issues over the past four months with availability of linens, specifically washcloths to complete morning care for residents.
Two other staff members indicated to Inspector #000726 on the morning of interviews, issues with availability of washcloths to complete morning care for the residents. They indicated issues with availability are long standing but does not occur daily.

Additional home staff members, indicated to Inspector #000726 an overall shortage of washcloths within the facility. They stated that management is aware and is in the process of ordering more washcloths.

By failing to ensure supplies specific to washcloths and towels are not readily available at the home can increase the risk in meeting the nursing and personal care needs of residents.

Sources: Observation by Inspector #000726, staff interviews throughout home [000726]

WRITTEN NOTIFICATION: Responsive behaviours

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that when multiple residents demonstrated responsive behaviours, that actions were taken to respond to the residents' needs, including assessment, reassessments, interventions, and that the residents' responses to interventions were documented.

Rationale and Summary
#1
A review of a resident's plan of care identified that the resident had a history of

sexually responsive behaviours. On a specific day, an incident of alleged sexual abuse occurred by the resident towards a co- resident. The resident started on Dementia Observation System (DOS) monitoring post incident for seven days as requested by the Nurse Practitioner.
The DOS monitoring documentation was reviewed for the seven day time period. It was noted that DOS documentation was not completed for multiple dates and times.
Two staff members stated that DOS monitoring is usually completed for seven days and is documented in Point Click Care .
The Director of Care (DOC) stated that the expectation is that staff complete the DOS monitoring in Point Click Care. The DOC acknowledged that staff should have completed the documentation for the identified missing DOS entries.

As such, failing to complete the documentation of the intervention of DOS monitoring identified in the resident plan of care potentially increased the risk of the resident's sexually responsive behaviours not being fully analyzed and evaluated, placing other residents at risk.

Sources: resident progress notes, resident care plan, resident DOS documentation staff and DOC interviews. [000723]

#2
On a specific date, an incident of alleged resident to resident physical abuse. A resident was started on Dementia Observation System (DOS) monitoring and safety checks every 15 minutes post incident with no end date identified.
The DOS monitoring documentation was reviewed for a five day time period post incident. It was noted that DOS documentation was not completed for was not completed for multiple dates and times.
The documentation for the safety checks every 15 minutes was reviewed for a five day time period post incident. It was noted that documentation was not completed for multiple dates and times. Two staff members stated that DOS monitoring, and

safety checks are to be documented in Point Click Care .
The Director of Care (DOC) confirmed that the expectation is that staff complete the DOS and safety checks documentation in Point Click Care. The DOC acknowledged that staff should have completed the documentation for the identified missing DOS and safety checks entries.
As such, failing to complete the documentation of the interventions of DOS monitoring and safety checks identified in the resident's plan of care, potentially increased the risk of resident's physically responsive behaviours not being fully analyzed and evaluated, placing other residents at risk.

Sources: resident progress notes, DOS and safety checks documentation in Point Click Care , staff and DOC interviews[000723]

#3
On a specific date at time, a resident was found hugging and kissing a co- resident. The residents' care plan was updated post incident, and identified that the resident had been seen inappropriately touching/kissing co-residents. Directions to staff were to separate the residents and divert activity if this behaviour occurred.
On a specific date and time, the resident was found partially clothed in the room of a co-resident. Several minutes later, both residents were found kissing each other and attempting to get into bed together. An hour later, the resident was seen trying to take co-resident back to their room.

Review of the dementia observation scale (DOS) mapping in Point of Care (POC), identified there were missing entries for multiple days and multiple shifts. The care plan was updated two months later and directed staff to minimize potential altercations for these two residents and to document behaviours and potential causes.
On a specific date, the same resident entered the room of another co-resident and was found partially clothed sitting on their bed. Staff assisted the resident to dress, and the resident refused to leave the room. Staff left the door open to the room of

the co-resident room with a staff member assigned to monitor and then several minutes later the door was shut again. The staff member found the co-resident lifting the shirt of the resident and putting their hand underneath.
The same resident was found again in co-residents' room and it was identified in progress notes that both residents were left unattended for several minutes after staff witnessed sexual behaviours between both residents.
On a specific date, both these residents barricaded themselves in the same room. Later that day a 1:1 sitter was assigned to the first resident, and they were able to wander back into the co-resident's room where they had been found in bed with co-resident kissing. A review of the dementia observation scale (DOS) mapping noted missing entries for multiple days and multiple shifts.
The first resident was seen by registered staff going in and out of the co-resident's room and closing the door; they were also seen disrobing the co-resident. The co-resident became agitated and closed their bedroom door and barricaded both residents in their room.

The Behavioral support worksheet identified that the first resident behaviours were:
- latching on to co-residents
- inviting themself into co-resident's rooms
- sexually active physically

BSO recommendations to staff were to cue, redirect and watch the residents' moves. The care plan was updated and identified that this resident required High intensity 1:1 supervision and directions to staff were to call a code white if unable to deescalate internally and if becomes physically aggressive, staff would contact 911 for police assistance.
Resident was transferred to another unit in the home.

On a specific date on the new home area, the resident was found unclothed in a co-resident room sitting on the bed and co- resident was found sitting on the floor.
The Geriatric Outreach Consult assessed resident the next day and recommendations as below were identified to manage behaviours:

- resident seeks comfort and affection
- distract and remove from situation if making sexual advances

Progress notes identified that the resident had 1:1 sitter and that they kissed the same co-resident while staff present. Progress notes a week later noted that both residents were found together in bed partially clothed. At this time the first resident was assigned High intensity 1:1 and had been left unattended by 1:1 sitter.

Review of this residents' High intensity funding request form for a specific month, a sexual abuse incident, 1:1 sitter was ordered and implemented. An internal transfer occurred and seven days later deemed by the Nurse Practitioner (NP) that the resident no longer required the 1:1 supervision. Eight days later, another sexual abuse incident occurred and the 1:1 supervision was reinstated as the sexual behaviours continued even with 1:1 staffing. Resident followed by Royal Ottawa Hospital Geriatric Psychiatry, trialing medication adjustments.
Safety checks had been initiated following the initial incident and it was identified that there were missing entries for multiple days and multiple shifts relating to safety checks Review of Point of Care (POC) over a four month period.

During an interview conducted by Inspector #000724 with the DOC it was reported that:
- there had been several incidence between these two residents;
- there had been at least five incidents of sexual behaviours with other residents and a 1:1 sitter was placed after the most recent incident;
- that the resident had a 1:1 sitter on the previous home area.

During an interview conducted by Inspector #000723 with an RN it was reported:
- they stated that during the second incident, these two residents were very resistive to opening the door but staff were able to see into the bedroom window from the balcony and did not observe any significant sexual interactions;
- they stated that the police were called to help them separate the residents but the

residents opened the door before the police arrived;
- they stated that the resident was moved to another home area after the second incident.
A further interview conducted by Inspector #000723 with another RN, reported that the resident assumed the co-resident was their spouse and would go to their room seeking sexual interaction.
A staff member reported during an interview, when both residents were found in the bed together, they were assigned the 1:1 sitter duties. They were at that time assisting another resident and not supervising. The staff member confirmed that they should have been supervising the resident.
Interview conducted by Inspector #000723 with Director of Quality and Risk (DQR), reported that the staff member assigned to monitor the resident, had not been assigned to monitor as frequently as a 1:1 and that the incident with the door closing to the co- resident's room occurred within several minutes.

An interview with an RPN reported that they could not identify triggers and that the resident favoured this co-resident.
The DQR reported to the inspector that the expectation for DOS monitoring is to be completed for 7-14 days, reviewed and followed-up on by registered staff. Staff are expected to complete the DOS mapping every 30 minutes when it has been initiated for residents exhibiting responsive behaviours.
The DOC confirmed that staff are required to complete the documentation and confirmed that the POC documentation is required to be completed including DOS. They also confirmed that the directions to staff were not clear in the residents' plan of care regarding safety checks.

As such, insufficient actions were taken to respond to the needs of the resident which included reassessments and interventions to manage the sexual responsive behaviours towards multiple co-residents during a four month period.

Sources: Progress notes, care plan, POC, Behavioral support worksheet, Geriatric

Outreach Consult; multiple staff and DOC interviews . [742466]

#4
On a specific day and time, an incident of alleged resident to resident physical abuse occurred. The first resident was started on Dementia Observation System (DOS) monitoring, with no end date identified. Two days later, DOS monitoring was ordered by the Nurse Practitioner, for a period of seven days.

In review of the clinical record, two versions of DOS monitoring were found to have been initiated. One copy in the electronic health care record- Point of Care (POC) following the incident and a paper version of the DOS monitoring document two days following the incident.
Both versions of the DOS monitoring documentation were reviewed for a seven day period . Multiple missed entries with dates and times were noted in the DOS documentation (electronic and paper version).
A staff member indicated the DOS monitoring is documented in POC and a Registered Practical Nurse (RPN) indicated the Personal Support Workers (PSW) were made aware the DOS monitoring documentation has been ordered for the resident during change of shift report. They stated the PSW staff are accountable to complete the DOS monitoring form.
A Registered Nurse (RN) indicated the PSWs are informed at shift report if DOS monitoring documentation has been implemented for a resident, and that the PSWs are responsible to complete. The RN indicated they will initiate the BSO monitoring task when required. PSW staff are accountable to complete BSO monitoring documentation. RN will initiate the BSO monitoring task when required.
The DOC indicated the DOS monitoring can either be completed using the paper version of the document or in Point of Care (POC) by the PSWs.

In failing to follow the interventions of DOS monitoring over a 7 day period of time as ordered by the Nurse Practitioner, potentially increased the risk of the residents' physically responsive behaviours not being fully analyzed and evaluated, placing other residents at risk.

Sources: Nurse Practitioner orders, care plan, progress notes, POC, BSO monitoring form, staff and DOC interviews. [000726]

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act.

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 112 (1) 2. ii.

Licensees who report investigations under s. 27 (2) of Act

s. 112 (1) In making a report to the Director under subsection 27 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:

2. A description of the individuals involved in the incident, including,

ii. names of any staff members or other persons who were present at or discovered the incident, and

The licensee has failed to ensure that in making a report to the Director under subsection 27 (2) of the Act, that the names of any staff members or persons who were present at or discovered an alleged, witnessed, or suspected incident of abuse of a resident were included in the report.

Rationale and Summary

In a review of Critical Incident Reports (CIR) #3063-000027-23, #3063-000051-23, #3063-000052-23, and #3063-000054-23 for incidents of alleged resident to

resident physical and sexual abuse, Inspector #000723 noted that the names of the staff members who witnessed or discovered the incidents were incorrect.

Inspector #000724 reviewed CIR #3063-000064-23 for an incident of alleged resident to resident sexual abuse and noted that the name of the staff member who discovered the incident was incorrect. Inspector #000726 reviewed CIR #3063-000073-23 for an incident of alleged staff to resident emotional abuse and noted that the name of a staff member who discovered the incident was missing.

For each incident, it was identified either during a record review or during interviews, that it was a PSW who witnessed or discovered the incidents, not the registered staff members identified in the CIRs.
The DOC acknowledged that the names of the staff members who witnessed or discovered the incidents should have been included in the CIRs.

As such, failing to ensure that the names of the staff members who were present at or discovered the above incidents of alleged, suspected or witnessed abuse of residents were included in the report to the Director may delay the investigation, placing residents at risk of harm.

Sources: CIRs #3063-000027-23, #3063-000051-23, #3063-000052-23, #3063-000054-23, #3063-000064-23, #3063-000073-23, resident health records, and interview with DOC. [000723]

COMPLIANCE ORDER CO #001 Plan of care

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care
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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

a) Provide education and training on all applicable policies, procedures, and appropriate practices to one-to-one (1:1) sitters, including personal support workers and other staff who may assist in 1:1 sitter duties. A written record of this training must be kept, and;

b) Every designated 1:1 sitter for resident #028, shall document, at a minimum, twice per shift, while assigned to the resident regarding activities and interventions performed and the effectiveness of these interventions for resident #028, and;

c) When a designated 1:1 sitter takes their required break, a record will be kept of the time and name of the staff member replacing the 1:1 sitter for each of their breaks, and;

d) A weekly audit will conducted by a member of the home's management team to ensure that the required documentation is being completed by the assigned 1:1 sitters of the resident for three weeks, and;

e) A written record must be kept for steps (a), (b). (c) and (d), until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan of care. Specifically, the licensee has failed to ensure that the designated 1:1 sitter for this resident remained with the resident at all times during the hours of their assigned shift and ensured that breaks were covered by staff as required.

Progress notes indicated that the resident was placed on 1:1 supervision on a specific date after the resident was found unclothed sitting on a co-residents' bed and the co-resident was found sitting on the floor.

Review of the residents' High Intensity Funding request form indicated post incident for sexual abuse, a 1:1 sitter was ordered and put into place. An internal transfer occurred for the resident. It was deemed by the Nurse Practitioner (NP) that the resident, no longer required 1:1 supervision a week later. The following week, another sexual abuse incident occurred, and the resident was on 1:1 supervision. The care plan indicated that the resident had sexually inappropriate behaviours and wandered, and required high intensity 1:1 supervision.

An interview with a staff member reported when both residents were found in bed together, the staff member assigned as a 1:1 sitter and was not supervising the resident as they were helping with another resident. An RPN confirmed that the expectation of staff doing 1:1 supervision for the resident was to have coverage if they had a break or could not supervise.
The staff member failed to provide 1:1 supervision for the resident as documented in their plan of care. This led to the resident wandering into the co-resident's room increasing the risk of sexual behaviours between both residents.

Sources: Progress notes, care plan, staff interviews. [742466].

This order must be complied with by February 29, 2024

COMPLIANCE ORDER CO #002 Duty to protect

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

a) Provide training to all staff from every department, including full-time, part-time and casual staff on sexual abuse as per legislation definition and actions to be taken, such as immediate interventions to protect residents when information is known that meets the definition, and;

b) A written record of staff training shall include a copy of the training provided, those who attended with dates/times, as well as the name of the person who provided the training and must be kept for the requirements under step (a) of this compliance order, until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to protect multiple residents from the sexual behaviors of a resident. In O. Reg 246/22 s. 2 (1) (b) defines sexual abuse as any non-consensual touching, behaviours, remarks of a sexual nature or sexual exploitation directed towards a resident by a person.

Resident #028 had a cognitive performance score (CPS) of 4.
On a specific day and time, a resident was found hugging and kissing another resident.
Their care plan was updated post an incident, and identified that the resident had been seen inappropriately touching/kissing other residents. Directions to staff were to separate the resident and divert activity if this behaviour occurred.
Another incident involving this resident found them partially clothed in a co-resident's room. Several minutes later, both residents were found kissing each other and attempting to get into bed together. Approximately one hour later, the resident was seen trying to take the co-resident back to their room.

Review of the dementia observation scale (DOS) mapping in Point of Care (POC) that was initiated identified during a two week period, there were missing entries for multiple days and multiple shifts.
The care plan was updated and indicated that for this resident, direction to staff were to minimize potential for altercations with co-resident (physical/verbal/sexual) due to increased confusion/wandering and document behaviours and potential causes.
Progress notes, a week later after the first incident, indicated that the resident entered the room of another co-resident and was found partially clothed sitting on the co-residents' bed of who was also in their room. Staff assisted the resident to dress, and the resident refused to leave the room. Staff left the door

open to the room with a staff member assigned to monitor both residents. Several minutes later the door was found shut again and the staff member found the co-resident lifting the shirt of the resident putting their hand underneath the shirt. Progress notes further indicated that the resident was found in co-residents' room and identified that both residents were left unattended for several minutes after staff witnessed sexual behaviours between both residents.

The next day, both residents barricaded themselves in the co-residents' room. Several hours later, the resident was assigned a 1:1 sitter and wandered back into the co-residents' room and both residents were found in bed together kissing.
Review of the dementia observation scale (DOS) mapping in POC for a two week period identified that there were missing entries for multiple days and multiple shifts.
Ongoing review of the residents' progress notes indicated that they were seen by registered staff going in and out of the co-residents' room and closing the door. The resident was seen to be unclothing the co-resident. The resident became agitated, closed their bedroom door and barricaded themselves in their room.

The Behavioral Support worksheet identified that this residents' behaviours were latching on to co-residents, inviting themselves into co-resident's rooms and being physically sexually active.
The Behavioural Support Ontario (BSO) recommendations to staff were to cue, redirect and watch this residents' moves.
The care plan was updated and identified that this resident required high intensity 1:1 supervision and directions to staff were to call a code white if unable to deescalate internally and, if the resident becomes physically aggressive, staff would contact 911 for police assistance.
The resident was transferred to another unit in the home on the same day of the BSO recommendations.

A week later, the resident was found unclothed in a co-resident's room sitting on the bed and the co-resident was found sitting on floor.
Review of the resident's High Intensity Funding request form indicated that a 1:1 sitter was ordered and implemented post sexual abuse incident. An internal transfer occurred. It was deemed by the Nurse Practitioner (NP) a week later, that the resident, no longer required 1:1 supervision. The following week, another sexual abuse incident occurred, and the resident was started on 1:1 supervision as sexual tendencies continued even with 1:1 staffing. The resident was followed by Royal Ottawa Hospital Geriatric Outreach (ROH), trialing medication adjustments.

The Geriatric Outreach Consult identified for resident several incidents of sexual behaviour with co-residents including being found partially or fully unclothed in co-residents' rooms. The report identified when the resident's behaviours started and was required to have 1:1 observation to keep co-resident's and staff safe. The report identified that the resident had impulsivity and sexual disinhibition, seeking affection and comfort. The recommendations for managing the behaviours were to mitigate sexually responsive behaviours with distraction and remove them from the situation if making sexual advances.
Further progress notes identified:
-the resident had a 1:1 sitter and they kissed the same co-resident while staff were present in the area.
-both residents were found together in bed and were semi-clothed.
-at this time the resident was assigned High Intensity 1:1 sitter and had been left unattended.

Throughout several months, safety checks were initiated following the first incident and it was identified after reviewing of Point of Care (POC) for these months, there were missing entries for multiple days and multiple shifts relating to safety checks.

Interview conducted by Inspector #000723 with and a staff member, reported that the resident assumed co-resident was their spouse and would go to their room seeking sexual behaviours.
Interview with another staff member reported that they could not identify sexual behaviour triggers and that this resident favoured this co-resident.

An interview conducted by Inspector #000723 with the DQR, reported that the staff member assigned to monitor the residents, had not been assigned to monitor as frequently as a 1:1 and that the incident with the door closing occurred within several minutes.
Interview with another staff member, reported when both residents were found in bed together, a staff member was assigned 1:1 sitter duties with the resident. They were at that time assisting another resident and not supervising this resident as required. The staff member also confirmed that they should have been 1:1 supervising this resident.
Interview conducted by Inspector #000724 with the DOC, reported that:
- there had been several incidents of sexual behaviours between both residents
- there were at least five incidents of sexual behaviours with other co-residents prior to the most recent incident
- the 1:1 sitter was placed after the last incident.
- the resident had 1:1 sitter when they were residing on the other floor.
The DOC also identified that directions to staff were not clear in this residents' plan of care regarding safety checks.

As such, failure to protect the resident from exhibiting sexual behaviours towards multiple co-residents, resulted in multiple incidents of sexual responses by co-residents.

Sources: Progress notes, Geriatric Outreach consult, Behavioural support

worksheet, care plan, High Intensity Funding request form, POC, DOS mapping, multiple staff and DOC interviews. [742466]

This order must be complied with by March 22, 2024

COMPLIANCE ORDER CO #003 Plan of care

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

a) The licensee will provide training to all care staff on the documentation requirements for care as per the legislation, and;

b) Conduct bi-weekly audits of three residents on each shift on all home areas for a period of three weeks related to the completion of Point of Care tasks (POC), and;

c) Document the audit results and corrective actions taken, and;

d) A written record must be kept of everything required under step (a), (b) and (c) of

this compliance order, until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

The licensee failed to ensure that the provision of care set out in the plan of care for multiple residents were documented

#1

On a specific day, a resident had an altercation with another resident as reported to the Director in Critical Incident (CI) #3063-000063-23. The resident's care plan stated 15 minute checks for elopement. The Documentation Survey Report had active 15 minute checks for wandering and elopement. On a specific day, there was missed documentation on two separate occasions for the 15 minute Behaviour-Wandering checks.

A staff member stated that the resident had 15 minute checks that month for resident safety and that the checks must be documented in the resident's electronic chart. Another staff member stated that the resident had ongoing 15 minute checks for resident safety and elopement and that the checks must be documented in the resident's electronic chart. The RPN and the DOC stated that the resident had ongoing 15 minute checks for resident safety and elopement, and that the checks must be documented in the residents' electronic chart.

By not ensuring that the resident 15 minute safety checks were documented in the resident's electronic chart, a risk was present that the resident's most recent status was not communicated to other staff members.

Sources: Multiple staff and DOC interviews; resident's care plan and Documentation Survey Report [740785]

#2
A resident had sustained a fall and was transferred to the hospital. Upon residents' return from the hospital, there were directions to be followed at specified times for resident safety. The care plan had been updated to reflect the new directions. The Documentation Survey Report, a tool in the residents' electronic chart, indicated the directions and specified times had been initiated.
Upon further review of the Documentation Survey Report, there had been multiple dates and times that had no documentation indicating that the directions and specified times had been followed.

A staff member and the Director of Care (DOC) had both confirmed that the directions were to be fully documented in the resident electronic chart at the specified times. A further review of the Documentation Survey Report with the DOC, confirmed that the directions and specified times were to be fully completed by staff and acknowledged that the multiple dates and times of missed entries had not been completed as per plan of care. The DOC had also stated that the expectation is to fully complete these directions.

By not ensuring that the directions were fully documented, staff would not be aware of the resident's actions thus placing them at risk of personal injury and altered skin integrity.

Sources: Interview with staff member, DOC, resident care plan and Documentation Survey Report for a specific month. [000724]

#3
On a specific day and time, an incident of alleged resident to resident physical abuse occurred. The first resident was started on safety checks every 15 minutes post incident with no end date identified.

The documentation for the safety checks every 15 minutes had been reviewed for a five day time period post incident. It was noted that the documentation had multiple missed entries for dates and times. Two staff members confirmed that safety checks are to be documented in Point Click Care by the PSWs.
The DOC stated that the expectation is for staff to complete the safety checks documentation in Point Click Care and acknowledged that the staff should have completed the documentation for the identified missing entries.

As such, failing to ensure that the provision of the care set out in the resident's plan of care was documented, increased the risk that this resident did not receive the safety checks to protect them from further incidents of abuse.

Sources: resident progress notes, safety checks documentation in Point Click Care staff and DOC interviews. [000723]

#4

On a specific date, an incident of alleged resident to resident sexual abuse occurred. The first resident was started on safety checks every 15 minutes post incident with no end date identified.

The documentation for the safety checks every 15 minutes was reviewed for a five day time period post incident. It was noted that missed entries for dates and times were not completed.

Director of Quality and Risk (DQR) stated that the expectation is that staff complete the safety checks documentation in Point Click Care and acknowledged that staff should have completed the documentation for the identified missing entries.

As such, failing to ensure that the provision of the care set out in the resident's plan of care was documented, increased the risk that this resident did not receive the safety checks to protect them from further incidents of abuse.

Sources: resident progress notes, care plan, and safety checks documentation in Point Click Care, interview with DQR [000723]

#5

On a specific date, a resident demonstrated a behavior of sexual nature with a co-resident as reported in CI #3063-000059-23. The resident's care plan for a specific month, had been updated and stated every 15 minute checks for their behaviors . The resident's Documentation Survey Report for this month, showed no documentation for every 15 minute behaviour safety checks for multiple days and shifts.

A staff member stated that all frontline staff had been aware of the residents' every 15 minute safety checks for resident safety and that the checks were to be documented in the resident's electronic chart. An RPN stated that this resident had ongoing 15 minute checks for behaviors and that the checks must be documented in Point of Care. The DOC confirmed that all residents requiring 15 minute safety checks are to be documented in the resident's electronic chart.

By not ensuring that the residents' 15 minute safety checks were documented in the resident's electronic chart as instructed in the care plan, there was a potential safety risk for other residents.

Sources: Multiple staff and DOC interviews, resident's care plan and POC, Documentation Survey Report for a specific month. [000724]

#6

Review of the homes Continence Care Management program (Extendicare 2023; RC-14-01-01) indicates that care staff are required to complete all relevant and required documentation and verify documentation accuracy.

Progress notes from a certain day indicated that a resident had been assisted with care by a family member.

A review of Point of Care (POC) for a specific month, identified there were multiple missed entries for required care that should have been documented and review of the residents' care plan indicated specific care directions for staff to follow.

An interview with a staff member and the DOC, confirmed that PSW's are required to document completed tasks in POC regarding all care provided.

By failing to ensure that the provision of the care set out in the plan of care for the resident was documented, increased the risk that the care directions were not provided for the resident.

Sources: Continence Care Management program (Extendicare 2023; RC-14-01-01), progress notes, POC, care plan, staff and DOC interviews [742466]

#7

A resident care plan identified that Behavioral Support Ontario (BSO) was initiated on a specific date and the resident required monitoring four times/ day as the resident had escalated behaviours. The care plan also identified that the resident required safety checks every 15 minutes and every 30 minutes.

A review of the homes policy for Responsive Behaviours (RC-17-01-04, March 2023) indicated that staff are to complete documentation of each episode of behaviour (record total number of times the behaviour occurred) on each shift for all residents

observed to display responsive behaviours and were required to document under the Dementia Observation Score (DOS) in Point of Care.

A four month review of Point of Care (POC), identified missing entries for multiple days and multiple shifts relating to safety checks.

Review of the DOS mapping documentation in POC for the resident, identified that in specific dates in specific months were missing entries for multiple days and multiple shifts.

Interview with a staff member reported that staff are required to document safety checks in Point of Care (POC).

Interview conducted by Inspector 000723 with the Director of Quality and Risk (DQR) , reported that the expectation for DOS monitoring is that it is done for 7-14 days and then reviewed and followed-up on by registered staff.

A second interview with DQR reported that staff are expected to complete DOS mapping every 30 minutes when it has been initiated for residents exhibiting responsive behaviours.

An interview with the DOC, reported that staff are required to complete documentation and confirmed that POC documentation is required to be completed including DOS mapping.

By staff failing to complete documentation to monitor and identify the behaviours , there was an increased risk of not identifying and preventing triggers for behaviours of this resident towards co-residents.

Sources: Responsive Behaviours (RC-17-01-04, March 2023), care plan, POC (safety checks & DOS mapping), staff and DOC interviews. [742466]

#8

A review of the documentation in Point of Care (POC) shows inconsistent documentation over a 3 month period for provision of care for multiple shifts, on multiple days from as it relates to:

- Day Care and Evening Care

- Continence Care

- Falls prevention

- Behaviour

- Nutrition

- Safety checks

Interview with staff member reported that care is documented in POC and they are required to document care in POC. However, because of time constraints the staff member reported that they do not always document care in POC.

Interview with Director of Care confirmed that staff are required to document in POC regarding all care provided.

By failing to ensure that the provision of the care set out in the plan of care for this resident was documented, increased the risk that care was not provided.

Sources: POC, staff and DOC interview. [742466]

This order must be complied with by April 26, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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