



**Ministry of Health and
Long-Term Care**

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

**Ministère de la Santé et des
Soins de longue durée**

**Rapport d'inspection
prévus le Loi de 2007 les
foyers de soins de longue**

Health System Accountability and Performance
Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la performance et de la
conformité

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HAMILTON, ON, L8P-4Y7
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Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 21, 22, 24, 28, Sep 11, 24, 25, 27, Oct 1, 9, 10, 12, 17, 18, 2012	2012_061129_0010	Critical Incident

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

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

THE VILLAGE OF SANDALWOOD PARK
425 Great Lakes Drive, BRAMPTON, ON, L6R-2W8

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

PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection



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

During the course of the inspection, the inspector(s) spoke with residents, family members, registered and unregulated nursing staff, the Acting Director of Care, the Quality Improvement Nurse and the Acting Administrator.

During the course of the inspection, the inspector(s) observed residents, reviewed clinical record documents as well as homes records and policies and procedures in relation to Log #H-000427-12, #H-002574-11 and #H-001131-12.

PLEASE NOTE: The following areas of non-compliance related to this inspection were identified and issued on Inspection Report #2012_011290_0008:

1. Related to the rights of the residents to be protected from abuse. [LTCHA s. 3(1)2]
2. Related to the written policy to promote zero tolerance of abuse and neglect containing an explanation of the duty to make mandatory reports under section 24 of the Act. [LTCHA s. 20(2)(d)]
3. Related to the requirement to immediately inform the Director where a person has reasonable grounds to suspect that abuse of a resident by anyone has occurred. [LTCHA s. 24(1) 2].
4. Related to the requirement to implement an organized interdisciplinary program with a restorative care philosophy. [LTCHA O.Reg., s. 8(1)(a)]
5. Related to the requirement to ensure that all staff who provide direct care to the resident receive annual training in behaviour management. [LTCHA O.Reg. s 76(7)3]
6. Related to the requirement that all staff receive annual retraining in the areas of the Resident's Bill of Rights and the homes policy to promote zero tolerance of abuse and neglect. [LTCHA O. Reg., s. 76(4)]

The following Inspection Protocols were used during this inspection:

Pain

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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



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Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee failed to protect residents from abuse by anyone, in relation to the following: [19(1)]

a) The licensee failed to protect resident #6 from abuse by a co-resident who was well known to staff to be physically and verbally abusive to both other residents and staff.

- Staff confirmed and it is documented in the clinical record that resident #6 was physically and verbally abused by a co-resident on 5 occasions. An assessment of the resident following the last incident indicated that the resident denied pain related to the incident but was emotionally upset by the incident.

- Resident #6 confirmed fear of this co-resident and that all incidents were reported to staff in the home, but the home took no action to prevent further incidents.

- Staff in the home were aware of the co-resident's behaviours as all incidents were documented in the clinical record and assessments completed for the co-resident indicated that there was a longstanding conflict between these residents, however the home did not take action to protect resident #6 for sixteen days following the last incident.

b) The licensee did not take action to protect resident #8 from abuse by a co-resident who was well known to staff to demonstrate hypersexual behaviour.

- Staff confirmed and it is documented in the clinical record that this resident was inappropriately touched in a sexual manner when a co-resident was found to be fondling this resident's genital area. An assessment of the resident following this incident indicated that the resident was clearly upset and crying.

- Resident #8's care needs indicated that the resident would not have been able to consent to this touching.

- The co-resident is known to staff to have hypersexual behaviour and was referred to a specialist 4 times over a 3 year period related to inappropriate sexual behaviour with co-residents and staff. Recommendations made following the referral completed 8 months prior to this incident indicated that if there were no improvements in the hypersexual behaviour that a medication specifically designed to reduce this behaviour should be considered. Staff documented 5 incidents between the referral and this incident where the resident continued to touch co-residents in a sexual manner, asked staff to engage in inappropriate sexual behaviour and was sexually demanding with care givers, however the recommendations contained in the referral were not considered or implemented. At the time of this inspection the co-resident continued to reside on the same home area as resident #8.

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 subsections:

s. 6. (3) The licensee shall ensure that the plan of care covers all aspects of care, including medical, nursing, personal support, nutritional, dietary, recreational, social, restorative, religious and spiritual care. 2007, c. 8, s. 6 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care for resident #7 covered all aspects of care, in relation to the following: [6(3)]

Staff document in the clinical record that resident #7 experiences pain at discomforting, distressing, horrible and excruciating levels and that the resident received both regularly scheduled analgesic and as necessary medication to manage pain. Staff confirmed that there is not a plan of care in place related to pain management that provides direction to staff in the use of as necessary medication for pain management, care directions for reducing pain being experienced by this resident or directions for action to take when pain is not managed with medication.



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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 and ensuring that the plan of care covers all aspects of care, including medical, nursing, personal support, nutritional, dietary, recreational, social, restorative, religious and spiritual care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records
Specifically failed to comply with the following subsections:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure that where the Act or the Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is to insure that the plan, policy, protocol, strategy or system is complied with, regarding the following: [8(1)(b)]

The licensee did not ensure the following policies included in the organized program of Nursing service where complied with:

1. The home's policy [Pain Management] identified as (Tab 04-48) and last reviewed in January 2011 directs staff:
 - a) When using a weekly pain assessment tool and if the resident scores 4 or higher, further interventions are required.
- Weekly pain assessments completed for resident # 7 over a two month period of time in 2012 indicated the resident's pain at 4 (discomfort level) twice, at 5 (distressing level) once, at 8 (horrible level) twice and at 10 (excruciating level) once. Registered staff confirmed that although the resident's pain scores were at or above level 4 six of eight times during this period of time the resident continued to experience pain and no further interventions were considered or implemented.
 - b) That if a resident is receiving regularly prescribed analgesic or the pain Resident Assessment Protocol (RAP) is triggered, a care plan will be created, updated, or renewed quarterly or as necessary.
- Staff confirmed that resident #7 had been receiving a narcotic analgesic twice a day for four months and also received both narcotic analgesic and non narcotic analgesic as necessary when the resident experienced pain, however a care plan has not been created related to pain and pain management.

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 and ensuring that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours



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Specifically failed to comply with the following subsections:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:

1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

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

Findings/Faits saillants :

1. The licensee did not ensure that written approaches to care, including screening protocols, assessments, reassessments and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social or environmental were developed to meet the needs of residents demonstrating responsive behaviours, in relation to the following: [53(1)1]

The General Manager confirmed that written approaches to care were not included in the home's policy [Responsive Behaviour/Aggression Prevention] identified in Tab 02-15 last reviewed in January 2011 or in any other document that provides guidance to staff in the care for residents demonstrating responsive behaviours.

2. The licensee did not ensure that for each resident demonstrating responsive behaviours, behavioural triggers for the resident are identified where possible, in relation to the following: [53(4)(a)]

Staff confirmed that an attempt to identify behavioural triggers for responsive behaviours being demonstrated by resident #5 was not made.

Resident # 5's clinical record indicated that over a 4 month period of time there were 14 episodes of physical and or verbal aggression towards staff and other residents. These behaviours included many incidents of verbal aggression towards a co-resident, attempting to strike staff and other residents and included two critical incident reported to the Ministry in 2011, one of which indicated the resident was observed to punch a co-resident, resulting in 2 red welts on the co-resident's head. The clinical record and staff confirmed that there has not been an attempt to determine triggers for this resident's physical and verbal abusive behaviour towards both co-residents and staff. A review of clinical record documentation for a 4 month period of time in 2012 indicated that the resident continued to demonstrate these behaviours with 9 episodes of verbal and physical aggression towards staff and co-residents.

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 and ensuring compliance with LTCHA, 2007 -O. Reg. 79/10, s. 53(1)1 and 53(4)(a), to be implemented voluntarily.

Issued on this 18th day of October, 2012



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



**Ministry of Health and
Long-Term Care**

Order(s) of the Inspector

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

**Ministère de la Santé et
des Soins de longue durée**

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2012_061129_0010
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Aug 21, 22, 24, 28, Sep 11, 24, 25, 27, Oct 1, 9, 10, 12, 17, 18, 2012
Licensee / Titulaire de permis :	OAKWOOD RETIREMENT COMMUNITIES INC. 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	THE VILLAGE OF SANDALWOOD PARK 425 Great Lakes Drive, BRAMPTON, ON, L6R-2W8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ZOHORA MOHAMMED

To OAKWOOD RETIREMENT COMMUNITIES INC., you are hereby required to comply with the following order(s) by the date(s) set out below:



**Ministry of Health and
Long-Term Care**

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

**Ministère de la Santé et
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de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée*, L.O. 2007, chap. 8

Order # / Ordre no :	Order Type / Genre d'ordre :
001	Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that residents #6 and #8 are protected from abuse by co-residents and shall take immediate action to protect all residents from co-residents who have demonstrated abusive behaviour and those residents who have the potential to become abusive to other residents.

Grounds / Motifs :

1. Previously identified as non compliant on October 4, 2011 as a WN.
2. Two of three residents reviewed experienced abuse from co-residents who were known to staff in the home to demonstrate abusive behaviour and were demonstrating behaviours that had the potential to become abusive to other residents in the home.
3. Resident #6 confirmed fear of a co-resident who was well known to staff to be physically and verbally abusive to both other residents and staff. Resident #6 experienced physical and emotional abuse over a seven month period of time by this co-resident. This abuse included threatening the resident with physical violence, being stuck by the co-resident on the leg, the back of the head and the forehead as well as struck in the face by an object purposely thrown by this co-resident.
4. Staff confirmed and it is documented in the clinical record that resident #8 was exposed to non-consensual sexual touching by a co-resident who was known to staff to demonstrate hypersexual behaviour. Resident #8's care needs indicated the resident would not have been able to consent to this sexual touching and an assessment of the resident indicated that the time of the incident the resident was found to be clearly upset and crying. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2012



**Ministry of Health and
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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

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REVIEW/APEAL 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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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 and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

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

Health Services Appeal and Review Board and the

Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.



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Ordre(s) de l'inspecteur
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RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 18th day of October, 2012

**Signature of Inspector /
Signature de l'inspecteur :**

**Name of Inspector /
Nom de l'inspecteur :**

PHYLLIS HILTZ-BONTJE

Service Area Office /

Bureau régional de services : Hamilton Service Area Office