Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 8, 2016	2016_483637_0004	005802-16	Complaint

Licensee/Titulaire de permis

THE BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING WEST
100 Michaud Street STURGEON FALLS ON P2B 2Z4

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

AU CHATEAU
100 MICHAUD STREET STURGEON FALLS ON P2B 2Z4

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

MISHA BALCIUNAS (637)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 12-15, 2016, and May 3, 2016.

This inspection was completed for two complaints. The first complaint was related to air temperature. The second complaint inspection was related to the reporting requirements for suspected abuse.

A complaint inspection related to medication administration, bathing and laundry services was conducted concurrently with this inspection. For details see inspection #2016_425639_0004.

A complaint inspection related to allegations of abuse, neglect and retaliation, improper care/harm and duty to protect was conducted concurrently with this inspection. For details, see inspection #2016_429642_0003.

A critical incident inspection related to an unexpected death was also conducted concurrently with this inspection. For details, see inspection #2016_483637_0005.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Administrative Assistant, Head of Maintenance, Housekeeping and Laundry, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Health Care Aides (HCAs), Human Resource (HR) Manager, Disability Management/Occupational Health/Staff Development/Infection Control Coordinator, and a contract service provider employee.

The inspector(s) also conducted a tour of resident care areas, including obtaining air temperatures, conducted record reviews, interviewed staff members and reviewed the computerized heating system.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents of the home were protected from abuse by anyone and failed to ensure that residents were not neglected by the licensee or staff.

On a particular day a health care aide (HCA) revealed to the Inspector that they had concerns related to the responsive behaviours exhibited by a specified resident and questioned what information should be reported to the Director regarding suspected sexual abuse. The HCA indicated that the specified resident had exhibited inappropriate responsive behaviours on several occasions; they stated the home was trying to fix the problem internally.

Throughout the inspection, Inspector #637 identified the following:

1. A review of the specified resident's care plan identified the resident as having specific responsive behaviours towards certain residents and staff. The specified resident was to be monitored, using a specific system and redirected away from certain residents. The plan of care identified triggers and there was to be specific equipment to be used in response to these triggers. Specific monitoring equipment was to be used in areas that the specified resident frequented.

An interview with a HCA revealed they were unaware of the specified resident's monitoring system.

An interview with a Registered Practical Nurse (RPN) revealed they were unaware of the specified resident's monitoring system.

A review of the specified resident's clinical record revealed incidences of specific

responsive behaviours.

No investigation was completed for the occurrences on the specified dates. A review of the home's abuse policies titled “Abuse to Resident, A-005," and "Resident Abuse, P.P.P. 02-061," revealed that it was the home's expectation that all suspected incidences of abuse were to be investigated immediately.

An interview with the DOC confirmed that incidents that had occurred between specificed dates, involving the specified resident were not investigated.

According to the LTCHA 2007, s. 23, every licensee of a long-term care home shall ensure that, every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated.

2. A review of the specified resident progress notes revealed that incidents of sexual abuse had occurred between specific dates.

A review of the home’s abuse policies titled, “Abuse to Resident,” A-005, last reviewed December, 2014, and “Resident Abuse, P.P.P.,” 02-061, last reviewed May, 2014, revealed that all alleged, suspected or witnessed abuse of any type must be reported immediately to the RN in charge and administration, to determine which action must be taken. The Administrator/delegate/RN in charge was expected to use the decision tree published by the Ministry of Health and Long Term Care.

A review of the home's reporting documentation confirmed that none of the incidences of sexual abuse on specified dates, had been reported to the Director.

The DOC confirmed that none of the incidents of sexual abuse involving the specific resident were reported to the Director.

An interview with the Administrator confirmed that all situations regarding suspected abuse should have been reported to the Director.

According to the LTCHA, 2007, s. 20(1), the licensee without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

In addition, according to the LTCHA, 2007, s. 24, a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm to the resident occurred or may occur, immediately report the suspicion and the information upon which it is based to the Director.

3. Inspector #637 reviewed the home's written policies titled, "Abuse to Resident, A-005," and "Resident Abuse, P.P.P. 02-061," and noted that they did not address the training and retraining requirements for all staff including:

a) identification of measures and strategies to prevent abuse and neglect,

b) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and

c) situations that may lead to abuse and neglect and how to avoid such situations.

An interview with the DOC confirmed that the home's policies to promote the zero tolerance of abuse and neglect of residents did not identify strategies to prevent abuse and neglect, the training and retraining requirements for power imbalances nor did the policy contain situations that may lead to abuse and neglect and how to avoid such situations.

According to O. Reg. 79/10, s.96 every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect to residents, identifies measures and strategies to prevent abuse and neglect and identifies the training and retraining requirements for all staff included in clause (e) i and ii.

4. Inspector #637 was unable to locate any documentation regarding the evaluation of the home's abuse policies.

An interview with the home's administrator confirmed that there was no written record of who was involved with the evaluation of the policy, the people who participated in the evaluation nor the changes and improvements that were implemented.

According to O.Reg. 79/10, s.99, every licensee of a long-term care home shall ensure

that a written record of everything provided for in the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents, included the date, the names of the persons who participated in the evaluation and the dates that the changes and improvements were implemented, was promptly prepared.

5. A review of the training records revealed that two staff members had not completed the annual required training for abuse recognition and prevention.

The HR manager confirmed that two employees had not completed the abuse training for 2015.

An interview with the Administrator confirmed that they were aware that some employees had not completed the abuse training for the home.

According to LTCHA, 2007, s.76 (7), 1., every licensee shall ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the area of abuse recognition and prevention.

In conclusion the home failed to protect residents from abuse and neglect by:

Incidents of specific responsive behaviours were displayed by the specific resident, between identified dates, and were not investigated;

Specific incidents of sexual abuse occurred between identified dates and were not reported to the director;

Two staff had not completed the home's training on abuse recognition and prevention;

The home's written policies to promote zero tolerance of abuse and neglect of residents did not address the training and retraining requirements for all staff and;

There was no written record of who was involved with the evaluation of the home's policy to promote zero tolerance of abuse and neglect, the people who participated in the evaluation or the changes and improvements that were implemented.

Therefore, the home failed to protect all residents, including specific residents, from abuse by the specified resident. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written policy that promoted zero tolerance of abuse and neglect of residents and that it was complied with.

A review of the specified resident's progress notes revealed that incidents of responsive behaviours had occurred between specific dates.

A review of the home's documentation revealed that the home had two separate abuse policies; "Abuse to Resident, A-005," last reviewed December, 2014, and "Resident Abuse, P.P.P. 02-061," last reviewed May, 2014.

A review of the home's two abuse policies revealed that all alleged, suspected or witnessed abuse of any type must be reported immediately to the RN in charge and administration, to determine which action must be taken. The Administrator/delegate/RN in charge was expected to use the decision tree published by the Ministry of Health and Long Term Care.

A review of the home's reporting documentation confirmed that none of the incidences of sexual abuse on the specified dates, had been reported to the Director.

A review of the home's abuse policies revealed that it was the home's expectation that all suspected incidences of abuse were to be investigated immediately.

An interview with the DOC confirmed that specified incidents of sexual abuse that had occurred between specified dates, involving the specified resident were not investigated.

An interview with the Administrator confirmed that all situations regarding suspected abuse should have been reported to the Director. [s. 20. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident occurred or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

On a particular day a health care aide revealed to the Inspector that they had concerns related to the responsive behaviours exhibited by a specified resident and questioned what information should be reported to the Director regarding suspected sexual abuse. The health care aid indicated that the specific resident had exhibited specific inapproprate responsive behaviours on several occasions; they stated the home was trying to fix the problem internally.

A review of the home's abuse policies revealed that all alleged, suspected or witnessed abuse of any type must be reported immediately to the RN in charge and administration, to determine which action must be taken. The Administrator/delegate/RN in charge was to use the decision tree published by the Ministry of Health and Long Term Care.

The DOC confirmed that none of the incidents of responsive behaviours involving the specified resident were not reported to the Director, and should have been. [s. 24. (1)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policies to promote zero tolerance of abuse and neglect of residents identified the training and retraining requirements for all staff including:

a) identification of measures and strategies to prevent abuse and neglect,

b) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and

c) situations that may lead to abuse and neglect and how to avoid such situations.

A review of the home's abuse policies, "Abuse to Resident, A-005," last reviewed December, 2014, and "Resident Abuse, P.P.P. 02-061," last reviewed May, 2014, revealed there were no strategies to prevent abuse and neglect or the training and retraining requirements for power imbalances. Neither policy contained examples of situations that may lead to abuse and neglect, and how to avoid such situations.

An interview with the DOC confirmed that the home's written policies to promote zero tolerance of abuse and neglect of residents, did not identify strategies to prevent abuse and neglect, the training and retraining requirements for power imbalances or situations that may lead to abuse and neglect, and how to avoid such situations. [s. 96. (e)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was promptly prepared of everything provided for in the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents, included the date, the names of the persons who participated in the evaluation and the dates that the changes and improvements were implemented, was promptly prepared.

The Inspector was unable to locate documentation regarding the evaluation of the home's abuse policies.

A review of the home's records revealed that the last revision to the abuse policies occurred in May of 2014.

An interview with the home's Administrator confirmed there was no written record of who was involved with the evaluation of the policy, the people who participated in the evaluation nor the changes and improvements that were implemented. [s. 99. (e)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that was reported was immediately investigated.

On a particular day a health care aide revealed to the Inspector that they had concerns related to the responsive behaviours exhibited by a specified resident and questioned what information should be reported to the Director regarding suspected sexual abuse. The health care aid indicated that the specific resident had exhibited specific inappropriate responsive behaviours on several occasions; they stated the home was trying to fix the problem internally.

Inspector #637 conducted a review of the specified residents clinical records revealed responsive behaviours.

A review of the home's abuse policies, Abuse to Resident, A-005, last reviewed December, 2014, and Resident Abuse, P.P.P. 02-061, last reviewed May, 2014, revealed that all alleged, suspected or witnessed abuse of any type must be reported immediately to the RN in charge and administration.

To determine which action must be taken, the Administrator/delegate/RN in charge was to use the decision tree published by the Ministry of Health and Long Term Care for direction. The abuse policies stated that all incidents of alleged, suspected or witnessed abuse would be investigated immediately.

An interview with the DOC confirmed that all incidents of abuse alleged to have been perpetrated on residents by the specified resident should have been investigated and they were not. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported is investigated immediately, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section. 2007, c. 8, s. 76. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provides direct care to residents received training related to abuse recognition and prevention annually.

A review of the training records revealed that two staff members had not completed the required annual training for abuse recognition and prevention.

The HR manager confirmed that two employees had not completed the abuse training for 2015.

An interview with the Administrator confirmed that they were aware that some employees had not completed the abuse training for the home. [s. 76. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff who provide direct care to residents receive training related to abuse recognition and prevention annually, to be implemented voluntarily.

Issued on this 28th day of July, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MISHA BALCIUNAS (637)
Inspection No. / No de l'inspection :	2016_483637_0004
Log No. / Registre no:	005802-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 8, 2016
Licensee / Titulaire de permis :	THE BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING WEST 100 Michaud Street, STURGEON FALLS, ON, P2B-2Z4
LTC Home / Foyer de SLD :	AU CHATEAU 100 MICHAUD STREET, STURGEON FALLS, ON, P2B-2Z4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JACQUES DUPUIS

To THE BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING WEST, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:

a) Ensure that all residents are protected from abuse by anyone and not neglected by the licensee or staff.

b) Perform an audit of all residents of the home demonstrating responsive behaviours to ensure that the behaviours have been identified and the plan of care clearly identifies the interventions. The home will maintain a record of the audit, who completed the audit, when the audit was completed, the results of the audit and how the identified interventions will be implemented.

c) Ensure that for every resident identified as demonstrating responsive behaviours that cannot be managed effectively within the home, are referred to BSO and/or external resources in a timely manner.

d) Ensure that all the home's residents are protected from abuse by the behaviours of the specified resident.

e) Ensure that the care plans are updated for certain resident's, with interventions in place to protect them from the specified resident.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents of the home were protected from abuse by anyone and failed to ensure that residents were not neglected by the licensee or staff.

On a particular day a health care aide (HCA) revealed to the Inspector that they

had concerns related to the responsive behaviours exhibited by a specified resident and questioned what information should be reported to the Director regarding suspected sexual abuse. The HCA indicated that the specified resident had exhibited inappropriate responsive behaviours on several occasions; they stated the home was trying to fix the problem internally.

Throughout the inspection, Inspector #637 identified the following:

1. A review of the specified resident's care plan identified the resident as having specific responsive behaviours towards certain residents and staff. The specified resident was to be monitored, using a specific system and redirected away from certain residents. The plan of care identified triggers and there was to be specific equipment to be used in response to these triggers. Specific monitoring equipment was to be used in areas that the specified resident frequented.

An interview with a HCA revealed they were unaware of the specified resident's monitoring system.

An interview with a Registered Practical Nurse (RPN) revealed they were unaware of the specified resident's monitoring system.

A review of the specified resident's clinical record revealed incidences of specific responsive behaviours.

No investigation was completed for the occurrences on the specified dates. A review of the home's abuse policies titled "Abuse to Resident, A-005," and "Resident Abuse, P.P.P. 02-061," revealed that it was the home's expectation that all suspected incidences of abuse were to be investigated immediately.

An interview with the DOC confirmed that incidents that had occurred between specificed dates, involving the specified resident were not investigated.

According to the LTCHA 2007, s. 23, every licensee of a long-term care home shall ensure that, every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated.

2. A review of the specified resident progress notes revealed that incidents of sexual abuse had occurred between specific dates.

A review of the home's abuse policies titled, "Abuse to Resident," A-005, last reviewed December, 2014, and "Resident Abuse, P.P.P.," 02-061, last reviewed May, 2014, revealed that all alleged, suspected or witnessed abuse of any type must be reported immediately to the RN in charge and administration, to determine which action must be taken. The Administrator/delegate/RN in charge was expected to use the decision tree published by the Ministry of Health and Long Term Care.

A review of the home's reporting documentation confirmed that none of the incidences of sexual abuse on specified dates, had been reported to the Director.

The DOC confirmed that none of the incidents of sexual abuse involving the specific resident were reported to the Director.

An interview with the Administrator confirmed that all situations regarding suspected abuse should have been reported to the Director.

According to the LTCHA, 2007, s. 20(1), the licensee without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

In addition, according to the LTCHA, 2007, s. 24, a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm to the resident occurred or may occur, immediately report the suspicion and the information upon which it is based to the Director.

3. Inspector #637 reviewed the home's written policies titled, "Abuse to Resident, A-005," and "Resident Abuse, P.P.P. 02-061," and noted that they did not address the training and retraining requirements for all staff including:

a) identification of measures and strategies to prevent abuse and neglect,

b) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and

c) situations that may lead to abuse and neglect and how to avoid such situations.

An interview with the DOC confirmed that the home's policies to promote the zero tolerance of abuse and neglect of residents did not identify strategies to prevent abuse and neglect, the training and retraining requirements for power imbalances nor did the policy contain situations that may lead to abuse and neglect and how to avoid such situations.

According to O. Reg. 79/10, s.96 every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect to residents, identifies measures and strategies to prevent abuse and neglect and identifies the training and retraining requirements for all staff included in clause (e) i and ii.

4. Inspector #637 was unable to locate any documentation regarding the evaluation of the home's abuse policies.

An interview with the home's administrator confirmed that there was no written record of who was involved with the evaluation of the policy, the people who participated in the evaluation nor the changes and improvements that were implemented.

According to O.Reg. 79/10, s.99, every licensee of a long-term care home shall ensure that a written record of everything provided for in the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents, included the date, the names of the persons who participated in the evaluation and the dates that the changes and improvements were implemented, was promptly prepared.

5. A review of the training records revealed that two staff members had not completed the annual required training for abuse recognition and prevention.

The HR manager confirmed that two employees had not completed the abuse training for 2015.

An interview with the Administrator confirmed that they were aware that some employees had not completed the abuse training for the home.

According to LTCHA, 2007, s.76 (7), 1., every licensee shall ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the area of abuse recognition and prevention.

In conclusion the home failed to protect residents from abuse and neglect by:

Incidents of specific responsive behaviours were displayed by the specific resident, between identified dates, and were not investigated;

Specific incidents of sexual abuse occurred between identified dates and were not reported to the director;

Two staff had not completed the home's training on abuse recognition and prevention;

The home's written policies to promote zero tolerance of abuse and neglect of residents did not address the training and retraining requirements for all staff and;

There was no written record of who was involved with the evaluation of the home's policy to promote zero tolerance of abuse and neglect, the people who participated in the evaluation or the changes and improvements that were implemented.

Therefore, the home failed to protect all residents, including specific residents, from abuse by the specified resident.

The decision to issue this compliance order was based on the severity, which indicated actual harm/risk, the scope which indicated a pattern and the compliance history, which indicated previous non-compliance (NC) issued,which included a NC for inspection 2015_282543_008, on April 7, 2015. (637)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2016

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee shall:

1) Develop and implement a process which identifies when the home's abuse policy is not being followed.

2) Ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that there was a written policy that promoted zero tolerance of abuse and neglect of residents and that it was complied with.

A review of the specified resident's progress notes revealed that incidents of specific responsive behaviours had occurred between specific dates.

A review of the home's documentation revealed that the home had two separate abuse policies; "Abuse to Resident, A-005," last reviewed December, 2014, and "Resident Abuse, P.P.P. 02-061," last reviewed May, 2014.

A review of the home's two abuse policies revealed that all alleged, suspected or witnessed abuse of any type must be reported immediately to the RN in charge and administration, to determine which action must be taken. The Administrator/delegate/RN in charge was expected to use the decision tree published by the Ministry of Health and Long Term Care.

A review of the home's reporting documentation confirmed that none of the incidences of sexual abuse on the specified dates, had been reported to the Director.

A review of the home's abuse policies revealed that it was the home's expectation that all suspected incidences of abuse were to be investigated immediately.

An interview with the DOC confirmed that specified incidents of sexual abuse that had occurred between specified dates, involving the specified resident were not investigated.

An interview with the Administrator confirmed that all situations regarding suspected abuse should have been reported to the Director.

The decision to issue this non-compliance was based on the severity, which indicated minimal harm or potential for actual harm, the scope which indicated widespread and the compliance history, which indicated previous non-compliance (NC) issued, including a voluntary plan of correction (VPC) for inspection 2015_332575_007, on September 14, 2015. (637)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 08, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee shall:

1) Ensure that all persons who have reasonable grounds to suspect that any of the following has occurred or which may occur, immediately report the suspicion and the information upon which it was based to the Director.

a) improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident,

b) abuse of a resident by anyone or neglect of a resident by the licensee or staff that result in harm or a risk of harm to the resident, and

c) unlawful conduct that resulted in harm of a risk of harm to a resident.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident occurred or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

On a particular day a health care aide revealed to the Inspector that they had concerns related to the responsive behaviours exhibited by a specified resident and questioned what information should be reported to the Director regarding suspected sexual abuse. The health care aid indicated that the specific resident had exhibited inappropriate responsive behaviours on several occasions; they stated the home was trying to fix the problem internally.

A review of the home's abuse policies revealed that all alleged, suspected or witnessed abuse of any type must be reported immediately to the RN in charge and administration, to determine which action must be taken. The Administrator/delegate/RN in charge was to use the decision tree published by the Ministry of Health and Long Term Care.

The DOC confirmed that none of the incidents of responsive behaviours involving the specified resident were not reported to the Director, and should have been.

The decision to issue this compliance order was based on the severity which indicated actual harm/risk, the scope which indicated isolated, and the compliance history, which indicated previous non-compliance (NC) issued, including a compliance order (CO) for inspection 2015_332575_0017, on September 14, 2015. (637)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 15, 2016

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 96. Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,

(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;

(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

(e) identifies the training and retraining requirements for all staff, including,

(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and

(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Order / Ordre :

The licensee shall:

1) Ensure that the home maintains a singular policy on the prevention of abuse and neglect.

2) Ensure that the home's written policy on zero tolerance of abuse and neglect of residents, is updated to include strategies and measures to prevent abuse and neglect,

a) Ensure that the persons responsible for the prevention of abuse and neglect in the home are aware of their responsibilities, and that it is reflected within the home's policy.

3) The home's written policy on zero tolerance of abuse and neglect of residents, will be updated to include the training and retraining requirements for all staff, including:

a) Training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care.

b) Situations that may lead to abuse and neglect and how to avoid such situations.

4) The home is to provide training to all staff of the home on the revised singular resident abuse policy.

b) The home will maintain a record of who completed the training, when the training was completed as well as what training materials were used

5) Develop and implement a process for documenting, and conducting an investigation related to abuse.

6) Maintain a record of all changes to the home's revised abuse policy, including when it occurred and who was involved.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the home's written policies to promote zero tolerance of abuse and neglect of residents identified the training and retraining requirements for all staff including:

a) identification of measures and strategies to prevent abuse and neglect,

b) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and

c) situations that may lead to abuse and neglect and how to avoid such situations.

A review of the home's abuse policies, "Abuse to Resident, A-005," last reviewed December, 2014, and "Resident Abuse, P.P.P. 02-061," last reviewed May, 2014, revealed there were no strategies to prevent abuse and neglect or the training and retraining requirements for power imbalances. Neither policy contained examples of situations that may lead to abuse and neglect, and how to avoid such situations.

An interview with the DOC confirmed that the home's written policies to promote zero tolerance of abuse and neglect of residents, did not identify strategies to prevent abuse and neglect, the training and retraining requirements for power imbalances or situations that may lead to abuse and neglect, and how to avoid such situations. [s. 96. (e)]

The decision to issue this compliance order was based on the severity which indicated minimal harm or potential for actual harm, the scope which indicated the issue as being widespread and unrelated non-compliance, in other areas. (637)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2016

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 99. Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Order / Ordre :

The licensee shall:

1) Ensure an analysis is performed of all incidences of abuse from twelve months prior to the issuance of this order.

a) Develop and implement a procedure for the analysis of the incident, including who is involved in the analysis and the step by step process it entails.

2) Ensure that an analysis is completed regarding every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it.

3) Ensure that at least annually an evaluation is made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents and what changes and improvements are required to prevent further occurrences.

a) Ensure a written record is maintained including the dates of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements are implemented.

b) Ensure that the outcomes from the incident analysis are considered in the evaluation.

c) Ensure that any changes from the evaluation are promptly implemented within the home.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that a written record was promptly prepared of everything provided for in the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents, included the date, the names of the persons who participated in the evaluation and the dates that the changes and improvements were implemented, was promptly prepared.

The Inspector was unable to locate documentation regarding the evaluation of the home's abuse policies.

A review of the home's records revealed that the last revision to the abuse policies occurred in May of 2014.

An interview with the home's Administrator confirmed there was no written record of who was involved with the evaluation of the policy, the people who participated in the evaluation nor the changes and improvements that were implemented. [s. 99. (e)]

The decision to issue this non-compliance order was based on the severity which indicated minimal harm or potential for actual harm, the scope which indicated being widespread and the compliance history, which indicated previous non-compliance, in unrelated areas. (637)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 08, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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 8th day of July, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Misha Balciunas

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