Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée


**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Sep 16, 2020 | 2020_784762_0017 | 010433-20, 013955-20 | Critical Incident System |

### Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Bay Ridges
900 Sandy Beach Road PICKERING ON L1W 1Z4

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

MOSES NEELAM (762)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): August 13-14, 17-21, 2020.**

**The following intakes were inspected up during this Critical Incident inspection:**
**Log/Critical Incident Report (CIR) related to alleged abuse**
**Log/Critical Incident Report (CIR) related to an incident that caused an injury for which the resident was taken to the hospital.**

**PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA,2007, c.8, s.19(1), was identified in a concurrent inspection #2020_784762_0016 (Log #003459-20) and is being issued in this Inspection Report.**

**During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Registered Practical Nurses (RPN), Staff Educator, Personal Support Workers (PSW), and residents.**

**During the course of the inspection, the inspector(s) toured residents' home areas, conducted observations and reviewed clinical records.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Housekeeping**
**Prevention of Abuse, Neglect and Retaliation**
**Safe and Secure Home**
**Sufficient Staffing**

**During the course of this inspection, Non-Compliances were issued.**
- **4 WN(s)**
- **2 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 protect resident #010 from emotional and physical abuse by

PSW #114.

Physical abuse as defined by O.Reg 79/10 is as follows:

“physical abuse” means, subject to subsection (2),
(a) the use of physical force by anyone other than a resident that causes physical injury or pain

Emotional abuse as defined by O.Reg 79/10 is as follows:

“emotional abuse” means,
(a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A call was made to the after hours line, followed by Critical Incident Report (CIR), regarding the alleged abuse of multiple residents by PSW #114.

A review of resident #010’s clinical electronic record indicated in a progress note written by RN #115, that an allegation of verbal abuse towards the resident was made by a staff. The progress note stated that this incident happened in the middle of the specified month.

A review of the LTCH's investigation notes, completed with RPN #106, indicated that PSW #114 had struck resident #010 in the mid section, to which resident responded “Ouch, you are hurting me”. Additionally, PSW #114 had indicated to the RPN that they were frustrated and had enough of residents' responsive behaviors. RPN #106 confirmed in an interview that abused had occurred.

A review of the LTCH's investigation notes, was conducted with PSW #107, who witnessed the incident. The investigation indicated that PSW #114 had threatened the resident during a shower. In the investigation notes PSW #114, denied all allegations with regards to resident #010. PSW #107 confirmed in an interview that the abuse occurred as written in the investigation notes.

The licensee has failed to protect resident #010 from emotional and physical abuse by PSW #114. [s. 19. (1)]

2. The licensee has failed to protect resident #012 from physical abuse by PSW #114.

A CIR was submitted to the Director, regarding the alleged abuse of multiple residents by PSW #114.

A review of resident #012's clinical electronic record indicated in a progress note written by DOC #104, that an allegation of abuse towards the resident was made. The progress note stated that this incident happened in the middle of the specified month.

A review of the LTCH's investigation notes, completed with RPN #106, indicated that PSW #114 had sprayed resident #012 in the face with specific spray, to which resident responded, "you are hurting me". As per RPN #106, this incident occurred on in the specified month. In the investigation notes, PSW #114, denied all allegations with regards to resident #012.

In an interview RPN #106, confirmed that they had witnessed resident #010 being sprayed by PSW #114, to which the resident responded, "you are hurting me".

The licensee has failed to protect resident #012 from physical abuse by PSW #114 [s. 19. (1)]

3. The licensee has failed to protect resident #013 from emotional and physical abuse PSW #114.

A call was made to the Director, followed by CIR that was submitted to the Director, regarding the alleged abuse of multiple residents by PSW #114.

A review of resident #013's clinical electronic record indicated in a progress note written by RN #115, that an allegation of verbal abuse towards the resident was made by a staff. The progress note stated that this incident happened in the middle of the specified month.

A review of the LTCH's investigation notes, completed with PSW #107, indicated that they witnessed PSW #114 speaking inappropriately to resident #013. Furthermore, PSW #114, had sprayed resident #013 with a spray, to which resident responded, "my eyes burned". As per PSW #106, this incident occurred on the specified date. Additionally, the investigation notes with PSW #109, indicated that PSW #109 witnessed resident #013 being sprayed in the face, however, did not recall the date. In the investigation notes,

PSW #114, admitted to spraying the resident in the face with a spray, however, denied all other allegations with regards to resident #013. Additionally, PSW #109 indicated that PSW #114 appeared to be irritated as they had an angry expression on their face and had made a comment which included a foul expletive when resident was having verbal responsive behaviors.

In an interview PSW #106, confirmed that they had witnessed resident #013 being sprayed with a spray by PSW #114, to which the resident responded, “my eyes burned” and that PSW #114 had made an inappropriate statement.

In an interview PSW #109, confirmed that they had witnessed resident #013 being sprayed with a spray.

The licensee has failed to protect resident #013 from emotional and physical abuse PSW #114.

4. The licensee has failed to ensure that resident #005 is protected from abuse by resident #004.

A complaint was received by the Ministry of Long Term Care (MLTC). The complainant indicated that resident #004 had an incident with a co-resident, that resulted in various injuries.

A review of resident #005 and #004’s clinical health records, indicated that on a specified date, resident #004 had entered resident #005’s room, and caused an incident that lead to injuries for resident #005.

In separate interviews, RPN #113 and BSORPN #112, indicated that resident #004 had entered resident #005’s room, and caused an incident that lead to injuries for resident #005. RPN #113 stated the incident was not witnessed, however, resident #005 was able to identify that resident #004 had been the one who had caused the injury, immediately after the incident.

The licensee has failed to ensure that resident #005 is protected from abuse by resident #004. [s. 19. (1)]

***Additional Required Actions:***

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

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**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 a written policy that promotes zero tolerance of abuse and neglect of residents is complied with, specifically with regards to residents #009, #010, #011, #012 and #013, where staff suspected abuse and did not immediately report that suspicion.

A call was made to the Director, followed by CIR regarding the alleged abuse of multiple residents by PSW #114 that occurred in a specified month.

A review of resident #009's clinical electronic record indicated in a progress note written by RN#115, that an allegation of verbal abuse towards the resident was made by a staff. The progress note stated that this incident happened in the middle of the specified month.

A review of the policy with the name "Mandatory Reporting of Resident Abuse or Neglect" with the last review date of March 31, 2019, indicated that any person who has a reasonable ground to suspect abuse must immediately verbally report the suspicion to the person in charge and together they will report this to the Director.

In an interview RPN #106, confirmed that they had witnessed abuse, but had not reported it because they were not trained on the prevention of abuse and were not aware of the reporting structure of the LTCH.

The licensee has failed to ensure that a written policy that promotes zero tolerance of abuse and neglect of residents is complied with, specifically with regards to resident #009, where staff suspected abuse and did not immediately report that suspicion to the person in charge or the director. [s. 20. (1)]

2. A review of resident #010's clinical electronic record indicated in a progress note, that an allegation of verbal abuse towards the resident was made by a staff. The progress note stated that this incident happened in the middle of the specified month.

A review of the LTCH's investigation notes, completed with RPN #106, and investigation notes, completed with PSW #107, indicated that abuse was suspected.

In separate interviews RPN #106 and PSW #107, confirmed that they had witnessed abuse, but had not reported it because they were not trained on the prevention of abuse and were not aware of the reporting structure of the LTCH.

The licensee has failed to ensure that a written policy that promotes zero tolerance of abuse and neglect of residents is complied with, specifically with regards to resident #010, where staff suspected abuse and did not immediately report that suspicion to the person in charge or the director. [s. 20. (1)]

3. A review of resident #011's clinical electronic record indicated in a progress note written by RN#115, that an allegation of verbal abuse towards the resident was made by a staff. The progress note stated that this incident happened in the middle of the specified month.

A review of the LTCH's investigation notes, completed with PSW #107, indicated that abuse was suspected.

In an interview PSW #107, confirmed that they had witnessed abuse, but had not reported it because they were not trained on the prevention of abuse and were not aware of the reporting structure of the LTCH.

The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of a resident #011 by a staff that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director. [s. 20. (1)]

4. A review of resident #012's clinical electronic record indicated in a progress note written by DOC #104, that an allegation of abuse towards the resident was made. The progress note stated that this incident happened in the middle of the specified month.

A review of the LTCH's investigation notes, completed with RPN #106, indicated that abuse was suspected. Additionally, PSW #114 had indicated to the RPN that they were frustrated and had enough of residents' responsive behaviors.

In an interview RPN #106, confirmed that they had witnessed abuse, but had not reported it because they were not trained on the prevention of abuse and were not aware of the reporting structure of the LTCH.

The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of a resident #012 by a staff that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director. [s. 20. (1)]

5. A review of resident #013's clinical electronic record indicated in a progress note, that an allegation of verbal abuse towards the resident was made by a staff. The progress note stated that this incident happened in the middle of the specified month.

A review of the LTCH's investigation notes, completed with PSW #109, and investigation notes, completed with PSW #107, indicated that abuse was suspected. Additionally, PSW #109 indicated that PSW #114 appeared to be irritated as they had an angry expression on their face and had made a comment which included a foul expletive when resident was having verbal responsive behaviors.

In separate interviews PSW #109 and PSW #107, confirmed that they had witnessed abuse, but had not reported it because they were not trained on the prevention of abuse and were not aware of the reporting structure of the home.

The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of a resident #013 by a staff that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based 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".***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home is a safe and secure environment for resident #007.

A CIR that was submitted to the Director, regarding an incident that caused harm for which the resident required to be taken to the hospital, which resulted in a significant change.

A review of electronic clinical records for resident #001, indicated that the resident had sustained an injury on a specified date, between specified hours, for which the resident was sent to the hospital and received treatment.

An observation of video footage conducted by inspector #762, showed the resident was walking into a room without a limp, between the specified hours and is seen coming out with a limp.

An observation conducted by inspector #762 with DOC #104 in the room showed a wardrobe with a sharp edge.

An observation conducted by inspector #762 with DOC #104, on resident #001's injury indicated that the base of the injury was located close to the wardrobes sharp edge.

In an interview DOC #104, indicated that the incident may have occurred due to the wardrobe, but cannot confirm as the sharp edge is only able to reach until the base of the injury. DOC #104 stated the room was cluttered and attempted to speak with the Substitute Decision Maker (SDM) of the resident of the room to declutter the room, without success. However, acknowledged that the edge could have had cushion on it to prevent any other resident from getting injured.

The licensee has failed to ensure that the home is a safe and secure environment for its residents. [s. 5.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, the home is a safe and secure environment for its residents, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 218. Orientation For the purposes of paragraph 11 of subsection 76 (2) of the Act, the following are additional areas in which training shall be provided:**
**1. The licensee's written procedures for handling complaints and the role of staff in dealing with complaints.**
**2. Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities.**
**3. Cleaning and sanitizing of equipment relevant to the staff member's responsibilities. O. Reg. 79/10, s. 218.**

**Findings/Faits saillants :**

1. The Licensee has failed to ensure that during the pandemic, the training required under section 76 of the Act must be provided (a) within one week of when the person had begun performing their responsibilities, with respect to the matters set out in paragraphs 1, 3, 4, 7, 8 and 9 of the subsection 76 (2) of the Act.

S. 76(2) of the Act:

Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: 1. The Residents' Bill of Rights. 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 4. The duty under section 24 to make mandatory reports. 7. Fire prevention and safety. 8. Emergency and evacuation procedures. 9. Infection prevention and control.

In March of 2020, Ministry of Long Term Care released urgent amendments to the Ontario Regulation 79/10 under the LTCH Act in response to the pandemic. The amendment included the training for new staff related to Section 24 and the duty to make mandatory reports. The amendment required the home to provide training to staff within one week of the staff member beginning to perform their duties. The requirement of the training included:
- The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
- The duty under section 24 of the Long-Term Care Homes Act, 2007 to make mandatory reports.

A call was made to the Director, followed by CIR that was submitted to the Director, regarding the alleged abuse of multiple residents by PSW #114.

A review of the Long-Term Care Home's orientation checklist indicated that RPN #106, PSW #107 and PSW #109, completed their training on a specified date and in an interview, DOC #104 indicated that the hire dates of the staff was on the specified dates. The checklist included the following areas of education: 1. The Residents' Bill of Rights. 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 4. The duty under section 24 to make mandatory reports. 7. Fire prevention and safety. 8. Emergency and evacuation procedures. 9. Infection prevention and control.

A review of a document with the Title "Covid-19 LTC & Ret Emergency Relief Hires Orientation Handbook, 1st week of hire April 2020", with a release date of April 24, 2020, contained the following information: Reveara's Mission, Vision and Values, Resident Bill of Rights, Resident Non- Abuse description, Examples of Abuse and Neglect, S.T.O.P abuse intervention, Reporting requirements, Infection Prevention and Control (IPC), Emergency Preparedness with all codes and directions as to what to do during codes and social media. The sign off sheet for receiving this package was located in the orientation checklist and was signed off by RPN #106, PSW #107 and PSW #109 on the specified date.

In an interview, Staff Educator #110, indicated that these staff members were trained on the specified date and that the orientation handbook had not been released until April 24, 2020.

The licensee has failed to ensure that during the pandemic, the training required under section 76 of the Act must be provided (a) within one week of when the person begins performing their responsibilities, with respect to the matters set out in paragraphs 1, 3, 4, 7, 8 and 9 of the subsection 76 (2) of the Act. [s. 218.]

***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 ensure that,***
***For the purposes of paragraph 11 of subsection 76 (2) of the Act, the following are additional areas in which training shall be provided:***

***1. The licensee's written procedures for handling complaints and the role of staff in dealing with complaints.***

***2. Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities.***

***3. Cleaning and sanitizing of equipment relevant to the staff member's responsibilities. O. Reg. 79/10, s. 218.***

***(2) Subsection 76 (3) of the Act does not apply during a pandemic, and instead, the training required under section 76 of the Act must be provided,***

***(a) within one week of when the person begins performing their responsibilities, with respect to the matters set out in paragraphs 1, 3, 4, 7, 8 and 9 of subsection 76 (2) of the Act; and***

***(b) within three months of when the person begins performing their responsibilities, with respect to the remaining matters set out in subsection 76 (2) of the Act. O. Reg. 72/20, s. 4., to be implemented voluntarily.***

**Issued on this 28th day of September, 2020**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

## Public Copy/Copie du rapport public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | MOSES NEELAM (762) |
| **Inspection No. / No de l'inspection :** | 2020_784762_0017 |
| **Log No. / No de registre :** | 010433-20, 013955-20 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Sep 16, 2020 |
| **Licensee / Titulaire de permis :** | AXR Operating (National) LP, by its general partners c/o Revera Long Term Care Inc., 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4 |
| **LTC Home / Foyer de SLD :** | Bay Ridges<br>900 Sandy Beach Road, PICKERING, ON, L1W-1Z4 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Vanda Cozier |

To AXR Operating (National) LP, by its general partners, you are hereby required to comply with the following order(s) by the date(s) set out below:

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

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**Order # / No d'ordre :** 001

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

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

The licensee must compliant with s.19(1) of the LTCHA.

The licensee shall prepare, submit and implement a plan to ensure resident #005, #010, #012 and #013 are protected from abuse.

The plan must include, but is not limited, to the following:

- A process for supervisory staff to monitor staff burnout that could lead to abuse or neglect
- A process where supervisory staff are monitoring staff to resident interactions during the provision of care, to ensure abuse is not happening.
- A plan to educate direct care staff to report any alleged witnessed abuse as in accordance to the home's policy.
- A process to identify, report and monitor residents at risk of abusing resident #005.

Please submit the written plan, for achieving compliance for inspection #2020_784762_0017, to Moses Neelam, LTC Homes Inspector, MLTC.

Please ensure that the submitted written plan does not contain any PI/PHI.

**Grounds / Motifs :**

1. The licensee has failed to protect resident #010 from emotional and physical abuse by PSW #114.

Physical abuse as defined by O.Reg 79/10 is as follows:

"physical abuse" means, subject to subsection (2),
(a) the use of physical force by anyone other than a resident that causes physical injury or pain

Emotional abuse as defined by O.Reg 79/10 is as follows:

"emotional abuse" means,
(a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A call was made to the after hours line, followed by Critical Incident Report (CIR), regarding the alleged abuse of multiple residents by PSW #114.

A review of resident #010's clinical electronic record indicated in a progress note written by RN #115, that an allegation of verbal abuse towards the resident was made by a staff. The progress note stated that this incident happened in the middle of the specified month.

A review of the LTCH's investigation notes, completed with RPN #106, indicated that PSW #114 had struck resident #010 in the mid section, to which resident responded "Ouch, you are hurting me". Additionally, PSW #114 had indicated to the RPN that they were frustrated and had enough of residents' responsive behaviors. RPN #106 confirmed in an interview that abused had occurred.

A review of the LTCH's investigation notes, was conducted with PSW #107, who witnessed the incident. The investigation indicated that PSW #114 had threatened the resident during a shower. In the investigation notes PSW #114, denied all allegations with regards to resident #010. PSW #107 confirmed in an interview that the abuse occurred as written in the investigation notes.

The licensee has failed to protect resident #010 from emotional and physical abuse by PSW #114. (762)

2. The licensee has failed to protect resident #012 from physical abuse by PSW #114.

A CIR was submitted to the Director, regarding the alleged abuse of multiple residents by PSW #114.

A review of resident #012's clinical electronic record indicated in a progress note written by DOC #104, that an allegation of abuse towards the resident was made. The progress note stated that this incident happened in the middle of the specified month.

A review of the LTCH's investigation notes, completed with RPN #106, indicated that PSW #114 had sprayed resident #012 in the face with specific spray, to which resident responded, "you are hurting me". As per RPN #106, this incident occurred on in the specified month. In the investigation notes, PSW #114, denied all allegations with regards to resident #012.

In an interview RPN #106, confirmed that they had witnessed resident #010 being sprayed by PSW #114, to which the resident responded, "you are hurting me".

The licensee has failed to protect resident #012 from physical abuse by PSW #114 (762)

3. The licensee has failed to protect resident #013 from emotional and physical abuse PSW #114.

A call was made to the Director, followed by CIR that was submitted to the Director, regarding the alleged abuse of multiple residents by PSW #114.

A review of resident #013's clinical electronic record indicated in a progress note written by RN #115, that an allegation of verbal abuse towards the resident was made by a staff. The progress note stated that this incident happened in the middle of the specified month.

A review of the LTCH's investigation notes, completed with PSW #107, indicated that they witnessed PSW #114 speaking inappropriately to resident #013. Furthermore, PSW #114, had sprayed resident #013 with a spray, to which resident responded, "my eyes burned". As per PSW #106, this incident occurred

on the specified date. Additionally, the investigation notes with PSW #109, indicated that PSW #109 witnessed resident #013 being sprayed in the face, however, did not recall the date. In the investigation notes, PSW #114, admitted to spraying the resident in the face with a spray, however, denied all other allegations with regards to resident #013. Additionally, PSW #109 indicated that PSW #114 appeared to be irritated as they had an angry expression on their face and had made a comment which included a foul expletive when resident was having verbal responsive behaviors.

In an interview PSW #106, confirmed that they had witnessed resident #013 being sprayed with a spray by PSW #114, to which the resident responded, "my eyes burned" and that PSW #114 had made an inappropriate statement.

In an interview PSW #109, confirmed that they had witnessed resident #013 being sprayed with a spray.

The licensee has failed to protect resident #013 from emotional and physical abuse PSW #114.

4. The licensee has failed to ensure that resident #005 is protected from abuse by resident #004.

A complaint was received by the Ministry of Long Term Care (MLTC). The complainant indicated that resident #004 had an incident with a co-resident, that resulted in various injuries.

A review of resident #005 and #004's clinical health records, indicated that on a specified date, resident #004 had entered resident #005's room, and caused an incident that lead to injuries for resident #005.

In separate interviews, RPN #113 and BSORPN #112, indicated that resident #004 had entered resident #005's room, and caused an incident that lead to injuries for resident #005. RPN #113 stated the incident was not witnessed, however, resident #005 was able to identify that resident #004 had been the one who had caused the injury, immediately after the incident.

The licensee has failed to ensure that resident #005 is protected from abuse by

resident #004.

The Severity of this issue was determined to be level 2 as there was minimal harm to resident's #005, #010, #012 and #013. The scope of this issue was a pattern as four out of eight residents reviewed experienced abuse. The home had a level 3 compliance history as they had previous non compliance with this section, specifically:
- Compliance order (CO) #001 issued on March 26, 2019 and complied on June 27, 2019 (2019_643111_0005)
- Written Notice (WN) issued on November 22, 2019 (2019_626501_0025)
- Voluntary Plan of Correct (VPC) issued on February 12, 2020 (2020_643111_0005)
(762)

**This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le :** Nov 30, 2020

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

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**Order # / No d'ordre :** 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 must be compliant with s.20(1) of the LTCHA.

Specifically the licensee must:
a) Ensure all newly hired staff members between the dates of March 20 - August 21, 2020 have been trained on the reporting requirement of abuse to the Director.

b) A record of this training must be kept. This record must include the content, facilitator, attendees, dates and times.

**Grounds / Motifs :**

1. The licensee has failed to ensure that a written policy that promotes zero tolerance of abuse and neglect of residents is complied with, specifically with regards to residents #009, #010, #011, #012 and #013, where staff suspected abuse and did not immediately report that suspicion.

A call was made to the Director, followed by CIR regarding the alleged abuse of multiple residents by PSW #114 that occurred in a specified month.

A review of resident #009's clinical electronic record indicated in a progress note written by RN#115, that an allegation of verbal abuse towards the resident was made by a staff. The progress note stated that this incident happened in the middle of the specified month.

A review of the policy with the name "Mandatory Reporting of Resident Abuse or

Neglect" with the last review date of March 31, 2019, indicated that any person who has a reasonable ground to suspect abuse must immediately verbally report the suspicion to the person in charge and together they will report this to the Director.

In an interview RPN #106, confirmed that they had witnessed abuse, but had not reported it because they were not trained on the prevention of abuse and were not aware of the reporting structure of the LTCH.

The licensee has failed to ensure that a written policy that promotes zero tolerance of abuse and neglect of residents is complied with, specifically with regards to resident #009, where staff suspected abuse and did not immediately report that suspicion to the person in charge or the director. (762)

2. A review of resident #010's clinical electronic record indicated in a progress note, that an allegation of verbal abuse towards the resident was made by a staff. The progress note stated that this incident happened in the middle of the specified month.

A review of the LTCH's investigation notes, completed with RPN #106, and investigation notes, completed with PSW #107, indicated that abuse was suspected.

In separate interviews RPN #106 and PSW #107, confirmed that they had witnessed abuse, but had not reported it because they were not trained on the prevention of abuse and were not aware of the reporting structure of the LTCH.

The licensee has failed to ensure that a written policy that promotes zero tolerance of abuse and neglect of residents is complied with, specifically with regards to resident #010, where staff suspected abuse and did not immediately report that suspicion to the person in charge or the director. (762)

3. A review of resident #011's clinical electronic record indicated in a progress note written by RN#115, that an allegation of verbal abuse towards the resident was made by a staff. The progress note stated that this incident happened in the middle of the specified month.

A review of the LTCH's investigation notes, completed with PSW #107, indicated that abuse was suspected.

In an interview PSW #107, confirmed that they had witnessed abuse, but had not reported it because they were not trained on the prevention of abuse and were not aware of the reporting structure of the LTCH.

The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of a resident #011 by a staff that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director. (762)

4. A review of resident #012's clinical electronic record indicated in a progress note written by DOC #104, that an allegation of abuse towards the resident was made. The progress note stated that this incident happened in the middle of the specified month.

A review of the LTCH's investigation notes, completed with RPN #106, indicated that abuse was suspected. Additionally, PSW #114 had indicated to the RPN that they were frustrated and had enough of residents' responsive behaviors.

In an interview RPN #106, confirmed that they had witnessed abuse, but had not reported it because they were not trained on the prevention of abuse and were not aware of the reporting structure of the LTCH.

The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of a resident #012 by a staff that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director. (762)

5. A review of resident #013's clinical electronic record indicated in a progress note, that an allegation of verbal abuse towards the resident was made by a staff. The progress note stated that this incident happened in the middle of the specified month.

A review of the LTCH's investigation notes, completed with PSW #109, and investigation notes, completed with PSW #107, indicated that abuse was

suspected. Additionally, PSW #109 indicated that PSW #114 appeared to be irritated as they had an angry expression on their face and had made a comment which included a foul expletive when resident was having verbal responsive behaviors.

In separate interviews PSW #109 and PSW #107, confirmed that they had witnessed abuse, but had not reported it because they were not trained on the prevention of abuse and were not aware of the reporting structure of the home.

The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of a resident #013 by a staff that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director.

The severity of this issue was determined to be a level 2 as there was minimal harm or minimal risk of harm to residents #009, #010, #011, #012 and #013. The scope of the issue was wide spread at level 3 as three out of three staff did not report this incident. The home had a level 3 compliance history as they had previous noncompliance with the same sub section of the LTCHA. Specifically:
- A written notice (WN) issued on September 23, 2019 (2019_715672_0010) (762)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Nov 30, 2020

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

**Issued on this 16th day of September, 2020**

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

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

**Service Area Office /**
**Bureau régional de services :** Central East Service Area Office