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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 5, 2019	2019_761733_0001	005633-18, 009341-18, 010674-18, 012646-18, 020156-18, 022702-18, 023225-18, 025382-18, 025626-18, 029821-18	Critical Incident System

Licensee/Titulaire de permis

The Glebe Centre Incorporated
950 Bank Street OTTAWA ON K1S 5G6

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

Glebe Centre
950 Bank Street OTTAWA ON K1S 5G6

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

MARK MCGILL (733), EMILY BROOKS (732), JOELLE TAILLEFER (211)

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): January 2, 3, 4, 7, 8, 9, 10, 11, 2019

The following logs were inspected:
Log #012646-18 (CI: 2811-000018-18), log #010674-18 (CI: 2811-000017-18) are related to the prevention of abuse, neglect and retaliation.
Log #020156-18 (CI: 2811-000019-18), log #023225-18 (CI: 2811-000022-18), log #005633-18 (CI:2811-000009-18) are related to falls prevention and management.
Log #029821-18 is related to a written complaint not being forwarded to the Director.
Log #022702-18 (CI: 2811-000021-18) is related to the misuse/misappropriation of a residents' money.
Log #025382-18 (CI: 2811-000024-18) is related to resident to resident physical abuse.
Log #025626-18 (CI: 2811-000025-18) is related to a missing resident for more than 3 hours.
Log #025382-18 (CI: 2811-000024-18) is related to responsive behaviours.
The following log was completed: #009341-18 (CI: 2811-000016-18).

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Executive Assistant, Program Facilitator, Manager of Nursing Operations, Coordinator of Nursing Programs, Director of Quality Management, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Housekeepers. The inspectors also reviewed residents' health care records, home policies and procedures, mandatory training records, staff work schedules, observed resident rooms, observed resident common areas, and observed the delivery of resident care and services, including resident-staff interactions.

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

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

13 WN(s)
5 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from abuse by anyone.

Sexual abuse is defined by the LTCHA, 2017, O.Reg 79/10, s. 2 (1) as (a) any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A Critical Incident Report (CIS) was submitted to the Director relating to alleged sexual abuse by resident #009 towards resident #011. The CIS indicated that a second incident occurred when staff observed resident #009 touching resident #010.

A review of resident #009's plan of care from a specified period of time, indicated that the resident had inappropriate sexual behaviour towards staff. The interventions were:
-To document a summary of each episode and report to the physician
-Remain calm and avoid angry reactions towards the resident
-Set limits for acceptable behaviour (Staff to tell the resident directly that this behaviour is inappropriate and that it has to stop)
-Staff are to escort the resident out of the dining room after their meal.

On a specified date, resident #009's health care records indicate that resident #009 attempted to inappropriately touch a co-resident.
A review of resident #009's plan of care showed that the focus, the goals and the interventions related to the resident's behaviour were removed.
On a specified date as a late entry, resident #009's health care records indicate that resident #009 inappropriately touched resident #010 and resident #009 was told by RN

#119 that the behaviour was inappropriate and will not be tolerated in the future.

Resident #009's health care records indicate that resident #009 was seen talking and touching resident #011 in a sexual manner at 0930 hours. Resident #009 was removed from the area and within 15 minutes, resident #009 returned. RN #104 heard resident #011 screaming "stop". RN #104 saw resident #009 beside resident #011 but did not see where resident #009's hand was placed. Resident #009 was immediately removed from the area and was told that the behaviour was inappropriate. RN #104 wrote that resident #011 did not recall the incident. The physician wrote that they spoke with resident #009 regarding the inappropriately touching of the PSW and the nurse. The physician wrote that these sexual behaviours had previously occurred.

A review of resident #009's plan of care indicated that the resident's sexual behaviour was initiated on the same day as the aforementioned incident with the following interventions:
-Call the Power of Attorney (POA) when resident has inappropriate behaviour. The POA will talk with the resident and will reinforce that the inappropriate behaviour has to stop.
-Document a summary of each episode and report to the physician
-Monitor the resident in the dining room; cannot be seated with a female resident
-Remain calm and avoid angry reactions towards the resident
-Set limits for acceptable behaviour (Staff to tell the resident directly that this behaviour is inappropriate and that it has to stop)
-Staff are to escort the resident out of the dining room after meals.

The following day, resident #009's progress notes indicate that the police were called in regards to the inappropriate touching towards resident #011.
The next day, resident #009's progress notes indicated that resident #009's family member suggested that a male staff should provide care to the resident when possible.
An interview with PSW #120 indicated that resident #009 demonstrated sexual behaviours since their admission. The resident only touched female residents or staff. PSW #120 stated that the staff were aware of the resident's sexual behaviours. The resident liked to flirt and touch female residents and staff buttocks or breasts. They were closely monitored during activities and meal times when resident #009 was sitting beside a female resident but the monitoring was not documented. PSW #120 stated that when they observed resident #009 demonstrating behaviour of a sexual nature, they immediately informed the nurse.

In an interview with RPN #119, they stated that they were unaware of resident #009's

past inappropriate sexual behaviours toward female residents. The resident's sexual inappropriate behaviour was communicated to RPN #119 by the student nurse during their shift on a specified date. The student nurse was told to document the incident in the resident's chart. The next day, RPN #119 was informed that the student nurse did not document the incident. Furthermore, RN #119 indicated that resident #009's inappropriate sexual behaviour toward resident #011 was not communicated to the next shift.

An interview with RN #104 indicated that they were aware that resident #009 was inappropriately touching the female staff. Conversely, they were unaware that the resident had sexual behaviour towards female residents since their admission. RN #104 showed that it was written in the resident's health care record that the resident had inappropriate sexual behaviour towards other residents or staff. RN #104 demonstrated that the resident's responsive behaviour of a sexual nature was resolved in late 2017, in resident #009's plan of care. RN #104 confirmed that the resident's sexual behaviour toward female residents and staff was not a component of resident #009's plan of care in early 2018. RN #104 indicated that the first time they heard that resident #009 touched a female resident was on a specified date after the date of the plan of care from early 2018. RN #104 stated that it was witnessed that resident #009 touched resident #011 sexually on a specified date. RN #104 indicated that resident #009 was sitting in the dining room and went to resident #011's table. They were separated immediately. RN #104 stated that resident #011 had no recollection of the incident. On that day, the inappropriate sexual behaviour was included in resident #009's plan of care. RN #104 also responded that the incident was identified as a criminal offense and the police should have been called immediately. It was confirmed that the police were called the next day.

PSW #130 stated in an interview that the staff were aware of resident #009's sexual behaviour towards female residents and staff since admission. Resident #009 would slowly touch an area of the body then gradually try to reach an inappropriate area of the body. When the staff saw resident #009 trying to touch a female resident, they would stop resident #009 before it went to inappropriate areas. PSW #130 stated not being able to remember specific female resident names that resident #009 had touched, but that the resident would touch anyone that was close.

In an interview with the Manager of Nursing Operations #106, they thought that resident #009's sexual behaviour was an isolated event. Manager of Nursing Operations #106 was unaware that the resident was exhibiting these sexual behaviours since admission. It

was after the incident, the manager was informed that the resident had exhibited responsive behaviour of a sexual nature in the past. The manager was informed by the PSWs that they were not reporting resident #009's sexual incidents because they were able to stop the responsive inappropriate behaviour before any incident occurred. The Manager of Nursing Operations #106 validated that resident #009' s plan of care from early 2018, did not identify that the resident had inappropriate behaviours. Furthermore, the manager was unaware for two business days, that resident #009 touched resident #010 in a sexual nature. The Manager of Nursing Operation #106 stated that RPN #119 forgot to initiate a follow-up after the incident was communicated the day that it occurred. Consequently, resident #009's responsive behaviour toward resident #010 was not investigated and the Director was not notified until two business days later. The Manager of Nursing Operations #106 indicated that the residents in the home were not protected from resident #009's responsive behaviour of a sexual nature.
[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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 was kept confidential.

Inspector #211 observed that resident #010's right cupboard door was opened. The inspector was able to view the resident's Kardex placed inside the right side door showing the following details: the resident's behaviour, mobility, activities of daily living and the fall risk.

An interview with PSW #120 stated that resident #010's Kardex was kept in the room. An interview with RPN #121 indicated that each resident on the unit should have their Kardex placed inside the cupboard door in their room. Inspector #211 went with RPN #121 into different residents' rooms and found resident Kardex's inside the cupboard door. Resident #011's room was then verified and RPN #121 did not locate resident #011's Kardex in the cupboard. RPN #121 did not understand the reason that resident #011's Kardex was not inside the cupboard door.

Inspector #211 and the Manager of Nursing Operation #106 walked into different residents' rooms. It was observed that most of the residents did not have their Kardex in their room, except resident #011. Resident #011's Kardex described the resident's behaviours and the activities of daily living. The Manager of Nursing Operation #106 confirmed that residents' Kardex should not be inside their room due to it being a breach of privacy and confidentiality.

The licensee has failed to ensure that the residents' Bill of Rights was respected and their personal health information was kept confidential. [s. 3. (1) 11. iv.]

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 his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 is kept confidential, to be implemented voluntarily.

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 its residents.

This finding is related to Intake log #025626-18.

A Critical Incident Reporting (CIR) indicated that resident #014 was missing from the home for over three hours on a specified date.
The CIR indicated that resident #014 was taken off the unit by a Program Facilitator to a concert. The concert ended, and the resident was not present. The police and the substitute decision maker were notified, and the resident was found by the police.

Reviews of the resident's plan of care and the quarterly Resident Assessment Instrument-Minimum Data Set (RAI-MDS) indicated that resident #014 had wandering behaviour. The resident's plan of care indicated that the resident uses a mobility device independently and due to the behaviours, the resident will attempt to leave the unit or the building if not prevented. The resident has chronic and progressive decline in intellectual functioning characterized by deficit in memory, judgment, and decision making related to short term memory.

The progress notes documented by RPN # 145, indicate the RPN was notified by a program facilitator that resident #014 was last seen in the activity room. A primary search of the second floor, basement and the front door was completed and the staff could not locate the resident.
RN #138, who was in charge was called immediately and they were advised to commence an immediate building search. A code yellow was announced, a search of the building was initiated and they were unable to locate the resident.

A review of the resident's progress notes from specified dates in 2018 indicated that resident #014 expressed a desire to leave the home.

A review of an email from volunteer #148 to Program Facilitator #149 indicated that the volunteer brought seven residents, including resident #014 from the first floor to the concert on the second floor. The email indicated that the volunteer thought they saw the resident going towards the bathroom. When the volunteer thought that the resident was taking too long in the bathroom, the volunteer knocked and found the bathroom empty. RN # 138 wrote the day before that the Director of Maintenance Services was called and came to the home to view the security camera.

In an interview with Program Facilitator #144, they stated that the activity began on the second floor. Program Facilitator #144 stated that volunteer #148 was to escort and supervise three to four residents including resident #014 during the activity. The volunteer and the residents used the elevator to the second floor for the concert activity. Program Facilitator #144 was informed that the volunteer assumed resident #014 was in the bathroom situated on the second floor and after a certain time, the volunteer realized that the resident was nowhere to be found.

Inspector #211 observed that the Glebe Center home has the main entrance facing Monk Street. The main entrance has two double sliding doors and two regular doors separated by a lobby.

An interview with Program Facilitator #103 indicated that many residents attended the concert. During the activity, the volunteer responsible for resident #014 noted that the resident was not present. The Program Facilitator #103 said that the volunteer went to the resident's locked unit on the first floor to ask the nurse if the resident was on the unit. The volunteer returned to the gathering place to inform the three Program Facilitators that resident #014 was missing.

In an interview with Director of Environmental Services #143, they stated that they believed the commotion in the gathering place from many residents gave an opportunity for resident #014 to escape into the elevator. The Director of Environmental Services stated that the video was erased. The Director of Environmental Services indicated that the video showed resident #014 leaving the building on the specified date. The video showed the resident coming out from the elevator on the first floor following a visitor to the main entrance on the first floor. The Director of Environmental Services indicated that the receptionist at the front desk in the main entrance leaves at 1700 hours. At that time, the two sliding double doors and the two regular doors were closed and locked and an access card was hanging beside the regular door on the wall. The visitors need to swipe the card to be able to exit the building. The Director of Environment Services indicated

that resident #014 was found two to three kilometers from the nursing home.
RN # 146 documented in the resident's progress notes that resident #014 was found and located. The resident was brought back to the unit accompanied by the Ottawa Police Department and no injury was observed.

In an interview with Coordinator of Volunteer of Services #139, they stated that the Program Facilitator has the responsibility to give a residents' list and the instructions to the volunteer and to have the residents closely monitored. The Coordinator of Volunteer of Services stated that the video showed that resident #014 was following a family member. The family member held the door for resident #014 to come out of the building.

An interview with the Program Facilitator #147 indicated that a volunteer can escort two to four residents for an activity. The amount of residents that a volunteer can escort will depend on multiple factors. However, Program Facilitator #147 stated that one volunteer to escort seven residents was too much especially if the residents were from the locked unit. Program Facilitator #147 acknowledged that resident #014 should have been supervised one on one (1:1) by a volunteer since the resident was known to be exit seeking.

The licensee has failed to ensure that resident #014, identified as a risk for elopement on a specified date, had a safe and secure environment during an evening activity.
[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.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that different aspects of care are integrated and are consistent with and complement each other.

This finding is related to Intake log #010674-18

On a specified date, resident #009's health care records indicated that resident #009 attempted to inappropriately touch a co-resident.
A review of resident #009's plan of care indicated, from a specified time frame, that the resident had inappropriate sexual behaviour towards staff. The interventions in place were:
-Document a summary of each episode and report to the physician
-Remain calm and avoid angry reactions towards the resident
-Set limits for acceptable behaviour (Staff to tell the resident directly that this behaviour is inappropriate and that it has to stop)

-Staff are to escort the resident out of the dining room after meals.

Reviews of the resident Assessment Instrument-Minimum Data Set (RAI-MDS) over one year indicated that resident #009 did not demonstrate socially inappropriate or disruptive behaviour including sexual behaviour.

A review of resident #009's health care record indicate that the resident's inappropriate sexual behaviour was resolved late 2017. Resident #009 inappropriately touched, in a sexual nature, two different residents, on two specified dates in 2018.
An interview with PSW #120 indicated that resident #009 demonstrated a trend of sexual behaviors since their admission. The resident only touched female residents or staff.
Interviews with RPN #119 and Manager of Nursing Operations #106 indicated that they were not aware of resident #009's sexual behaviors before the incidents on two specified dates in 2018.

An interview with RN #104 stated that resident #009's inappropriate sexual behaviour was resolved in late 2017, because there was no documentation in the resident's health care records indicating that the resident was still exhibiting the responsive behaviour. Therefore, the RAI-MDS completed every three months reflected that the resident did not display the behaviour.

In an interview with the DOC, they stated that nurses would not document resident's sexual behaviour in the resident's progress notes if the PSWs did not report resident #009's inappropriate sexual behaviour toward female residents or the staff. The DOC stated that the resident's sexual behaviour became normalized and staff were no longer reporting the resident's behaviours. Consequently, when the documentation was not done in the resident's progress notes, the behaviour would not trigger the coding in the RAI-MDS.

The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #009 collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

2. Resident #013 has a history of responsive behaviours. High intensity needs (HIN) one to one was ordered for this resident. On a specified date, resident #013 exhibited responsive behaviours, resulting in injury to resident #015. Resident #013 did not have a HIN 1:1 staff that day.

On January 9, 2019, Inspector #732 reviewed resident #013 Physician Order sheets. Order written one month prior to the above incident, to "continue HIN 1:1 as previous, except nights, Wednesday days, and Saturday days."

Inspector #732 clarified this order with progress note written by physician after the incident. Physician note dated four days later stated that “Staff update that triggers have not been noted, and that these occur quickly and sporadically. Currently on 1:1 on days and evenings (except Wednesday and Saturday days). No night 1:1. Co-resident no longer has night 1:1 Staff update that at times altercations occur when scheduled 1:1 is not available.”

Inspector #732 reviewed resident #013 progress notes for the date of the incident. Inspector #732 noted that this incident occurred on a Thursday, day shift. Registered Nurse (RN) #118 documented that no HIN were staffed that shift.

RN #118 confirmed with Inspector #732 in an interview that resident #013 was supposed to have a HIN 1:1 that shift, but that it was not staffed.
Inspector #732 interviewed Director of Care (DOC) #101. DOC #101 gave Inspector #732 a schedule of the staff on for the date of the incident, day shift. DOC #101 confirmed that there was no HIN 1:1 staff for resident #013 on that shift.

The Licensee has failed to provide resident #013 with a high intensity need 1:1 staff as specified in the plan of care.

The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

3. Resident #001 was started on behaviour mapping through 15 minute checks by RPN #128 after they demonstrated inappropriate behaviour towards a co-resident.
In an interview with RPN #128, the Inspector asked if the Behaviour Mapping Flow Sheets were to be filled out by staff on all shifts to which RPN #128 replied yes. This was due to not knowing when the resident may have a behaviour and to ensure that all

possible behaviours are captured. The Inspector then asked how it is communicated to staff that a resident is on these checks and that the flow sheets are to be completed. They replied that the sheets are placed in a Behavioural Support Outreach (BSO) binder located at the nursing station. Staff are also informed verbally during shift change.

A review of the Behaviour Mapping Flow Sheet indicates that it was only partially completed with checks documented starting at 1500 hours. The next day, the checks started at 1600 hours and on the following day, it is documented that the checks started at 0700 hours and continued through 1400 hours with no other times documented as being completed.

A review of the progress notes for the above dates and times does not indicate if the resident was behaviour mapped/checked every 15 minutes. Staff Point of Care (POC) records also do not indicate if these checks were performed.

By failing to ensure that the provision of the care set out in the plan of care was documented, it is unknown if that care was provided to the resident as planned.
[s. 6. (9) 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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with.

Resident #012 was noted to have some confusion and unsteady gait in the days leading up to two falls that occurred on back to back days with the second occurring approximately five hours after the first. This second fall resulted in transfer to hospital with subsequent injury. A fall risk assessment was not completed on resident #012 after either fall, or in the days leading up to the falls where there was a change in resident #012 status.

In an interview with Director of Care #101 Inspector #732 was told that the home uses Scott's Fall Risk Assessment tool and it should be completed after every fall.
On January 7, 2019, Inspector #732 reviewed the policy "Falls Prevention and Management Program" with Coordinator of Nursing Programs (CNP) #110. This policy was dated May, 2013 and was found in the Resident Care Manual on a specified unit. CNP #110 confirmed that this is the current policy distributed throughout the home. Inspector #732 noticed conflicting instructions within the policy for when a fall frisk assessment should be completed. To clarify, CNP #110 showed Inspector #732 a slideshow from March, 2017 that states a fall risk assessment tool must be completed on admission (during the day shift), after a fall, and following a change in status. CNP #110 confirmed that this is the standard of practice at this time within the home, and the most up to date policy. CNP #110 told Inspector #732 that all staff were to have received an in-service on this information.

Inspector #732 reviewed resident #012's progress notes on PointClickCare in the days

leading up to the fall that sent resident #012 to hospital. In a nursing note dated six days prior to the fall, resident #012 "appeared to be confused today. When getting up after lunch was pushing their chair out of the dining room. Gait also noted to be unsteady". In a note dated three days prior to the fall, it states "Appetite poor at supper time. Ate fairly well @ snack time. Noted confusion this eve. and very morose. At 2230hrs. found in bed crying, stated they did not feel well". In another note, dated two days prior to the fall, it was written "Resident was weak ++ and tired at 1500, resident walking with one staff assist on the unit. Crying and complained that they won't stay in their room because someone goes to their room, they are afraid of being in their room alone". Nursing note dated the day before the fall, says "Resident has been awake most of the night, walking and pacing the unit, crying often, removing their clothes, and resident attempted to urinate on the floor by pulling down their pants. Redirected by staff and became very agitated, screaming at the staff. Will discuss with day nurse to check for UTI/delirium etc".
Inspector #732 reviewed resident #012 chart on PointClickCare. No fall risk assessment had been completed on resident #012 after the two falls discussed above, as well as an additional fall on another date. Resident #012 did not receive a fall risk assessment upon return to the home from hospital after a change in status. The last documented fall risk assessment for resident #012 on PointClickCare was dated several months prior to any of the above mentioned falls.

Inspector confirmed the above information with CNP #110 and told Inspector #732 that there should be other fall risk assessments completed for this resident.
Inspector #732 met with Manager of Nursing Care Operations #106 and informed MNCO #106 that no fall risk assessment was completed for any falls past a specified date in 2018, or upon return of resident #012 from hospital and change in status. MNCO #106 agreed that an assessment should have been completed.

Resident #003 had a fall that resulted in transfer to hospital and subsequent injury requiring surgery. No fall risk assessment was completed at the time of the fall. Resident had a previous fall with no injury. No fall risk assessment was completed at that time. The last Falls Risk Assessment was done seven months prior.

Inspector #732 reviewed resident #003's chart on Point Click Care. No fall risk assessment had been completed on resident #003 after their falls on the two specified dates.

In an interview, Coordinator of Nursing Programs (CNP) #110 confirmed that no fall risk

assessment was completed on resident #003 after their fall on a specified date. CNP #110 stated that a fall risk assessment does not take very long and should have been completed on resident #003 after their fall, and before their transfer to hospital.

Resident #004 had a fall resulting in transfer to hospital, subsequent injury, and change in status upon return to home. Inspector #732 reviewed resident #004's chart on PointClickCare. Prior to this fall, resident #004 also had two previous falls. No fall risk assessment had been completed on resident #004 after any of their three falls.

The Licensee failed to ensure that the home's Falls Prevention and Management Program was complied with.
[s. 8. (1) (a),s. 8. (1) (b)]

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 Falls Prevention and Management Program is complied with, to be implemented voluntarily.

WN #6: 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. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the persons who have received training under subsection 76 (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

All staff are to receive retraining on the protections afforded by s. 26 at annual intervals as per r. 219 (1).

In an interview with RPN #115, Inspector #733 asked if they had received training regarding whistle-blowing protection and if they understood what this term meant. They replied no and that they were not sure what the term meant. In an interview with PSW #116 the same question was asked to which they replied that they had not heard of this term.

The Surge Learning Education Status Report for 2018 for RPN #115 was provided by the Director of Quality Management #127. It indicates that one course was assigned and taken under Resident care – abuse prevention entitled Resident Abuse Awareness and Prevention. A review of the course document revealed that it did not contain any information on whistle-blowing. This was the only course on abuse assigned to PSW #116 and RN #118 when their Surge Learning Education Status Report for 2018 was reviewed by the Inspector.

The Surge Learning staff record for abuse training for the year 2017 was reviewed. It contains three courses that were to be taken by staff. This includes a review of the homes Resident Abuse and Neglect policy. It is noted that there is no mention of whistle-blowing protection provisions included in any of the courses that were offered.

The licensee failed to retrain staff on whistle-blowing protection provisions.
[s. 76. (4)]

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 persons who have received training under subsection 76 (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations., to be implemented voluntarily.

WN #7: 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 the home's written policy put in place to promote zero tolerance of abuse and neglect of residents, shall ensure that the policy was complied with.

This finding is related to Intake log #010674-18.

A Critical Incident Report (CIS) was submitted to the Director relating to alleged sexual abuse from resident #009 towards resident #011. The CIS indicated that a second incident occurred when staff observed resident #009 touching resident #010.

An interview with PSW #120 indicated resident #010 was sitting at the nursing station. Resident #009 went to the nursing desk and approached resident #010. PSW #120 observed resident #009 touching an inappropriate area of resident #010 over their clothes. PSW #120 stated that the incident was communicated to RPN #119.
An interview with RPN #119 indicated that a student nurse informed RPN #119 about the second inappropriate sexual incident. The incident was not documented in resident #009's health care records.

In an interview with RN #104, they stated that they observed resident #009 touch resident #011 as per the CIS and that the police were called the next day.
In an interview with Manager of Nursing Operations #106, they indicated that they were unaware until two business days later that resident #009 touched resident #010 in a sexual nature. Manager of Nursing Operations #106 stated that RPN #119 forgot to initiate a follow-up after the information of the incident was communicated on that day. Manager of Nursing Operations #106 indicated the police were called the next day regarding the inappropriate touching from resident #009 to resident #011.

A review of the home's policy # RC 4.00.00 titled Resident Abuse and Neglect, reviewed on March 2015 and January 2018 indicates the following:
Employee (s) who are reporting that they have witnessed or suspect alleged incident of resident abuse or neglect.
-Coordinate with any others as needed to fully investigate the incident and complete the documentation of all known details of the reported incident.
-Notify the MOHLTC if the alleged, suspected or witnessed or un-witnessed incident of abuse of a resident meets the criteria for Ministry Notification.
-To submit a report to the MOHLTC on weekends, Statutory Holiday or after business hours, the notification must be to the MOHLTC pager number (See Appendix E),
-Notify the Director of Care or designate or if after hours, the manager on call immediately should the investigation lead to notification or reporting beyond the facility,
-The home will notify the resident's SDM, if any, and any other person the resident specifies;
• immediately upon the home becoming aware of an alleged, suspected or witnessed incident of abuse of the resident that resulted in physical injury or pain to the resident's health and well-being,
• within 12 hours of becoming aware of any other alleged, suspected or witnessed incident of abuse of a resident,

The report relating the investigation and response is to be submitted to the Ministry of Health and Long-Term Care using the Mandatory Critical Incident System form, using the "Mandatory Report Section" immediately upon becoming aware of the incident. The timeline within which a home must submit the report within 10 days includes, but is not limited to, the results of the investigation and any action in response to incident of abuse, following becoming aware of an alleged, suspected or witnessed incident. If the Home cannot submit the report within 10 days, it will submit a preliminary report to the MOHLTC Director.

The licensee has failed to ensure that the written home's policy put in place to promote zero tolerance of abuse and neglect of residents, ensure that the policy was complied with:
-Writing the details of the alleged or witnessed abuse as soon as possible
-Nurse who received the report, conduct an investigation,
-Cooperate fully with the home administrative staff and the police for the investigation
-Notify the MOHLTC if the alleged, suspected or witnessed or un-witnessed incident of abuse,
-Notify the resident's SDM, if any, and any other person the resident specifies immediately,
-The report relating the investigation and response is to be submitted to the Ministry of Health and Long-Term Care using the Mandatory Critical Incident System form, using the "Mandatory Report Section" immediately upon becoming aware of the incident.

[s. 20. (1)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure when the long-term care home received a written complaint concerning the care of a resident or the operation of the long-term care home, the written complaint was immediately forwarded to the Director.

This finding is related to Intake log #029821-18.

Inspector #211 reviewed resident #006's Substitute Decision Maker (SDM) complaint letter sent to the licensee on a specified date related to resident #006's care and the operation of the long-term care home. The complaint letter was forward to the Director three days later.

An interview with the DOC indicated that the resident's SDM sent a written letter to the licensee related to multiple concerns already discussed between the licensee and the resident's SDM. The DOC stated that the complaint letter indicated that the SDM was not satisfied with the resident care. The DOC indicated that they were not aware of the legislation related to LTCHA s. 22 (1).

The licensee failed to ensure that the complaint letter from resident #006's SDM was immediately forwarded to the Director concerning the resident care and the operation of the long-term care home.
[s. 22. (1)]

WN #9: 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 is reported to the licensee, is immediately investigated.

This finding is related to Intake log #010674-18.

A Critical Incident Report (CIS) was submitted to the Director relating to alleged sexual abuse from resident #009 towards resident #011. The CIS indicated that a second incident occurred when staff observed resident #009 touching resident #010.

An interview with RPN #119 stated the incident when resident #009 touched resident #010 it was not documented. RPN #119 did not remember if the information was transmitted to the Manager of Nursing Operations #106 on that day.

An interview with the Manager of Nursing Operations #106 indicated the manager was unaware until three business days later, that resident #009 touched resident #010. Manager of Nursing Operations #106 stated that RPN #119 forgot to initiate a follow-up after they were informed of the incident on that day. An investigation was not initiated the day that the incident occurred.

The licensee has failed to ensure that the alleged, suspected or witnessed incident of abuse of resident #010 by resident #011 was reported to the licensee was immediately investigated.
[s. 23. (1) (a)]

WN #10: 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 has reasonable grounds to suspect misuse or misappropriation of resident's money shall immediately report the suspicious and the information upon which it is based to the Director.

This finding is related to Intake log #022702-18

A Mandatory Report CIS received through the Critical Incident System, stated that resident #005 informed the Program Facilitator #103 on a specified date, that a specified amount was placed inside the wallet in the bag at the bottom of their bed when resident #005 laid down for a nap. When resident #005 woke up, the money was no longer in the wallet.
A review of the form titled Missing Items of Significant Value Investigation completed by RN #104 indicated that the resident reported the missing money. A translated English letter was attached to the form indicating that the resident complained of missing money for the past 6 months. The resident indicated that a specified amount placed inside an envelope disappeared from the wallet inside the bag while the resident was taking a nap in the room. RN #104 also wrote that a specified amount was taken from the resident's wallet at an earlier date but resident #005 could not remember the exact date.

According to a progress note with the confirmation of RN #104, a written letter was given by resident #005 to the Program Facilitator #103. The Program Facilitator translated the

letter. The letter indicated that resident #005 was missing money for the past six months. The resident wrote that a specified amount was missing. RN #104 indicated that the form titled Missing Items of Significant Value Investigation was submitted to the Director of Environmental Services #143.

In an interview with Program Facilitator #103, they stated that resident #005 communicated missing a specified amount placed inside an envelope in the bag after waking up from the nap.

An interview with Manager of Nursing Care Operations #106 revealed that resident #005 was cognitively able to make their own decisions. Resident #005 refused to have the family member called and the police notified. Manager of Nursing Care Operations #106 indicated that the CIS was not sent until 13 days later, since the manager wanted to have the investigation completed including speaking with the family member. Moreover, the investigation included the participation of the department of Human Resources to find if there was a common staff or visitor that could be involved with the missing money. Manager of Nursing Care #106 indicated that the regulation related to S.O. 2007, C. 8, s. 24 (1) 4 of the Act was not followed.

The licensee failed to ensure when a person has reasonable grounds to suspect misappropriation of resident #005's money, to immediately inform the Director.

2. A person who has reasonable grounds to suspect that any 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 has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

This finding is related to Intake log #010674-18.

Inspector #211 reviewed resident #009 and resident #010's health care record documentation and there was no information indicating that the licensee reported immediately to the Director the alleged incident of sexual abuse on a specified date. The incident was reported five days later by a Critical Incident Report (CIS).
An interview with Manager of Nursing Operations #106 indicated that the responsive behavior of an alleged sexual nature when resident #009 touched resident #010 was not reported immediately to the Director. Manager of Nursing Operations #106 was informed of the incident five days later.

The licensee, who has reasonable grounds to suspect sexual abuse from resident #009 to resident #010 did not report immediately the suspicion and the information to the Director.
[s. 24. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1.The licensee has failed to ensure that the resident's substitute decision maker, if any, and any other person specified by the resident are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that cause distress to the resident that could potentially be detrimental to the resident's health or well-being.

This finding is related to Intake log #010674-18.

The critical Incident Report submitted as an amendment indicated that resident #009 touched resident #010 in a sexual manner.
In an interview with PSW #120 it was alleged that resident #009 touched resident #010 in a non-consensual sexual nature on a specified date and the incident was communicated to RPN #119 on that day.

An interview with Manager of Nursing Operation #106 indicated that RPN #119 forgot to initiate a follow-up after they were informed of the incident.
A review of resident #010's progress notes dated five days after the incident, indicated that the resident's family members were notified of the inappropriate touching from a resident towards resident #010.

The licensee has failed to ensure that resident #010's substitute decision maker was notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse that could potentially be detrimental to the resident's health or well-being.
[s. 97. (1) (b)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offense.

The two incidents of alleged abuse of non-consensual touching of a sexual nature identified when resident #009 touched resident #010 and when resident #009 touched resident #010 were not reported immediately to the police.

A review of the resident #009's plan of care on indicated that the police were notified on a specified date related to the inappropriate touching incident from resident #009 towards resident #011 the day prior.

Interview with Manager of Nursing Operations #106 confirmed that the police were not contacted immediately related to the two alleged incidents of sexual abuse.
The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of sexual abuse of resident #010 and resident #011 by resident #009 that the licensee suspected may constitute a criminal offense.
[s. 98.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that, subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition, is reported to the Director within one business day.

Resident #004 had an unwitnessed fall on a specified date. The resident was transferred to hospital with injury, requiring surgery, and change in the resident's health condition. Inspector #732 reviewed Critical Incident Report (CIR) for the incident. The director was not informed of the incident until 12 days later, when the CI was submitted.
Manager of Nursing Care Operations (MNCO) #106 told Inspector # 732 in an interview that they were aware they reported the incident late and understood it should have been reported earlier.

Subject to subsection (3.1), the licensee has failed to inform the director within one business day of resident #004 fall, resulting in transfer to hospital, injury, and significant change in the resident's health condition.
[s. 107. (3) 4.]

Issued on this 8th day of March, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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) :	MARK MCGILL (733), EMILY BROOKS (732), JOELLE TAILLEFER (211)
Inspection No. / No de l'inspection :	2019_761733_0001
Log No. / No de registre :	005633-18, 009341-18, 010674-18, 012646-18, 020156-18, 022702-18, 023225-18, 025382-18, 025626-18, 029821-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 5, 2019
Licensee / Titulaire de permis :	The Glebe Centre Incorporated 950 Bank Street, OTTAWA, ON, K1S-5G6
LTC Home / Foyer de SLD :	Glebe Centre 950 Bank Street, OTTAWA, ON, K1S-5G6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lawrence Grant

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

To The Glebe Centre Incorporated, 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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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 must be compliant with s. 19 of the LTCHA, 2007.
The licensee shall:

1. Ensure that RPN #119 and all other staff who have reasonable grounds to suspect that any behaviour of a sexual nature towards a resident that has occurred or may have occurred is reported immediately to the Director.

2. Ensure that at the beginning of every shift, all direct care staff are advised of residents who may exhibited behaviour of a sexual nature that present a risk for residents.

3. Ensure that the home's written policy is followed and complied with to promote zero tolerance of resident's abuse by the licensee.

4. Ensure that every incident of suspected, alleged or witnessed resident's sexual abuse reported is investigated immediately.

5. Ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of sexual abuse of a resident that the licensee suspects may constitute a criminal offence.

6. Ensure that the substitute decision-maker, if any, and any other person specified by the resident, is notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of sexual abuse of a resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well being.

7. Ensure that all incidents of a resident's sexual behaviour are documented in the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) and interventions are implemented to protect residents from sexual abuse by anyone.

Grounds / Motifs :

1. The licensee has failed to ensure that residents are protected from abuse by anyone.

Sexual abuse is defined by the LTCHA, 2017, O.Reg 79/10, s. 2 (1) as (a) any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A Critical Incident Report (CIS) was submitted to the Director relating to alleged sexual abuse by resident #009 towards resident #011. The CIS indicated that a second incident occurred when staff observed resident #009 touching resident #010.

A review of resident #009's plan of care from a specified period of time, indicated that the resident had inappropriate sexual behaviour towards staff. The interventions were:
-To document a summary of each episode and report to the physician
-Remain calm and avoid angry reactions towards the resident
-Set limits for acceptable behaviour (Staff to tell the resident directly that this behaviour is inappropriate and that it has to stop)
-Staff are to escort the resident out of the dining room after their meal.
On a specified date, resident #009's health care records indicate that resident #009 attempted to inappropriately touch a co-resident.

A review of resident #009's plan of care showed that the focus, the goals and the interventions related to the resident's behaviour were removed.

On a specified date as a late entry, resident #009's health care records indicate that resident #009 inappropriately touched resident #010 and resident #009 was told by RN #119 that the behaviour was inappropriate and will not be tolerated in the future.

Resident #009's health care records indicate that resident #009 was seen talking and touching resident #011 in a sexual manner at 0930 hours. Resident #009 was removed from the area and within 15 minutes, resident #009 returned. RN #104 heard resident #011 screaming "stop". RN #104 saw resident #009 beside resident #011 but did not see where resident #009's hand was placed. Resident #009 was immediately removed from the area and was told that the

behaviour was inappropriate. RN #104 wrote that resident #011 did not recall the incident. The physician wrote that they spoke with resident #009 regarding the inappropriately touching of the PSW and the nurse. The physician wrote that these sexual behaviours had previously occurred.

A review of resident #009's plan of care indicated that the resident's sexual behaviour was initiated on the same day as the aforementioned incident with the following interventions:
-Call the Power of Attorney (POA) when resident has inappropriate behaviour. The POA will talk with the resident and will reinforce that the inappropriate behaviour has to stop.
-Document a summary of each episode and report to the physician
-Monitor the resident in the dining room; cannot be seated with a female resident
-Remain calm and avoid angry reactions towards the resident
-Set limits for acceptable behaviour (Staff to tell the resident directly that this behaviour is inappropriate and that it has to stop)
-Staff are to escort the resident out of the dining room after meals.

The following day, resident #009's progress notes indicate that the police were called in regards to the inappropriate touching towards resident #011.

The next day, resident #009's progress notes indicated that resident #009's family member suggested that a male staff should provide care to the resident when possible.

An interview with PSW #120 indicated that resident #009 demonstrated sexual behaviours since their admission. The resident only touched female residents or staff. PSW #120 stated that the staff were aware of the resident's sexual behaviours. The resident liked to flirt and touch female residents and staff buttocks or breasts. They were closely monitored during activities and meal times when resident #009 was sitting beside a female resident but the monitoring was not documented. PSW #120 stated that when they observed resident #009 demonstrating behaviour of a sexual nature, they immediately informed the nurse.

In an interview with RPN #119, they stated that they were unaware of resident #009's past inappropriate sexual behaviours toward female residents. The

resident's sexual inappropriate behaviour was communicated to RPN #119 by the student nurse during their shift on a specified date. The student nurse was told to document the incident in the resident's chart. The next day, RPN #119 was informed that the student nurse did not document the incident. Furthermore, RN #119 indicated that resident #009's inappropriate sexual behaviour toward resident #011 was not communicated to the next shift.

An interview with RN #104 indicated that they were aware that resident #009 was inappropriately touching the female staff. Conversely, they were unaware that the resident had sexual behaviour towards female residents since their admission. RN #104 showed that it was written in the resident's health care record that the resident had inappropriate sexual behaviour towards other residents or staff. RN #104 demonstrated that the resident's responsive behaviour of a sexual nature was resolved in late 2017, in resident #009's plan of care. RN #104 confirmed that the resident's sexual behaviour toward female residents and staff was not a component of resident #009's plan of care in early 2018. RN #104 indicated that the first time they heard that resident #009 touched a female resident was on a specified date after the date of the plan of care from early 2018. RN #104 stated that it was witnessed that resident #009 touched resident #011 sexually on a specified date. RN #104 indicated that resident #009 was sitting in the dining room and went to resident #011's table. They were separated immediately. RN #104 stated that resident #011 had no recollection of the incident. On that day, the inappropriate sexual behaviour was included in resident #009's plan of care. RN #104 also responded that the incident was identified as a criminal offense and the police should have been called immediately. It was confirmed that the police were called the next day.

PSW #130 stated in an interview that the staff were aware of resident #009's sexual behaviour towards female residents and staff since admission. Resident #009 would slowly touch an area of the body then gradually try to reach an inappropriate area of the body. When the staff saw resident #009 trying to touch a female resident, they would stop resident #009 before it went to inappropriate areas. PSW #130 stated not being able to remember specific female resident names that resident #009 had touched, but that the resident would touch anyone that was close

In an interview with the Manager of Nursing Operations #106, they thought that

resident #009's sexual behaviour was an isolated event. Manager of Nursing Operations #106 was unaware that the resident was exhibiting these sexual behaviours since admission. It was after the incident, the manager was informed that the resident had exhibited responsive behaviour of a sexual nature in the past. The manager was informed by the PSWs that they were not reporting resident #009's sexual incidents because they were able to stop the responsive inappropriate behaviour before any incident occurred. The Manager of Nursing Operations #106 validated that resident #009' s plan of care from early 2018, did not identify that the resident had inappropriate behaviours. Furthermore, the manager was unaware for two business days, that resident #009 touched resident #010 in a sexual nature. The Manager of Nursing Operation #106 stated that RPN #119 forgot to initiate a follow-up after the incident was communicated the day that it occurred. Consequently, resident #009's responsive behaviour toward resident #010 was not investigated and the Director was not notified until two business days later. The Manager of Nursing Operations #106 indicated that the residents in the home were not protected from resident #009's responsive behaviour of a sexual nature.

Further to this compliance order:

-Findings of non-compliance under WN # 7 LTCHA s. 20 (1) are issued in regards that the licensee has failed to ensure when RPN #119 who was informed by PSW #120 that resident #009's exhibited sexual behaviour toward resident #010, complied with the home's written policy to promote zero tolerance of abuse of residents. The written home's policy # RC 4.00.00 titled Resident Abuse and Neglect, dated January 2018, indicated the following:
1. Coordinate with others as needed to fully investigate the incident,
2. Writing the details of the alleged or witnessed abuse as soon as possible,
3. Nurse who received the report, conduct an investigation immediately,
4. Notify the Director of Care or designate or if after hours, the manager on call immediately should the investigation lead to notification or reporting beyond the facility,
5. Cooperate fully with the home's administrative staff,
6. Notify the MOHLTC if the alleged, suspected or witnessed of sexual abuse of a resident that meets the criteria for Ministry Notification immediately.
7. To submit a report to the MOHLTC on weekends, Statutory Holidays or after business hours "immediately upon becoming aware of the incident", the

notification must be to the MOHLTC After-Hours pager number # 1-888-999-6963, (See Appendix E),
8. Complete the report relating to the investigation and response and to be submitted to the Ministry of Health and Long-Term Care using the Mandatory Critical Incident System form, using the "Mandatory Report Section" immediately upon becoming aware of the incident.
9. To notify the resident's SDM, if any, and any other person the resident specifies;
- Immediately upon the home becoming aware of an alleged, suspected or witnessed incident of abuse of the resident that resulted in physical injury or pain to the resident's health and well-being,
- Within 12 hours of becoming aware of any other alleged, suspected or witnessed incident of abuse of a resident.

- Findings of non-compliance under WN #9 LTCHA s. 23. (1) are issued in regards that the licensee has failed to ensure when RPN #119 was informed by PSW #120 that resident #009 demonstrated sexual behaviour toward resident #010, the incident was immediately investigated.

- Findings of non-compliance under WN #10 LTCHA s. 24 (1) are issued in regards that the licensee has failed to ensure when RPN #119 was notified by PSW #120 witnessing resident #009 touching resident #010 in a sexual nature that resulted in harm to the resident, was immediately reported to the Director.

- Findings of non-compliance under WN #4 LTCHA s. 6 (4) are issued in regards that the licensee has failed to ensure when staff who were involved with resident #009 and suspected inappropriate sexual behaviours toward female resident or any other person, collaborated with each other so their assessments are integrated and complemented by documenting the resident's responsive behaviours in the resident's health care records.
Consequently, the lack of documentation related to the resident's behaviours in their health care records did not trigger the coding information under responsive behaviour in the resident's quarterly Assessment Instrument-Minimum Data Set (RAI-MDS). As a result, the resident's inappropriate sexual behaviours were not developed and implemented in the resident's plan of care from a specified date to specified date.

- Findings of non-compliance under WN #12. Reg 79/10 s. 98. are issued in regards that the licensee failed to ensure the appropriate police force was immediately notified when the staff suspected or witnessed resident #009's exhibiting sexual behaviours that constituted a criminal offence:
- Toward resident #010 on a specified date by RN #119, and
- Toward resident #011 on a specified date by RN #104.

Both alleged sexual abuse incidents were not reported until a date after the specified dates.

-Findings of non-compliance under WN #11. Reg 79/10 s. 97 is issued in regards that the licensee failed to ensure that resident #010's substitute decision-maker was notified immediately upon RN #119 becoming aware of a suspected sexual behaviour from resident #009 toward resident #010 that causes distress and could potentially be detrimental to resident #010's health or well-being.

The risk is identified as a level 3 as there was actual harm or risk of harm related to resident #009's sexual behaviour toward residents #010 and #011. The scope is a level 2 as resident #009's sexual behaviours affected two residents out of potential other unknown female residents' name living in the home. The home had a level 4 compliance history as they had a past non-compliance with this section of the LTCH on March 4, 2018 and the issued order was resolved on June 10, 2016 (#2016_285126_0003).

(211)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 17, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 5th day of March, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Mark McGill

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