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

Division des foyers de soins de longue durée
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
Jun 4, 2019	2019_627138_0009	005415-19, 005690-19	Complaint

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

PAULA MACDONALD (138)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 7, 8, 9, 10, 21, 22, and 23, 2019.

The following intakes were inspected:
Follow Up log #005415-19 relating to resident abuse, and
Complaint log #005690-19 relating to alleged abuse of a resident and the safe use of mechanical lifts.

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Director of Human Resources, the Director of Quality Management, the Executive Assistant, the Executive Director, the Manager of Nursing Operations, personal support workers (PSWs), a registered nurse (RN), and registered practical nurses (RPNs).

The inspector also observed residents, observed a demonstration of the use of a mechanical lift, reviewed relevant policies, reviewed employee training records, reviewed the nursing schedule, reviewed health care records, reviewed an internal communication, reviewed a notice to nurses, reviewed Behavioural Support Ontario (BSO) meeting minutes and documentation, and reviewed the Critical Incident System and a specific critical incident.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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 failed to ensure that residents shall be protected from sexual abuse by

anyone.

The definition of resident to resident sexual abuse according to O.Reg 79/10 is "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than the licensee or staff member".

A) The licensee failed to ensure that resident #005, resident #006, and resident #019 were protected from abuse by resident #004.

The inspector reviewed a complaint that alleged resident #004 exhibited sexual behaviours towards resident #005 by touching them on their private parts and then, in a separate incident on a another date, resident #004 went into resident #006's room while the resident was in bed and was observed attempting go under the blankets to touch resident #006 while the resident was sleeping.

The inspector reviewed the health care record for resident #004 and found the following progress notes in support of the complaint allegation:

- an incident documented in December 2018 in which resident #005 had reported that resident #004 had touched them in their private area and then screamed at resident #004 not to touch them. And,

- another incident documented in January 2019, in which resident #004 had been found by staff in the room of resident #006 with their hand on resident #006's bed rail while resident #006 was in bed.

The inspector also reviewed other progress notes that outlined two additional incidents of sexual behaviours of resident #004 towards resident #019 and, again, to resident #005:

- a progress note in November 2018, in which resident #004 went into resident #019's room and attempted to touch the resident and get in the resident's bed. And,

- another progress note in January 2019, in which resident #004 attempted to touch resident #005 again on the private areas causing resident #005 to scream at resident #004 not to touch them.

These above progress notes outline four incidents of sexual behaviours of resident #004 to either resident #005, resident #006, or resident #019 in November 2018, December

2018, ands two incidents in January 2019. In addition to these four incidents, the following sexual behaviours were also documented in the progress notes of resident #004's health care record:

- a progress note in October 2018, in which a PSW reported an inappropriate sexual remark and gesture by resident #004 towards the staff.

- a progress note in December 2018, in which resident #004 exhibited sexually inappropriate behaviours to staff while care was being provided. This same entry also documented that resident #005 often complains of being touched in the private areas by resident #004.

- another progress note in December 2018, in which resident #004 exhibited sexual behaviours with staff during care provision.

The inspector reviewed the plan of care for resident #004 and noted that the plan of care did not include direction to staff relating to resident #004's sexual behaviours.

The inspector spoke with RPN #115 as this RPN wrote the progress notes for resident #004 related to the four incidents of November 2018, December 2018, and two incidents in January 2019. RPN #115 stated that they had not believed any of the incidents were considered sexual abuse as there was no harm to any of the residents. RPN #115 further stated that since there was no harm they felt there was no need to address the incidents further with management.

The inspector spoke with Director of Care #104 regarding resident #004's sexual behaviours and the specific four incidents outlined above. The Director of Care stated that they were unaware of such sexual behaviours of resident #004 and of the specific incidents by resident #004 in November 2018, December 2018, and two incidents in January 2019.

B) Further, according to section 20(1) of the LTCHA 2007, the licensee failed to ensure that the written policy in place to promote zero tolerance of abuse by residents was complied with.

The home's policy #RC 4.00.00 titled Resident Abuse and Neglect, January 2018 was reviewed in context of the four incidents outlined above for resident #004. The following are components of the policy that were not complied with:

(a) The policy states that the nurse receiving the report of abuse is to notify the MOHLTC of an alleged, suspected, witnessed or un-witnessed incident of abuse and that the Director of Care or the Manager on Call should be notified immediately.

RPN #115 did not report to the MOHLTC or the Manager on Call the four incidents that occurred in November 2018, December 2018, and two incidents in January 2019, involving resident #004. RPN #115 stated that the incidents were not reported as there was no harm to the residents.

(b) The policy states under "Nurse Receiving Report – Notifications" that the home will notify the substitute decision maker immediately or within 12 hours, depending on the circumstances, upon the home becoming aware of an alleged, suspected or witnessed incident of abuse.

The inspector reviewed the progress notes for resident #004, resident #005, resident #006, and resident #019 and was unable to locate any documentation to indicate that the substitute decision makers of the residents were notified for the incidents that occurred on November 2018, December 2018, and two incidents in January 2019. The inspector spoke with RPN #115 who stated that they would have not contacted the substitute decision makers as there was no harm to any of the residents.

(c) The policy states under "Nurse Receiving Report – Notifications" that all incidents of non consensual sexual behaviour must be reported to the police.

The inspector reviewed the progress notes for resident #004, resident #005, resident #006, and resident #019 and was unable to locate any documentation to indicate that the police were notified for the four incidents that occurred on November 2018, December 2018, and two incidents in January 2019. The inspector spoke with RPN #115 who stated that they would have not contacted the police as there was no harm to any of the residents.

The above mentioned in points A) and B) is further evidence to support Compliance Order #001 issued on March 5, 2019, during Critical Incident System inspection #2019_761733_0001 with a compliance due date of April 17, 2019.

Log #005690-19 [s. 19. (1)]

2. Inspector reviewed the health care record for resident #003 and noted an incident entered in the progress notes in April 2019, in which resident #003 was reported by resident #009 to have made a sexual gesture and that the resident requested resident #009 to watch.

As per the following, the licensee failed to ensure that resident #009 was protected from abuse by resident #003.

A) According to section 20(1) of the LTCHA 2007, the licensee failed to ensure that the written policy in place to promote zero tolerance of abuse by residents was complied with.

The home's policy #RC 4.00.00 titled Resident Abuse and Neglect, January 2018 was reviewed in context of the incidents outlined above for resident #003. The following are components of the policy that were not complied with:

(a) The policy states that the nurse receiving the report of abuse conducts an investigation using a check list and an incident report form.

The inspector spoke with RN #112 regarding the process when abuse is reported and RN #112 stated that once an incident of abuse is reported the registered nursing staff are required to complete an internal incident report form. RN #112 reviewed the internal incident report form with the inspector and also stated that once the form is completed, it must be submitted to management, either the Director of Care or the Manager of Nursing Operations, for review.

The inspector then spoke with Manager of Nursing Operations #105 to verify if an internal incident report form had been submitted for the incident occurring in April 2019, involving resident #003 and resident #009. The Manager of Nursing Operations stated that an internal incident report form had not been completed for this incident.

(b) The policy states that the nurse receiving the report of abuse may contact the physician for further assessment, treatment and follow up.

The inspector spoke with RPN #115 regarding communication to the physician for resident #003 with respect to the incident occurring in April 2019. RPN #115 stated that they had communicated the incident to the resident's physician by writing a note in the physician's communication binder. The inspector reviewed the physician's

communication binder specifically for resident #003 and noted that, while there was written communication to the physician about the resident, there was nothing regarding the specific incident. The inspector further reviewed resident #003's health care record and noted that there was a progress note entry by the physician three days after the incident in which the physician wrote that the incident was not communicated in the physician's binder. There was a corresponding physician's order for resident #003 that directed all sexually inappropriate behaviours to be communicated to the physician through the physician's binder.

(c) The policy states that the nurse receiving the report of abuse is to notify MOHLTC of alleged, suspected, witnessed or un-witnessed incident of abuse and that the Director of Care or the Manager on Call should be notified immediately.

The inspector spoke with RN #112 regarding the process for reporting abuse to MOHLTC. RN #112 stated that reports of abuse are to be reported by the registered nursing staff through an internal incident report form during normal business hours to management. From there, management will submit a Critical Incident Report to MOHLTC through the Critical Incident System. RN #112 stated that outside normal business hours, the registered nursing staff will still submit an internal incident report form to management but that the registered nursing staff must call the after hours emergency pager for MOHLTC. In this case, management of the home will follow up during normal business hours by sending MOHLTC a Critical Incident Report through the Critical Incident System.

Inspector spoke with RPN #115 about the reporting of the incident between resident #003 and resident #009 in April 2019, to MOHLTC. RPN #115 stated that the incident was not reported to MOHLTC as the RPN felt that it was not reportable as there was no harm to the residents.

(d) The policy states under "Nurse Receiving Report – Notifications" that the home will notify the substitute decision maker immediately or within 12 hours, depending on the circumstances, upon the home becoming aware of an alleged, suspected or witnessed incident of abuse.

The inspector reviewed the progress notes for resident #003 and resident #009 was unable to locate any documentation to indicate that the substitute decision makers of the residents were notified for the incident occurring in April 2019. The inspector spoke with RPN #115 who stated that they would not have contacted the substitute decision makers

as there was no harm to any of the residents.

(e) The policy states under "Nurse Receiving Report – Notifications" that all incidents of non consensual sexual behaviour must be reported to the police.

The inspector reviewed the progress notes for resident #003 and resident #009 was unable to locate any documentation to indicate that the police were notified for the incident occurring in April 2019. The inspector spoke with RPN #115 who stated that they would not have contacted the police as there was no harm to any of the residents.

B) The licensee failed to ensure as per section 24(1)2 of LTCHA 2007, that any person who has reasonable grounds to suspect abuse of a resident by anyone has occurred shall immediately report the information to the Director (MOHLTC).

The inspector spoke with RN #112 regarding the incident between resident #003 and resident #009 occurring in April 2019. RN #112 stated that they became aware of the incident three days later when the physician ordered medication changes for resident #003 in response to the incident. RN #112 stated that, because of events, they suspected that management was unaware of the incident and sent an email to the Director of Care to notify them of the incident. The inspector reviewed the email of a specific date sent from RN #112 to the Director of Care outlining that there had been an incident involving resident #003 and resident #009 that may not have been reported.

The Inspector spoke with Director of Care #104 who stated that they had become aware of the incident between resident #003 and resident #009 that occurred in April 2019, but that they did not report it to the Director (MOHLTC) as they felt the incident did not fit the definition of sexual abuse as there was no touching between the two residents.

C) The licensee failed to ensure as per section 6(1)(c) of LTCHA 2007, that the written plan of care for resident #003 sets out clear direction for staff and others who provide care to the resident.

The inspector spoke with RPN #115 regarding the interventions put in place in response to the incident between resident #003 and resident #009 occurring in April 2019. RPN #119 stated that all chairs around resident #003 are removed by staff so that other residents will not have the opportunity to sit near resident #003. RPN #119 also stated that interactions between resident #003 and resident #009 are monitored and the two residents are kept separated.

Inspector spoke with PSW #119 who stated that they regularly provide care to resident #003. The inspector asked PSW #119 to outline interventions in place to prevent inappropriate sexual behaviours but PSW #119 failed to outline the interventions in place, as indicated above, stated by RPN #115.

The inspector reviewed the current plan of care for resident #003. There was no indication on the plan of care of the interventions outlined by RPN #115.
Log #005415-19 [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 O.Reg 79/10, s. 219. Retraining

Specifically failed to comply with the following:

s. 219. (1) The intervals for the purposes of subsection 76 (4) of the Act are annual intervals. O. Reg. 79/10, s. 219 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that PSW #116 and PSW #117 are trained annually on the safe and correct use of mechanical lifts.

In accordance with this section, section 76(2) and (4) of the LTCHA 2007, and section 218 of O.Reg 79/10 the licensee is required to ensure training to staff in the area of safe and correct use of mechanical lifts on an annual basis.

The inspector reviewed a complaint alleging an incident of incorrect use of a mechanical lift on a specific unit.

The inspector spoke with both Director of Care #104 and Manager of Nursing Care Operations #105 regarding the annual training on the safe and correct use of mechanical lifts. Both stated that annual training is either hands on training or the online module "General Lifting, Body Mechanics, and Back Care: A module By Surge Learning". Both also stated that hands on training has not been provided for several years and that the home has recently relied on the online module to retrain staff annually.

The inspector requested the training records for safe and correct use of mechanical lifts for PSW #116, PSW #117, and PSW #118 from Director of Quality Management #103 for 2018. The inspector received these records from the Director of Quality Management who stated that two of these PSWs did not complete such training in 2018.

The inspector reviewed the training records provided and noted, as per the Director of Quality Management, that PSW #116 and PSW #117 were not documented as completing the annual training on the safe and correct use of mechanical lifts for 2018. Log #005690-19 [s. 219. (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 staff receive training on the safe and correct use of mechanical lifts annually, to be implemented voluntarily.

Issued on this 4th day of June, 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

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

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) :	PAULA MACDONALD (138)
Inspection No. / No de l'inspection :	2019_627138_0009
Log No. / No de registre :	005415-19, 005690-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 4, 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

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)

Linked to Existing Order / Lien vers ordre existant: 2019_761733_0001, CO #001;

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 section 19.(1) of the LTCHA.

Specifically the licensee shall:

- ensure the written plan of care for resident #003 and any other resident exhibiting inappropriate sexual behaviours sets out clear direction to staff and others who provide care to the resident about the interventions in place to manage inappropriate sexual behaviours,

- retrain members of the management team, RPN #119, and all direct care staff on the definition of sexual abuse and in sexual abuse recognition and prevention.

Grounds / Motifs :

1. The licensee has failed to comply with Compliance Order #001 from inspection #2019_761733_0001 issued on March 5, 2019 with a compliance date of April 17, 2019.

The licensee was ordered to 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."

The licensee was compliant with step 2) in Compliance Order #001
The licensee was not complaint with step 1), 3), 4), 5), 6), and 7) in Compliance Order #001.

The licensee failed to ensure that residents shall be protected from sexual abuse by anyone.

The definition of resident to resident sexual abuse according to O.Reg 79/10 is "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than the

licensee or staff member".

Inspector reviewed the health care record for resident #003 and noted an incident entered in the progress notes in April 2019, in which resident #003 was reported by resident #009 to have made a sexual gesture and that the resident requested resident #009 to watch.

As per the following, the licensee failed to ensure that resident #009 was protected from abuse by resident #003.

A) According to section 20(1) of the LTCHA 2007, the licensee failed to ensure that the written policy in place to promote zero tolerance of abuse by residents was complied with.

The home's policy #RC 4.00.00 titled Resident Abuse and Neglect, January 2018 was reviewed in context of the incidents outlined above for resident #003. The following are components of the policy that were not complied with:

(a) The policy states that the nurse receiving the report of abuse conducts an investigation using a check list and an incident report form.

The inspector spoke with RN #112 regarding the process when abuse is reported and RN #112 stated that once an incident of abuse is reported the registered nursing staff are required to complete an internal incident report form. RN #112 reviewed the internal incident report form with the inspector and also stated that once the form is completed, it must be submitted to management, either the Director of Care or the Manager of Nursing Operations, for review.

The inspector then spoke with Manager of Nursing Operations #105 to verify if an internal incident report form had been submitted for the incident occurring in April 2019, involving resident #003 and resident #009. The Manager of Nursing Operations stated that an internal incident report form had not been completed for this incident.

(b) The policy states that the nurse receiving the report of abuse may contact the physician for further assessment, treatment and follow up.

The inspector spoke with RPN #115 regarding communication to the physician for resident #003 with respect to the incident occurring in April 2019. RPN #115 stated that they had communicated the incident to the resident's physician by writing a note in the physician's communication binder. The inspector reviewed the physician's communication binder specifically for resident #003 and noted that, while there was written communication to the physician about the resident, there was nothing regarding the specific incident. The inspector further reviewed resident #003's health care record and noted that there was a progress note entry by the physician three days after the incident in which the physician wrote that the incident was not communicated in the physician's binder. There was a corresponding physician's order for resident #003 that directed all sexually inappropriate behaviours to be communicated to the physician through the physician's binder.

(c) The policy states that the nurse receiving the report of abuse is to notify MOHLTC of alleged, suspected, witnessed or un-witnessed incident of abuse and that the Director of Care or the Manager on Call should be notified immediately.

The inspector spoke with RN #112 regarding the process for reporting abuse to MOHLTC. RN #112 stated that reports of abuse are to be reported by the registered nursing staff through an internal incident report form during normal business hours to management. From there, management will submit a Critical Incident Report to MOHLTC through the Critical Incident System. RN #112 stated that outside normal business hours, the registered nursing staff will still submit an internal incident report form to management but that the registered nursing staff must call the after hours emergency pager for MOHLTC. In this case, management of the home will follow up during normal business hours by sending MOHLTC a Critical Incident Report through the Critical Incident System.

Inspector spoke with RPN #115 about the reporting of the incident between resident #003 and resident #009 in April 2019, to MOHLTC. RPN #115 stated that the incident was not reported to MOHLTC as the RPN felt that it was not reportable as there was no harm to the residents.

(d) The policy states under "Nurse Receiving Report – Notifications" that the

home will notify the substitute decision maker immediately or within 12 hours, depending on the circumstances, upon the home becoming aware of an alleged, suspected or witnessed incident of abuse.

The inspector reviewed the progress notes for resident #003 and resident #009 was unable to locate any documentation to indicate that the substitute decision makers of the residents were notified for the incident occurring in April 2019. The inspector spoke with RPN #115 who stated that they would not have contacted the substitute decision makers as there was no harm to any of the residents.

(e) The policy states under "Nurse Receiving Report – Notifications" that all incidents of non consensual sexual behaviour must be reported to the police.

The inspector reviewed the progress notes for resident #003 and resident #009 was unable to locate any documentation to indicate that the police were notified for the incident occurring in April 2019. The inspector spoke with RPN #115 who stated that they would not have contacted the police as there was no harm to any of the residents.

B) The licensee failed to ensure as per section 24(1)2 of LTCHA 2007, that any person who has reasonable grounds to suspect abuse of a resident by anyone has occurred shall immediately report the information to the Director (MOHLTC).

The inspector spoke with RN #112 regarding the incident between resident #003 and resident #009 occurring in April 2019. RN #112 stated that they became aware of the incident three days later when the physician ordered medication changes for resident #003 in response to the incident. RN #112 stated that, because of events, they suspected that management was unaware of the incident and sent an email to the Director of Care to notify them of the incident. The inspector reviewed the email of a specific date sent from RN #112 to the Director of Care outlining that there had been an incident involving resident #003 and resident #009 that may not have been reported.

The Inspector spoke with Director of Care #104 who stated that they had become aware of the incident between resident #003 and resident #009 that occurred in April 2019, but that they did not report it to the Director (MOHLTC) as

they felt the incident did not fit the definition of sexual abuse as there was no touching between the two residents.

C) The licensee failed to ensure as per section 6(1)(c) of LTCHA 2007, that the written plan of care for resident #003 sets out clear direction for staff and others who provide care to the resident.

The inspector spoke with RPN #115 regarding the interventions put in place in response to the incident between resident #003 and resident #009 occurring in April 2019. RPN #119 stated that all chairs around resident #003 are removed by staff so that other residents will not have the opportunity to sit near resident #003. RPN #119 also stated that interactions between resident #003 and resident #009 are monitored and the two residents are kept separated.

Inspector spoke with PSW #119 who stated that they regularly provide care to resident #003. The inspector asked PSW #119 to outline interventions in place to prevent inappropriate sexual behaviours but PSW #119 failed to outline the interventions in place, as indicated above, stated by RPN #115.

The inspector reviewed the current plan of care for resident #003. There was no indication on the plan of care of the interventions outlined by RPN #115.

The severity of this issue was determined to be a level 3 as there was actual risk to the residents. The scope of the issue was a level 1 as it related to one of three residents reviewed.
The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA that included Compliance Order #001 issued March 5, 2019, with a compliance due date of April 17, 2019, inspection #2019_761733_0001.

Log #005415-19 (138)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 11, 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 4th day of June, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PAULA MACDONALD

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