Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

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


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

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

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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Aug 6, 2020 | 2020_841679_0009 | 002949-20, 003382-20, 006249-20, 011571-20, 013208-20 | Critical Incident System |

### Licensee/Titulaire de permis

The Board of Management for the District of Nipissing East
400 Olive Street NORTH BAY ON P1B 6J4

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

Cassellholme
400 Olive Street NORTH BAY ON P1B 6J4

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

MICHELLE BERARDI (679), STEPHANIE DONI (681)

## 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): July 20-24, 2020.**

**The following intakes were inspected upon during this Critical Incident System (CIS) Inspection:**

**- Two intakes related to alleged staff to resident abuse;**
**- One intake related to improper care/neglect resulting in harm; and,**
**- One intake related to resident to resident abuse.**

**A Complaint Inspection (2020_841679_0008) was conducted concurrently with this inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Clinical Services, Support Services Manager, Physiotherapist (PT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Behavioural Supports Ontario (BSO) RPN, BSO Care Support, Personal Support Workers (PSWs), Housekeepers, Residents and families.**

**The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, as well as relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Medication**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**

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

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

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 to promote zero tolerance of abuse and neglect of residents was complied with.

The Ontario Regulation 79/10, defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A Critical Incident System (CIS) report was submitted to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIS report indicated that resident #001 was transferred to the hospital and diagnosed with an injury.

A) A further review of the CIS report indicated that during the home's investigation it was revealed that on a specified date, Personal Support Worker (PSW) #129 had transferred resident #001 in a specified manner. See WN #3 for further details.

B) Inspector #679 reviewed the home's internal investigation notes and identified a letter addressed to PSW #129. The letter indicated that on a specified date, the resident was noted to be sitting in a location for a specified period of time. The letter further identified that PSW #129 admitted that they had brought resident #001 to the location at a specified time and did not bring them to a different location for a specified period of time.

C) Inspector #679 reviewed the home's internal investigation notes and identified a letter addressed to PSW #129. The letter indicated that PSW #129 had documented that they had completed a specified intervention, but a review of camera footage confirmed this was not done. The letter further indicated that PSW #129 had documented that they had provided care as per the care plan, and that this was false documentation.

Inspector #679 reviewed the hand-written note titled “Camera Footage Observation”. The note indicated that it was documented that a specified task was completed. The note also indicated that PSW #129 did not enter the resident’s room after a specified time.

Inspector #679 reviewed the Point of Care (POC) documentation and identified a specified task. The task was documented as completed by PSW #129.

In an interview with PSW #108, they identified that resident #001 would be checked on and assisted with Activity of Daily Living (ADL) interventions at specified intervals. PSW #108 indicated this would be documented in the resident’s POC record.

D) Inspector #679 reviewed the home’s internal investigation notes and identified a letter addressed to PSW #129. The letter indicated when questioned, PSW #129 stated that the resident did not ask to be assisted with a specified ADL intervention, so they didn't assist the resident with the ADL intervention. The letter further indicated that the residents care plan clearly stated that the resident required a specified ADL intervention.

A review of the letter addressed to PSW #129 indicated that the staff members actions constituted resident neglect. The letter further indicated that PSW #129 had violated a number of the home's policies.

Inspector #681 reviewed the home's Abuse, Neglect, and Retaliation Prevention policy (Policy 05-03), last revised July 25, 2019, which indicated that all residents have the right to live in a home environment that treats them with dignity, respect, and was free from any form of abuse or neglect at all times, and in all circumstances.

In an interview with Manager of Clinical Services #101, they identified that resident #001 was left in a location until a specified time. Manager of Clinical Services #101 identified that the resident required specified interventions, and that PSW #129 did not follow the residents care plan. [s. 20.]

2. The Ontario Regulation 79/10, defines sexual abuse as any consensual or non-consensual touching, behaviour, or remarks of a sexual nature that are directed toward a resident by a licensee or staff member.

A CIS report was submitted to the Director related to an allegation of staff to resident verbal abuse. The CIS report indicated that Housekeeper #110 made an inappropriate comment to resident #003.

Inspector #681 reviewed the home's investigation notes related to the incident, which included documentation from an interview that occurred between the Support Services Manager and Housekeeper #110. The documentation indicated that Housekeeper #110 acknowledged that they made an inappropriate comment that was of a sexual nature to resident #003.

During an interview with Inspector #681, Housekeeper #110 acknowledged that they had made the inappropriate comment to resident #003, while they were cleaning a specified area.

Inspector #681 reviewed the home's Abuse, Neglect, and Retaliation Prevention policy (Policy 05-03), last revised July 25, 2019, which indicated that all residents have the right to live in a home environment that treats them with dignity, respect, and was free from any form of abuse or neglect at all times, and in all circumstances.

The Inspector reviewed a document that was issued to Housekeeper #110 for making an inappropriate comment to a resident.

During an interview with the Support Service Manager, they stated that, following their interview with Housekeeper #110, it was evident that a comment of a sexual nature had been made towards a resident. [s. 20. (1)]

3. The Ontario Regulation 79/10, defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A CIS report was submitted to the Director for an allegation of staff to resident verbal abuse. The CIS report indicated that Unit Coordinator #111 was informed that PSW #112 was overheard speaking to resident #004 in specified manner. The CIS report further indicated that the allegation of verbal abuse was substantiated through the home's investigation.

In an interview with Inspector #679, Registered Practical Nurse (RPN) #113 indicated that PSW #112 was overheard speaking inappropriately to resident #004. RPN #113 indicated that they reported the incident to Unit Coordinator #126.

Inspector #679 reviewed a letter written by RPN #113, which indicated that they had witnessed PSW #112 speaking inappropriately to resident #004.

Inspector #679 reviewed the home's investigation notes into the incident and identified a letter addressed to PSW #112, which indicated that they were witnessed speaking inappropriately to resident #004, and that the incident was reported to the Ministry of Health and Long-Term Care as verbal abuse of a resident.

In an interview with Manager of Clinical Services #101, they indicated that the incident was witnessed by Unit Coordinator #126. Manager of Clinical Services #101 further indicated that the home determined the abuse was substantiated. [s. 20. (1)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**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 care set out in the plan of care was provided to the resident as specified in the plan.

A CIS report was submitted to the Director for an incident of resident to resident abuse. The CIS report indicated that resident #006 was observed performing a specified action towards resident #007.

Inspector #679 reviewed resident #006's care plan which indicated a specified focus for responsive behaviours.

During two observations on a specified date, Inspector #679 observed resident #006 in a home area. The specified intervention in the resident's care plan was not followed.

In an interview with PSW #127 they indicated that they would reference a resident's Kardex to understand the residents care requirements. PSW #127 recalled resident #006 exhibiting responsive behaviours and indicated a specified intervention to manage the resident's responsive behaviours. PSW #127 confirmed the Inspectors observation.

In an interview with RPN #128, they identified that resident #006 exhibited responsive behaviours, and that there was a Behavioural Supports Ontario (BSO) binder that staff could reference for interventions to manage the behaviours. Together, Inspector#679 and RPN #128 reviewed the BSO tip sheet, which indicated the specified intervention. RPN #128 indicated that it was best to implement the specified intervention.

In an interview with Manager of Clinical Services #101, they indicated that staff were to implement a specified intervention for resident #006. Manager of Clinical Services #101 indicated that BSO staff had asked the PSW to implement the specified intervention, but that the PSW did not complete this. Manager of Clinical Services #101 indicated they had followed up with the staff to ensure that they were aware the intervention was in the care plan and needed to be completed. [s. 6. (7)]

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

A CIS report was submitted to the Director for an incident of resident to resident abuse. The CIS report indicated that resident #006 was observed performing a specified action towards resident #007.

Inspector #679 reviewed the current electronic care plan for resident #006, which identified a specified focus for responsive behaviours, as well as interventions to manage the resident's responsive behaviours.

In an interview with PSW #103, they identified that staff were to document responsive behaviours in the resident's progress notes, and report to their supervisor.

In an interview with RPN #105, they indicated that “anyone” was responsible for charting, and that these notes were completed in the progress notes.

In an interview with BSO Care Support #115 and RPN #116, they identified that the BSO team would follow the incident reports and progress notes each shift to determine if there were any issues.

Inspector #679 reviewed the home’s policy titled “Documentation- Procedure for Resident Care Notes (Policy D2.0.0)” last revised November 5, 2014. The policy indicated that staff were to “Document any changes in resident’s condition and care needs. Behaviors are to be documented in detail in the Resident Care Notes. Including behavior observed, interventions used, time spent, number of staff intervening, effectiveness”.

In an interview with Manager of Clinical Services #101, they indicated that the RN was following up regarding the incident, and at this time staff had shared that the behaviours were something that were occurring frequently under specified circumstances. Manager of Clinical Services #101 indicated that this was when they found out that resident #006's behaviours had been occurring, but staff weren’t documenting the occurrences. [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 ensuring that the care set out in the plan of care is provided to residents as specified in the plan, and that the provision of care set out in the plan of care is documented, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A CIS report was submitted to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CI report indicated that resident #001 was transferred to hospital and diagnosed with an injury.

A further review of the CIS report indicated that during the home's investigation it was revealed that on a specified date, Personal Support Worker (PSW) #129 had transferred resident #001 in a specified manner

Inspector #679 reviewed the resident's electronic care plan in place at the time of the incident, which indicated that resident #001 required a specified level of assistance for transferring.

In an interview with PSW #108, they identified that they would reference a resident's Kardex to determine their care needs. PSW #108 further indicated that resident #001 required a specified level of assistance transferring.

In an interview with RPN #114, they indicated that staff would reference a resident's care plan to determine their care needs. RPN #114 indicated that resident #001 required a specified level of assistance for transferring.

Inspector #679 reviewed the home's internal investigation notes, which contained a letter addressed to PSW #129. The letter indicated that PSW #129 acknowledge that they assisted the resident with care on a specified date. The process of providing the specified care involved the resident being transferred. The letter further identified that the staff member violated the home's "Lift and Transfer" policy.

In an interview with Inspector #679, Manager of Clinical Services #101 indicated that the home's process for safe lifts and transfers was that staff were to follow what was in the resident's care plan. Manager of Clinical Services #101 indicated that resident #001 required a specified level of assistance for transfers. Manager of Clinical Services #101 further indicated that PSW #129 did not follow the care plan. [s. 36.]

***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 ensuring that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.***

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**WN #4: 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 the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy or protocol, the policy or protocol was complied with.

In accordance with Ontario Regulation 79/10, s.114 (2), the licensee was required to ensure that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, destruction, and disposal of all drugs used in the home.

Specifically, staff did not comply with the licensee’s policy 6-6 titled "Shift Change Monitored Drug Count", last revised November 2018.

The Inspector reviewed the policy titled "Shift Change Monitored Drug Count", which indicated that the procedure for the Shift Change Monitored Drug Count was for two staff, together:

a) count the actual quantity of medications remaining;
b) record the date, time, quantity and sign in the appropriate spaces on the "Shift Change Monitored Medication Count" form;
c) confirm actual quantity was the same as the amount recorded on the "Individual Monitored Medication Record" for prn, liquid, patches, or injectable.

A CIS report was submitted to the Director regarding a missing or unaccounted for controlled substance. The CIS report indicated that RPN #114 noticed that a specified controlled substance was missing when they went to administer a dose to resident #002. The CIS report further indicated that, during the home's investigation, it was identified that the home's process for completing narcotic counts was not being properly followed by RPN staff.

Inspector #681 reviewed the home's investigation notes related to the incident, which included an interview between Unit Coordinator #126 and RPN #114. RPN #114 indicated that when they completed a specified narcotic count with RPN #125 on a specified date, both RPNs did not look at the quantity of the missing controlled substance or the Shift Change Monitored Medication Count record because RPN #125 had their back turned to RPN #114.

The home's investigation notes also indicated that during an interview with Unit Coordinator #126, RPN #124 acknowledged that they had pre-filled the Shift Change Monitored Medication Count record prior to completing the narcotic count with RPN #116 on a specified date.

During an interview with RPN #114, they stated that a narcotic count was done at the end of every shift and the Shift Change Monitored Medication Count record was to be completed at the time the narcotic count was done. RPN #114 stated that the two RPNs who were completing the narcotic count must look at both the quantity of narcotics remaining and the Shift Change Monitored Medication Count record.

The Inspector reviewed letters that were issued to RPNs #125, #124, and #116 on a specified date, for failure to follow proper policies and procedure when completing shift change narcotic counts.

During an interview with the Manager of Clinical Services #101, they stated that during the home's investigation, it was identified that staff were not following the correct process when completing narcotic counts and this was the reason that multiple letters were

issued. [s. 8. (1) (b)]

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**WN #5: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:**
**2. A description of the individuals involved in the incident, including,**
**i. names of any residents involved in the incident,**
**ii. names of any staff members or other persons who were present at or discovered the incident, and**
**iii. names of staff members who responded or are responding to the incident.**
**O. Reg. 79/10, s. 107 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the names of any staff members or other persons who were present at or discovered the incident was reported to the Director within 10 days of becoming aware of the incident.

A CIS report was submitted to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIS report indicated that resident #001 was transferred to hospital and diagnosed with an injury.

A further review of the CIS report indicated that during home's investigation it was revealed that a staff member had violated the home's transfer policy, that the resident was left in a location for a specified amount of time, and that a specified intervention was not completed. Inspector #679 was unable to locate the name of the staff member involved in the incident in the CIS report.

In an interview with Manager of Clinical Services #101, they indicated that the name of the staff involved in the incident was to be included in the CIS report. Together, Inspector #679 and Manager of Clinical Services #101 reviewed the CIS report. Manager of Clinical Services #101 indicated that this piece was missed. [s. 107. (4) 2. ii.]

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**Issued on this 10th day of August, 2020**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

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

## Ordre(s) de l’inspecteur

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

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

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

## Public Copy/Copie du rapport public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l’inspecteur (No) :** | MICHELLE BERARDI (679), STEPHANIE DONI (681) |
| **Inspection No. / No de l’inspection :** | 2020_841679_0009 |
| **Log No. / No de registre :** | 002949-20, 003382-20, 006249-20, 011571-20, 013208-20 |
| **Type of Inspection / Genre d’inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Aug 6, 2020 |
| **Licensee / Titulaire de permis :** | The Board of Management for the District of Nipissing East<br>400 Olive Street, NORTH BAY, ON, P1B-6J4 |
| **LTC Home / Foyer de SLD :** | Cassellholme<br>400 Olive Street, NORTH BAY, ON, P1B-6J4 |
| **Name of Administrator / Nom de l’administratrice ou de l’administrateur :** | Jamie Lowery |

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

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

## Ordre(s) de l’inspecteur

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

To The Board of Management for the District of Nipissing East, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

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

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

**Order / Ordre :**

The licensee must be compliant with s. 20. (1) of the Long-Term Care Home's Act, 2007.

The licensee shall prepare, submit and implement a plan to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents is complied with.

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

a) how the licensee will ensure that the policy promoting zero tolerance of abuse and neglect is complied with;

b) implement a monitoring system to ensure that all staff comply with the home's policy regarding zero tolerance of abuse and neglect, and maintain a written record of the monitoring system.

Please submit the written plan by August 21, 2020.

Please ensure that the submitted written plan does not contain any personal information or personal health information.

**Grounds / Motifs :**

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The Ontario Regulation 79/10, defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A Critical Incident System (CIS) report was submitted to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIS report indicated that resident #001 was transferred to the hospital and diagnosed with an injury.

A) A further review of the CIS report indicated that during the home's investigation it was revealed that on a specified date, Personal Support Worker (PSW) #129 had transferred resident #001 in a specified manner. See WN #3 for further details.

B) Inspector #679 reviewed the home's internal investigation notes and identified a letter addressed to PSW #129. The letter indicated that on a specified date, the resident was noted to be sitting in a location for a specified period of time. The letter further identified that PSW #129 admitted that they had brought resident #001 to the location at a specified time and did not bring them to a different location for a specified period of time.

C) Inspector #679 reviewed the home's internal investigation notes and identified a letter addressed to PSW #129. The letter indicated that PSW #129 had documented that they had completed a specified intervention, but a review of camera footage confirmed this was not done. The letter further indicated that PSW #129 had documented that they had provided care as per the care plan, and that this was false documentation.

Inspector #679 reviewed the hand-written note titled "Camera Footage Observation". The note indicated that it was documented that a specified task was completed. The note also indicated that PSW #129 did not enter the resident's room after a specified time.

Inspector #679 reviewed the Point of Care (POC) documentation and identified a specified task. The task was documented as completed by PSW #129.

In an interview with PSW #108, they identified that resident #001 would be checked on and assisted with Activity of Daily Living (ADL) interventions at specified intervals. PSW #108 indicated this would be documented in the

resident's POC record.

D) Inspector #679 reviewed the home's internal investigation notes and identified a letter addressed to PSW #129. The letter indicated when questioned, PSW #129 stated that the resident did not ask to be assisted with a specified ADL intervention, so they didn't assist the resident with the ADL intervention. The letter further indicated that the residents care plan clearly stated that the resident required a specified ADL intervention.

A review of the letter addressed to PSW #129 indicated that the staff members actions constituted resident neglect. The letter further indicated that PSW #129 had violated a number of the home's policies.

Inspector #681 reviewed the home's Abuse, Neglect, and Retaliation Prevention policy (Policy 05-03), last revised July 25, 2019, which indicated that all residents have the right to live in a home environment that treats them with dignity, respect, and was free from any form of abuse or neglect at all times, and in all circumstances.

In an interview with Manager of Clinical Services #101, they identified that resident #001 was left in a location until a specified time. Manager of Clinical Services #101 identified that the resident required specified interventions, and that PSW #129 did not follow the residents care plan.
(679)

2. The Ontario Regulation 79/10, defines sexual abuse as any consensual or non-consensual touching, behaviour, or remarks of a sexual nature that are directed toward a resident by a licensee or staff member.

A CIS report was submitted to the Director related to an allegation of staff to resident verbal abuse. The CIS report indicated that Housekeeper #110 made an inappropriate comment to resident #003.

Inspector #681 reviewed the home's investigation notes related to the incident, which included documentation from an interview that occurred between the Support Services Manager and Housekeeper #110. The documentation indicated that Housekeeper #110 acknowledged that they made an

inappropriate comment that was of a sexual nature to resident #003.

During an interview with Inspector #681, Housekeeper #110 acknowledged that they had made the inappropriate comment to resident #003, while they were cleaning a specified area.

Inspector #681 reviewed the home's Abuse, Neglect, and Retaliation Prevention policy (Policy 05-03), last revised July 25, 2019, which indicated that all residents have the right to live in a home environment that treats them with dignity, respect, and was free from any form of abuse or neglect at all times, and in all circumstances.

The Inspector reviewed a document that was issued to Housekeeper #110 for making an inappropriate comment to a resident.

During an interview with the Support Service Manager, they stated that, following their interview with Housekeeper #110, it was evident that a comment of a sexual nature had been made towards a resident. (681)

3. The Ontario Regulation 79/10, defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A CIS report was submitted to the Director for an allegation of staff to resident verbal abuse. The CIS report indicated that Unit Coordinator #111 was informed that PSW #112 was overheard speaking to resident #004 in specified manner. The CIS report further indicated that the allegation of verbal abuse was substantiated through the home's investigation.

In an interview with Inspector #679, Registered Practical Nurse (RPN) #113 indicated that PSW #112 was overheard speaking inappropriately to resident #004. RPN #113 indicated that they reported the incident to Unit Coordinator #126.

Inspector #679 reviewed a letter written by RPN #113, which indicated that they

had witnessed PSW #112 speaking inappropriately to resident #004.

Inspector #679 reviewed the home's investigation notes into the incident and identified a letter addressed to PSW #112, which indicated that they were witnessed speaking inappropriately to resident #004, and that the incident was reported to the Ministry of Health and Long-Term Care as verbal abuse of a resident.

In an interview with Manager of Clinical Services #101, they indicated that the incident was witnessed by Unit Coordinator #126. Manager of Clinical Services #101 further indicated that the home determined the abuse was substantiated.

The severity of the issue was determined to be a level two, as there was minimal harm. The scope of the issue was a level three, as it related to three of four incidents reviewed. The home has a level three compliance history with related non-compliance in the last 36 months with this section of the LTCHA. Including:

- A Voluntary Plan of Correction (VPC) issued February 2020, during inspection #2020_782736_0006;
- A VPC issued August 2019, during inspection #2019_565674_0019; and
- A VPC issued May 2018, during inspection #2018_668543_0010. (679)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Sep 04, 2020

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

## Order(s) of the Inspector

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

## Ordre(s) de l’inspecteur

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

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

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

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

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

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

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

**Issued on this 6th day of August, 2020**

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

**Name of Inspector /**
**Nom de l’inspecteur :** Michelle Berardi

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