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 le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Sep 28, 2015;	2015_360111_0014 (A1)	001301-14, 001441-14, 001522-15, 001691-15, 002174-15, 001940-15, 002157-15, 002270-15, 002312-15	Critical Incident System

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

LYNDA BROWN (111) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

HI Garry,
Your 2 orders (001 & 002) have been amended to included complaince date of Aug.15, 2015 as requested.
Thanks
Lynda Brown

Issued on this 28 day of September 2015 (A1)

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

Original report signed by the inspector.

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

LYNDA BROWN (111) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): June 3-5, 8-10, 12 & 15, 2015

Nine critical incident inspections were completed concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing Services, the Director of Care(DOC), Staff Educator, Resident Care Area Managers (RCAM), Director of Programs, Program Leads, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Resident's, and Behavioural Support Ontario (BSO) staff.

During the course of the inspection, the inspector also reviewed health records of current and deceased residents, reviewed the homes investigations, reviewed employee files, reviewed complaint logs, and reviewed the home's policies on complaints, prevention of abuse and neglect, and responsive behaviours.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Responsive Behaviours

Skin and Wound Care

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

11 WN(s)
0 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 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 Resident # 15, #16 & #17 were protected from physical and/or emotional abuse by the licensee or staff in the home.

Under O.Reg. 79/10, s.2(1) For the purposes of the definition of "abuse" in subsection 2(1) of the Act, "emotional abuse" means, (a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour, or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a residents.

Under O.Reg. 79/10, s. 2(1) For the purposes of the definition of "abuse" in subsection 2(10 of the Act, "physical abuse" means, subject to subsection (2),(a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Related to log # 002157:

A critical incident report was received by the Director on a specified date for a staff to resident abuse/neglect that occurred towards Resident #15. The CIR indicated on the same date,the resident reported to Staff #109 the resident "had been experiencing difficulty" with Staff #108.

Review of the home's investigation indicated that 13 days before the CIR was submitted, Staff#109 had received two written complaints (from Staff #110 & #111) regarding allegations of improper care towards Resident #15 by Staff #108, Resident #15 had expressed fear of Staff #108, did not want Staff #108 to provide their care, Resident #15 "was upset and crying", and indicated this staff member "has a history of getting back at staff and residents when complaints about [Staff #108] are made". The actions taken (by Staff #109)indicated "spoke with resident" and informed the resident Staff # 109 would be monitoring Staff #108 for a 2 week period. Thirteen days later, a third written complaint (by Staff #109)was received by the DOC indicating Resident #15 "was asked how things had been going with [Staff #108]". The resident stated Staff #108 "does not speak to me" when providing personal care, the resident "feels sick" when Staff #108 "is going to be on duty for the next 3-4 days", and reported Staff

#108 continued to not provide assistance with toileting. Staff #108 was interviewed by DNS & DOC on the same day the third complaint letter was received and was to receive disciplinary action but the DNS indicated it did not occur until further allegations were received.

Interview of Staff #109 by the inspector, indicated that all "client feedback forms" (complaint letters) are forwarded to DOC and DNS. Staff #109 indicated when the first two complaint letters were received (13 days earlier), Staff #108 was not interviewed, did not document the incident on the resident's health record, did not report the complaints to the other staff (to monitor), and did not check on Resident #15 daily (to ensure no further incidents of emotional abuse occurred and the resident was toileted) until thirteen days later when the resident indicated the concerns continued and escalated.

Interview of Resident #15 indicated the resident was initially upset with Staff #108 (thirteen days earlier) because Staff #108 refused to provide the proper diet to the resident. The resident stated the staff member "made a big scene" in the dining room and left the resident tearful. Resident #15 indicated reporting concerns [to Staff #110 & #111] but expressed regret in reporting as [Staff #108] continued to be emotionally abusive as the staff member continued to provide the resident's personal care.

Interview of the DNS and DOC indicated awareness of written complaints received (13 days prior to submitting the CIR) and awareness of Staff #109 submitting a written complaint letter (regarding concerns with Staff #108 towards Resident #15). The DNS indicated Staff #108 "had previous disciplinary action" for improper care and was currently suspended pending investigation related to another allegation of staff to resident physical abuse towards another resident. The DNS indicated Staff #109 "took action" following the two written complaints and the DNS was unable to interview Staff #108 (after receiving the third complaint letter) because Staff #108 "was on vacation" at that time. The DNS indicated the disciplinary action was to occur following the return of Staff #108 from vacation, but was not completed yet as "other allegations came forward".

Review of the staffing schedule indicated Staff #108 was working on the day the first two written complaints were received, then worked 9 more shifts (which included the day the third complaint letter was received and one day after). Staff #108 did not go on vacation until 16 days after the first two complaint letters were received and 3 days after the third complaint letter was received. Staff #108 continued to work (and did not receive any disciplinary action) for an additional 6 more shifts when the staff member

was suspended from duty (pending the home's investigation).

Review of the Staff #108 employee record indicated the staff member had received two prior disciplinary actions for violating "resident's right to dignity" and "violating the policy on employee conduct and behaviour".

Therefore, the licensee failed to ensure that Resident #15 was protected from ongoing emotional abuse by Staff #108 by:
-failing to immediately investigate (when two allegations of emotional abuse were initially reported), and take immediate action of protecting Resident #15 from further emotional abuse by Staff #108, as action was not taken until two additional allegations were received (by other resident's/staff), as indicated under LTCHA, s.23(1)(a)(b) under WN #4.
-failing to follow the home's prevention of abuse and neglect policy, as Staff #109, DOC, and DNS did not interview all individuals involved (specifically Staff #108) until 13 days later, after the third complaint was received, and continued to allow Staff #108 to provide care to Resident #15 (despite an allegation of emotional abuse), as indicated under LTCHA, s.20(1) under WN #3.
-failing to immediately report an allegation of staff to resident emotional abuse, as the allegations initially made, were not reported to the Director until 13 days later(after the third allegation), as indicated under LTCHA, s.24(1) under WN#5.
-failing to immediately notify the SDM of Resident #15 of allegations of emotional abuse, as the SDM was not notified until after the third allegation was received, as indicated under O.Reg. 79/10, s. 97(1)(a) under WN #7.
-failing to immediately notify the police of allegations of staff to resident emotional abuse as the police were not contacted until after the second allegation was received regarding Resident #15 and Staff #108, as indicated under O.Reg.79/10, s.98 under WN #8. [s. 19.(1)]

2. Related to log #002270:

A critical incident report was received by the Director on a specified date for an allegation of staff to resident physical abuse incident that occurred. The CIR indicated two days before, at a specified time, Resident #16 reported had received physical abuse by Staff #108. Resident #16 complained of pain to a specified area and sustained an injury, as a result.

The home also received a written complaint from the family of Resident #16 (on the same day the incident occurred). A copy of the complaint letter alleging staff to

resident abuse was not immediately provided to the Director (until six days later).

Review of the home's investigation indicated on the day of the incident, Staff #112 entered Resident #16 room to assist Staff #108 with a transfer. Staff #112 found the resident "crying and visible upset" but could not understand "what was wrong" due to language barrier. Staff #112 did not report the incident until the home began their investigation (6 days later). Staff #113 indicated on the day of the incident, staff reported (at start of shift) Resident #16 had an injury to a specified area. Staff #108 reported to Staff #113 (later in the shift) that Resident #16 had another injury to a different specified area. Staff #113 assessed the resident at that time, but was unable to determine cause of injury (due to language barrier). Staff #113 waited until approximately 2 hours later (to get a translator to determine cause of injury) when Resident #16 reported (with a translator) that Staff #108 had injured the resident (earlier in the shift) and expressed "I don't like [Staff #108]", and "I am so upset". Staff #113 then reported the incident to Staff #114. Staff #114 then notified the DOC (who instructed Staff # 114) to notify the family, police, physician, and the Director. Staff #108 was also relieved of duty pending an investigation.

Review of Resident #16 progress notes also indicated the day before the allegation was made, staff had reported a large injury was noted to a specified area on the resident of unknown cause. No internal incident report was completed and there was no indication of an investigation to determine the cause of that injury.

Therefore, the licensee failed to ensure that Resident #16 was protected from physical abuse by Staff #108 by:
-failing to provide the resident's care according to resident's plan of care as Staff #108 failed to transfer the resident according to the plan, as indicated under LTCHA, s.6(7) under WN #2.
-failing to follow the home's abuse policy by Staff #112 failing to immediately report suspicion of staff to resident physical abuse, and the home failing to immediately investigating Resident #16 sustaining a large injury to a specified area that occurred the day before the allegation was made, as indicated under LTCHA, s. 20(1) under WN #3.
-failing to provide the Director a copy of a complaint letter received by the home from the family of Resident #16, alleging staff to resident physical abuse, as indicated under O.Reg.79/10, s.103(1) under WN #10. [s. 19. (1)]

3. Related to log #002312:

On a specified date, the home disclosed to the inspector that the home was currently investigating a third allegation of staff to resident abuse (involving Staff #108).

A critical incident report (CIR) was submitted to the Director on a specified date for a staff to resident physical abuse incident that occurred. The CIR indicated Staff #115 reported to Staff #109 (3 days before the CIR was submitted and 5 days before it was reported to Staff #109)"overhearing Resident #17 stating "please stop hurting me", then overheard Staff #108 stating to Resident #17 "I'm not hurting you" and the resident responded "you are hurting me now". Staff #115 did not provide a written statement of the incident until eight days after the incident occurred.

Review of the home's investigation indicated that the incident actually occurred 6 days before the incident was reported (when Staff #108 was putting Resident #17 to bed) and Staff # 115 overheard the conversation outside the resident's room as the door was left slightly ajar. Staff #109 asked Staff #115 to provide a written statement (when it was reported 6 days later) and also notified the DOC. Staff #115 did not provide the written statement until until 9 days after the incident occurred (and 4 days after reporting it to Staff # 109). There was no indication the SDM, police or the Director was notified, or an investigation (when Staff #109 was first notified), until 9 days later, when the written statement was received.

Review of Staff #108 work schedule indicated the staff member was working on the day the incident was witnessed and not on the day it was reported as occurring on the CIR. Staff #108 was then relieved of duty 2 days after the incident (pending investigation).

Therefore, the licensee failed to ensure that Resident #17 was protected from physical abuse by Staff #108 by:
-failing to follow the home's abuse policy, as staff member failed to immediately report a suspected incident of staff to resident physical abuse, as indicated under LTCHA, s. 20(1) under WN #3.
-failing to notify the SDM (within 12 hours of suspected staff to resident abuse towards Resident #17),as the SDM was not notified until 5 days after the initial report of neglect and emotional abuse, as indicated under O.Reg. 79/10, s.97(1) under WN #7.
-failing to immediately notify the police of a suspected staff to resident abuse, as indicated under O.Reg.79/10, s.98 under WN #8.
-failing to immediately investigate a suspected incident of staff to resident abuse, as Staff #109/DOC/DNS had "reasonable grounds" to suspect abuse on a specified date and did not investigate until 3 days later, as indicated under LTCHA, s.23(1) under

WN #4.
-failing to immediately report to the Director, a witnessed staff to resident abuse on a specified date when Staff #109 was first notified, as indicated under LTCHA, s. 24(1) under WN #5. [s. 19. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. Related to log #002270:

The licensee has failed to ensure the care set out in the plan of care, was provided to Resident #16, as specified in the plan, related to bed mobility and transferring.

A critical incident report (CIR) was received by the Director on a specified date for an allegation of staff to resident abuse/neglect incident that occurred. The CIR indicated that three days earlier, at a specified time, Resident #16 reported had been physically abused by Staff #108.

Review of the plan of care(in place at time of incident)for Resident #16 indicated under transferring & bed mobility indicated the resident was to be transferred safely with assistance of 2 staff and a full mechanical lift, to instruct the resident to bend knees and assist with pushing self up in bed with two staff assistance, and requires 2 staff to get from laying to sitting position.

Review of the home's investigation indicated on a specified date, Staff #112 had entered Resident #16 (to assist Staff #108) with a transfer. When Staff # 112 entered the resident's room, found the resident sitting on side of bed "crying and visible upset".Therefore, the resident had been repositioned (from lying to sitting) on the side of the bed with only the assistance of one staff member and resulting in pain. [s.6.(7)]

2. The licensee has failed to ensure when the resident was reassessed and the plan of care was reviewed, it was revised when the resident's care needs changed, or was no longer necessary, or the care was no longer effective for Resident #4, related to responsive behaviours.

Related to log #001522:

Note:There was previous non-compliance in 2014 related to Resident #4 for resident to resident sexual abuse.

A critical incident report (CIR)was received by the Director on a specified date for a suspected incident of resident to resident sexual abuse. The CIR indicated the incident occurred two days before when Resident #5 was found in Resident #4 room, sitting across from Resident #4, with Resident #4 pants unfastened. Both residents are cognitively impaired. The CIR indicated Resident #4 "has a previous history of sexually inappropriate behaviours". The CIR indicated no injuries to Resident #5. The actions taken by the home to prevent a recurrence included: BSO referral, door alarm to Resident #4 (to alert staff), and placed on every 15 minute checks.

Review of the progress notes for Resident #4 (for an eight month period) indicated:
-on a specified date and time, Resident #18 had wandered into the resident's room (to lay on the bed). The resident was on "every 15 minute checks".

-4 days later, Resident #18 entered the resident's room and the resident grabbed the co-resident(no injuries noted).
-3 days later, an unidentified resident wandered into the resident's room and was redirected. The resident "Remains on every 15 minute checks".
-the following month, indicated on "every 30 minute checks for aggressive behaviour towards other residents".
-the following month, an unidentified resident was found in the resident's room attempting to hit the resident with a shoe (no injuries noted).
-3 days later, (not two days later as indicated on the CIR) staff witnessed Resident #5 sitting in a wheelchair in Resident #4 room. Resident #4 was sitting in a chair across from the resident with pants zipper was undone. Resident #5 was removed from the room. Staff noted "unaware of exact time last seen" but was last sitting at nursing station and "Every 15 minute checks" were started for 3 days.
-6 days later, BSO indicated "no further incidents or behaviours" but "DOS and every 15 minutes checks started".
-3 days later, staff indicated "spoke to maintenance to put a door alarm on resident's door to alert staff to all who come and go from room". The "door alarm in place and care plan updated".
-8 days later, the resident was relocated to a room closer to nursing station "for closer observation".
-7 days later, the resident was observed removing the yellow wander-guard strip from door, and attempting to wander into other resident's rooms. The resident "was angry" with redirection and threw the wander-guard at staff. Extra staff were called to the unit for assistance. The resident expressed being "upset" with use of door alarm and staff turned off the door alarm. Later in the shift the resident was observed "quickly entering and exiting the room to avoid setting off the door alarm. Remains on every 15 minute checks".
-2 days later, the resident was found hiding the yellow wander-guard.
-11 days later, the BSO noted "resident remains on BSO program, on every 15 minute checks, staff to ensure door alarm and yellow wander-guard is in place".

Observation of Resident #4 (over a two day period)indicated the resident's door was closed and the door alarm was in place and activated. There was no yellow wander guard in place.

Interview of Staff #116 indicated Resident #4 is unpredictable, can be physically & verbally aggressive towards staff and other residents, and has a history of sexually inappropriate behaviour (towards staff and other residents). Staff #116 indicated the resident no longer uses the yellow wander guard as "the resident doesn't understand

what it is for and removes it". Staff #116 indicated the resident is on every 30 minutes checks and door alarm in place/activated "unless the resident deactivates it or demands the door remain open and then staff have to turn it off".

Interview of BSO staff indicated the resident frequently will remove the yellow wander-guard and hide in room but it is to remain in place. The BSO staff indicated the resident always had a door alarm (previous to incident on the CIR) but the resident kept turning it off. The BSO staff indicated a different door alarm was put in place (8 days later) which was placed higher and more difficult for the resident to deactivate.

Review of the plan of care for Resident #4(in place prior to incident on CIR) indicated the resident demonstrated the following responsive behaviours:
1) wandering: staff allow the resident to wander the unit safely, door alarm in place to notify staff (when resident is in and out of the room) and if co-resident's are entering the residents room, staff are to respond promptly, and yellow wander-guard placed at door to prevent co-residents from entering.
3)Socially inappropriate or disruptive (teases other residents, "overly friendly" with specific co-residents (touching, will take them into own room, uses sexual inappropriate words towards staff, exposes/touches own genitals in presence of specific co-residents). Interventions included: staff to re-direct resident to own room if speaking in a sexually inappropriate manner, remove other co-residents who may react or resident may act inappropriate with, initiate behaviour tracking every 15 minutes (for a previous incident of inappropriate touching of a specific resident and exposing genitals, door alarm on door frame, avoid sitting resident next to any female residents if possible, monitor resident if wandering unit and if approaches other specific residents, remove specific resident if resident not able to be redirected, referral to Ontario Shores, monitor groin area for irritation to determine possible cause of exposure of private areas, and remind resident of unacceptable behaviour.

Therefore, the interventions of a door alarm, and yellow wander-guard, that were to be used to manage the responsive behaviours of sexually inappropriate behaviour, were supposed to be already in place (prior to the incident on the CIR and despite being indicated on CIR as actions taken to prevent recurrence), and when those interventions were determined to be no longer necessary or ineffective (as the resident and/or staff would remove/deactivate), the plan of care was not revised until 8 days later (when a new door alarm was applied). The care plan indicated the yellow wander-guard that was to be used (and which the resident continuously removed and continued to remain ineffective) was also not in place over a two day period (to prevent other residents from entering the resident's room). The progress notes also

indicated "a door alarm was not in place" until eight days after the the incident occurred. [s. 6. (10)]

3. Related to log #002174:

A critical incident report was received by the Director on a specified date for a resident to resident physical abuse incident. The CIR indicated on the same day and at a specified time, Resident #7 was found on the floor in own room and had reported to staff the resident "had been kicked" by Resident #8. Resident #7 sustained a an injury requiring transfer to hospital as a result. The long term actions indicated Resident #7 "already had a door alarm in place but was only activated during the night and will now be activated 24/7". Resident #8 "had a door alarm" put in place and both residents were "to be monitored every 15 minutes and already on BSO program".

Review of progress notes for Resident #8 (for a three month period) indicated:
-on a specified date, BSO noted "not showing any aggressive behaviour for 3 weeks so every 15 minute checks discontinued".
-13 days later, the resident was found in Resident #12 room sleeping in the resident's bed. Resident #12 was found sitting in wheelchair in the room.
-4 days later, BSO noted "discontinued from the BSO program due to no documentation of resident having any behaviours".
-10 days later, staff were attempting to redirect the resident out of Resident #13 room but resident became "physically abusive".
-5 days later, Resident #7 was found in own room sitting on the floor complaining of pain and injury to a specified area, requiring transfer to hospital. The resident reported Resident #8 had "kicked the resident" and Resident #8 was found sleeping in Resident #7 bed.
-13 days later, BSO noted "resident monitoring decreased from every 15 minutes to every 30 minutes as behaviours has now decreased".

Review of the care plan for Resident #8 (in place prior to incident on CIR) indicated the following responsive behaviours/interventions:
1) wandering: allow to wander in safe supervised areas of secure unit, seek and determine resident's whereabouts to ensure is safe, determine if any reason for wandering (eg. toileting needs), in BSO program, and respond to door alarms promptly.
2) physically abusive behaviour (unpredictable-will hit out at staff and other residents). Interventions included: 1:1 staff when needed, redirect from other residents when needed, ensure door alarm is on when in room so staff alerted when the resident

leaves the room, on every 15 minute checks for responsive behaviour (but discontinued if no behaviours noted in last 3 weeks).

Observation of Resident #8 room (on a specified date) indicated a staff member entered the resident's room. The staff member deactivated the door alarm and then failed to reactivate the door alarm upon exiting the room.

Review of the plan of care for Resident #7 related to responsive behaviours of wandering also indicated the resident already had a door alarm in place (prior to incident on the CIR) and did not indicate the door alarm was only activated "during the night" as indicated on the CIR.

Therefore, the interventions of a door alarm for Resident #8, (that was to be used to manage the responsive behaviours of physical aggression and wandering)were already in place prior to the incident, (despite what was indicated on CIR as actions taken to prevent recurrence). There was no indication in the progress notes that the door alarm for Resident #8 was activated (on three separate dates) when the resident was wandering into other resident's room. The plan of care for Resident #7 also already had a door alarm that was already in place as an intervention to manage the responsive behaviour of wandering and did not indicate was to be only activated during the night (as indicated on the CIR). The other interventions to manage Resident #8 responsive behaviour(BSO monitoring) was also discontinued despite the resident demonstrating aggressive /wandering behaviours. [s. 6. (10)]

4. Related to log #001441:

A critical incident report(CIR) was received by the Director on a specified date for an allegation by Resident #3 of sexual assault. The CIR indicated the incident occurred two days before at a specified time. In the "description of the occurrence" the resident was assessed (when returned to bed) and indicated "excoriation and swelling" and a small injury was noted to the same area. The resident also reported "someone came into my room" and sexually assaulted the resident.

Interview of Staff #101 indicated Resident#3 “has a history of" displaying and vocalizing inappropriate sexual responsive behaviours.

Interview of Staff #103 stated "I have heard on report in the past that [Resident #3] has displayed and vocalized some inappropriate sexual behaviours".

Interview of BSO team member #104 indicated BSO team was not aware of Resident #3 demonstrating "inappropriate sexual responsive behaviours" until after the allegation (that was made and on CIR) and a referral to BSO was received.

Interview of RAI-Coordinator indicated the plan of care for Resident #3 was revised after the allegation of sexual abuse was made.

Review of the progress notes for Resident #3 indicated:
- on a specified date and time, the resident was calling for help and complained of soreness to a specified area. The resident was assessed and treatment was provided to the reddened area. Staff noted the resident "has habit of" rubbing the specified area "causing redness" and expresses loneliness.
-3 days later, the RPN indicated "during supper, resident complained of soreness" to a specified area. The resident was assessed later that evening (after going to bed). Staff noted excoriation, swelling to the specified area and scant amount of blood. Resident reported "someone came to the room" and sexually assaulted the resident. Resident also stated "it was dark and screamed for help and no one came". No screaming was noted throughout the shift. POA was notified and "note left for MD". Treatment cream applied.
-2 days later, BSO member indicated "resident referred to BSO r/t unusual behaviour of sexually inappropriate comments/yelling in public areas (dining room). The resident has been expressing loneliness, has been reported to be displaying inappropriate sexual responsive behaviours in public areas and asking staff to assist with these behaviours. Staff noted the behaviours have been worsening "over the last 2 weeks". Diagnostic test completed to rule out infection and placed on every 30 minute checks. Staff to report any unusual/escalated behaviour exhibited by resident and rule out any physical cause (infections, discomfort, etc.). New order received from physician to restart antidepressant (was discontinued), further diagnostic test to rule out infections, and request Nurse Practitioner (NP) to complete an exam to the specified area. The NP completed the exam and indicated the resident reported "has been rubbing" to stop the discomfort that is ongoing. Staff provided specific cleaning instructions to specified area and a new order for treatment cream. Later that evening, police arrived for investigation of incident.
-the following day, the staff documented the resident was yelling out for help and reporting someone was inappropriately touching the resident but no one had entered the resident's room and remains on every 30 minute checks.
-two days later staff documented the resident remained on behavioural tracking as still vocalizing sexually inappropriate words.

Review of the care plan (was revised post incident)for Resident #3 indicated socially inappropriate or disruptive behaviour: reported to display and vocalize sexually inappropriate behaviours in public areas which was triggered with decrease in antidepressant. Interventions included: rule out possible causes (irritation, itchiness, or discomfort/rule out infection), move resident to private room if displaying seuxally inappropriate behaviours, remind/discourage resident of inappropriate comments disrupting other residents, assess symptoms and review medications. Staff to apply barrier treatment cream as ordered, keep skin dry and clean, staff to complete daily skin assessments and report to charge nurse any problems, report to charge nurse any displaying towards self of sexually inappropriate behaviours, notify MD/NP if irritation persists (to assess), and avoid using soap to area.

There was no indication the plan of care was reviewed and revised when the resident's needs/condition changed (re: possible infection as displayed as sexually inappropriate responsive behaviours) as the resident had been exhibiting responsive behaviours (that were not documented) and displaying alteration in skin integrity (as a result of the responsive behaviours) and interventions were not implemented until after the resident expressed "someone came into my room" and sexually assaulted the resident.[s.6.(10)(b)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, 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 written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Review of the home's policy " Abuse Policy-staff to resident and competent resident to another resident" (RSL-RR-010) indicated:
- on page 1 of 5: "all alleged/actual/suspected cases of abuse will be recognized, reported and investigated.
Under procedure for reporting abuse (page 3 of 5) indicated:
-upon knowing of any incident or alleged, actual or suspected abuse, the witness will immediately intervene to ensure the resident's well- being.
-immediately removing the persons allegedly or suspected of the inflicting of the abuse from the immediate area and any resident home areas, pending further investigation.
-the Registered Staff will update the plan of care and progress notes following the incident, inclusive of measures to assess the resident's physical and/or psychosocial well-being post incident as well as interventions supporting the resident and to prevent recurrences.
-the Administrator, DOC or designate will discuss the incident with the implicated individuals and develop a plan of action. The plan will be documented. [s.20.(1)]

2. Related to log # 001441:

A critical incident report(CIR)was received by the Director on a specified date for an allegation by Resident #3 of sexual abuse. The CIR indicated the incident occurred 2 days before it was reported to the Director. In the "description of the occurrence" (during a specified time) the resident reported complaints of discomfort to a specified area to the RPN. The resident was assessed approximately 2 hours later, and noted "excoriation and swelling" and a small bruise to the specified area. The resident also reported at that time had been sexually assaulted.

Review of the staff schedule indicated Staff #100, Staff #101 and Staff #103 worked

on the unit with Resident #3 on the date the incident was reported.

Interview of the DNS indicated she contacted Staff #100 the day after the incident to inquire why the staff member "had not called anyone to report the allegation of sexual abuse" and the staff member indicated "had reported the incident to the DOC". The DNS also indicated "the progress notes contained all the investigation".

Interview of the DOC indicated Staff #100 did not report any allegation by Resident #3 of sexual abuse and was not aware of the allegation until the following day.

Interview of Staff #103 indicated on the day the incident occurred, (at the specified time) heard Resident #3 calling out "Help, help!". Staff #103 indicated went to see Resident #3 and the resident reported being sexually assaulted. The staff member indicated the resident was provided reassurance and then immediately reported the incident to Staff #101.

Interview of Staff #101 indicated on the date of the incident, Resident #3 was complaining of discomfort to a specified area during a meal time (but has history of discomfort to the specified area) and indicated would assess later when resident was in bed. The staff member indicated approximately 2 hours later, heard the resident calling out. The staff member indicated that was when the resident reported being sexually assaulted. The staff member indicated completed an assessment of the resident, documented the assessment and then notified Staff #100.

Interview of Staff #100 indicated on the date of the incident, Staff #101 reported Resident #3 had alleged being sexually assaulted. The staff member "assumed" it may have been a staff member but Resident #3 was not questioned to determine "who" the resident was alleging had sexually assaulted the resident (to determine whether it was a staff, resident or visitor). The staff member indicated an assessment of the resident was then completed and then directed Staff #101 to complete an incident report, contact the POA and the physician. The staff member denied notifying the DOC or DNS, or the Administrator, did not call the after-hours for the MOHLTC, or contact the police, despite an allegation by a resident of being sexually assaulted.

Review of the progress notes for Resident #3 on the day the incident was reported, Staff #101 noted "note left for" physician".

Therefore, the home's policy was not complied with as an alleged case of sexual abuse was not immediately recognized, reported and investigated by the Staff #100

until the following day, when the DNS and DOC became aware of the incident and actions were taken. [s. 20. (1)]

3. Related to log # 002157:

Interview of the DNS and DOC on June 4, 2015, indicated that although there were 2 "client feedback forms" received on a specified date (regarding allegations of staff to resident improper care and emotional abuse by Staff #108 towards Resident #15), Staff #109 "had taken action to resolve the issue" at that time. The DNS indicated an investigation was not completed (until 13 days later) when a third complaint letter was received by Staff #109 alleging staff to resident emotional abuse and improper care by Staff # 108 (when Staff #108 returned from vacation). The DNS indicated Staff #108 was to receive disciplinary action for the first 3 reported incidents, but then additional information was received (regarding two additional incidents of staff to resident abuse by Staff #108 towards two other residents). The DNS indicated approximately one month later was when action was taken with Staff #108 (suspended pending the investigation into all the allegations).

Review of the staffing schedule for Staff #108 indicated the staff member worked on the day of the first two incidents that were reported, worked 9 more shifts (including the day the third complaint was received and the day after) before the staff member went on vacation. Staff #108 then returned from vacation and continued to work and was not suspended (pending investigation) until 5 days later (when the fifth and sixth complaints were received regarding other residents).

Interview of Staff #109 indicated two "client feedback forms" were received on a specified date, regarding concerns of neglect and emotional abuse of Resident #15 by Staff #108. Staff #109 indicated Staff #108 was not interviewed on the day the client feedback forms were received but only spoke to the resident. Staff #109 indicated the concerns identified on the "client feedback forms" were not reported to the other supervisor's to follow-up, did not document the incidents reported on the resident's health record, and did re-assess Resident #15 each day to ensure no further incidents occurred (until 13 days later) when Resident #15 was interviewed again by Staff #109. Staff # 109 indicated when Resident #15 was interviewed, indicated the concerns related to Staff #108 continued and escalated.

The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with as the RN failed to immediately remove the persons allegedly or suspected of the inflicting of the abuse from the

immediate area and any resident home areas, pending further investigation. Staff # 109 failed to update the plan of care and progress notes following the reported allegations of staff to resident emotional abuse and neglect, inclusive of measures to assess the resident's physical and/or psychosocial well-being (post incident) as well as interventions supporting the resident and to prevent recurrences. The Administrator, DOC or designate also did not discuss the incident with the implicated individual (Staff #108)and develop a plan of action to prevent a reoccurrence until approximately one month later(after 3 additional allegations were received). [s. 20. (1)]

4. Related to log # 002270:

Review of the progress notes for Resident #16 indicated on a specified date, the resident was found with a large injury to a specified area. There was no indication of an investigation to determine the cause of injury on that date. The following day, Staff #112 witnessed a "suspected" staff to resident physical abuse towards Resident #16(involving Staff #108) and did not report the incident for 4 days.

Therefore, the licensee failed to comply with the home's abuse policy by failing to immediately report, intervene, and investigate a suspected case of staff to resident physical abuse. [s. 20(1)]

5. Related to log #002312:

On June 12, 2015 the home disclosed to the inspector that the home was currently investigating a third allegation of staff to resident abuse (involving Staff #108).

A critical incident report (CIR) was submitted to the Director (the same day) for a staff to resident abuse/neglect incident that occurred 8 days before the CIR was submitted (and reported to the Inspector). The CIR indicated Staff #115 reported (4 days after the incident occured) witnessing a "suspected" staff to resident physical abuse towards Resident #17 by Staff #108.". Staff #115 did not provide a "written statement" to the management regarding the incident 8 days after the incident occurred.

Review of the home's investigation indicated 5 days after the incident was witnessed (not 4 as indicated on CIR), Staff #115 reported witnessing a suspected staff to resident physical abuse (towards Resident #17 by Staff #108) to Staff #109. Staff #109 asked Staff #115 to provide a written statement and then immediately notified the DOC of the incident. Staff #115 did not provide the written statement until 4 days later, and that was when the home began the investigation.

Therefore, the licensee failed to ensure the home's abuse policy was complied with as a staff member has reasonable grounds to suspect staff to resident physical abuse and did not report the incident for 6 days and then failed to provide a written statement for an additional 3 days, there was no indication an investigation was completed (when the incident was first reported to Staff #109), and there was no indication the SDM, police or the Director was notified, until 9 days later (when the written statement was received by Staff #115). [s. 20. (1)]

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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. Related to log # 001441:

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 is immediately investigated.

Review of the progress notes, interview of staff and review of the homes investigation indicated:
- on a specified date and time,the resident complained of discomfort to a specified area. The resident was assessed and had noted excoriation, scant amount of blood, and a small bruise noted to the area. The resident reported "someone came to the room" and sexually assaulted the resident.
-The RN did not investigate to determine who the resident was alleging.
-Interview of the DNS indicated the RN was contacted the following day to inquire why the RN "had not called anyone to report the allegation of sexual abuse" of Resident #3 and the RN indicated at that time, "had reported the incident to the DOC".
-the DOC denied receiving a call from the RN on the day the incident was reported and was not made aware of the allegation until the following day.
-The DNS had no written investigation "as the progress notes contained all the investigation". [s.23. (1)(a)]

2. Related to log # 002174:

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 is immediately investigated.

A critical incident report received by the Director on a specified date, indicated on the same day at a specified time, a resident to resident physical abuse incident had occurred. The CIR indicated Resident #8 allegedly kicked Resident #7 resulting in an injury which resulted in transfer to hospital and significant change in condition.

Interview of the DOC indicated there was no formal investigation completed into the incident "as we knew what happened and directed the staff to ensure the Ministry and Police were called and document the interventions on the progress notes". The DOC indicated the CIR would be the only other place where the investigation would be indicated.

The Director of Nursing Services stated "we only complete a formal investigation when staff are involved or the aggressive resident is cognitive" as both residents involved were cognitively impaired. [s. 23. (1) (a)]

3. Related to log # 002157:

Review of the home's investigation, interview of staff & resident, and review of the

resident's health record indicated that Staff #109 had received two written complaints on a specified date from Staff #110 & #111 regarding concerns of staff to resident emotional abuse and neglect towards Resident #15 by Staff #108. The written complaints alleged improper care and that Resident #15 was "fearful" of Staff #108 and did not want the staff member to continue to provide care. Staff #109 "spoke with resident" and told the resident that Staff #109 would be tracking concerns with Staff #108 for 2 weeks. There was no indication that this action was taken, and no indication of an investigation when the initial complaints were received. [s. 23.(1)(a)]

4. Related to log # 002312:

At the time of the inspection, the home disclosed to the inspector that the home was currently investigating further allegations of staff to resident abuse related to PSW #108. A critical incident report (CIR) was submitted to the Director the same day for a staff to resident abuse/neglect incident that occurred 8 days earlier.

Review of the home's investigation indicated that the staff member who witnessed a suspected staff to resident physical abuse failed to immediately report the suspicion for 6 days, and when the allegation was reported, there was no documented evidence of an investigation until the staff member provided a written statement (9 days later). [s. 23. (1) (a)]

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Related to log # 001441:

A critical incident report(CIR)was received by the Director on a specified date for an allegation by Resident #3 of sexual abuse. The CIR indicated the incident occurred the day before it was submitted at a specified time. Interview of the DOC confirmed the Director was notified until the following day[s.24 (1)].

2. Related to log # 001522:

A critical incident report (CIR)was received by the Director on a specified date for a suspected incident of resident to resident sexual abuse that occurred 2 days before the CIR was submitted at a specified time between Resident #4 & #5. Review of the health care record of Resident #4 & #5 indicated the incident actually occurred 2 days before the CIR was submitted.

Interview of the DOC indicated the CIR (that was submitted to the Director) was not required as both residents were "cognitively impaired". The DOC indicated after staff

were interviewed regarding the incident, they determined the the correct date of the occurrence.[s. 24. (1)]

3. Related to log # 001940:

The home had completed 3 internal "resident incident reports" on three separate dates (within a 3 week period) related to Resident #14's sustaining injuries to specified areas (of unknown cause). The Director was not notified until 5 days later, when the family member of Resident #14 submitted a written complaint regarding the injuries (of unknown cause). [s. 24. (1)]

4. Related to log # 002157:

Review of the home's investigation indicated that RN #109 had received two written complaints on a specified date from Staff #110 & #111 regarding concerns from Resident #15 towards Staff #108. The written complaints alleged improper care and that Resident #15 was "fearful" of Staff #108 and did not want the staff member to continue to provide their care.

Interview of Staff #109 indicated the Director was not notified on the day the written complaints were received (but the DNS & DOC were).
Interview of the DNS indicated Staff #109 "took action" at the time of the written complaints were received and the Director was not notified until 13 days later, when Staff #109 submitted a written complaint letter alleging staff to resident emotional abuse and neglect. [s.24(1)]

5. Related to log # 002312:

At the time of the inspection, the home disclosed to the inspector that the home was currently investigating further allegations of staff to resident abuse related to Staff #108.

A critical incident report (CIR) was submitted to the Director on the day it was reported to the Inspector for a staff to resident abuse/neglect indicating the incident which occurred 8 days earlier.

Review of the home's investigation indicated:
-the incident actually occurred 9 days before it was reported,
-Staff #112 witnessed a suspected staff to resident physical abuse by Staff #108

towards Resident #17 but did not report to Staff #109 for 5 days. Staff #109 reported the incident immediately to the DOC & DNS. The DNS indicated the investigation was not initiated when Staff # 109 reported it to DOC & DNS as they were "waiting for the written statement" by Staff #112 and the statement was not provided for 4 more days (which was when the allegation was reported to the Director). [s. 24. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(a) integrated into the care that is provided to all residents; O. Reg. 79/10, s. 53 (2).
(b) based on the assessed needs of residents with responsive behaviours; and O. Reg. 79/10, s. 53 (2).
(c) co-ordinated and implemented on an interdisciplinary basis. O. Reg. 79/10, s. 53 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that for all programs and services, the matters referred to in subsection (1) are (a) integrated into the care that is provided to all residents.

Review of the home's "Responsive Behaviours" (09-05-01) (revised September 2010) indicated the matters referred to in subsection (1) are identified in this policy. However, the home utilizes a Behavioural Supports Ontario (BSO) program in the home (for the past three years) and utilizes tools which are not identified in the homes Responsive Behaviours policy.

The DNS indicated the BSO program has been in use for the past 3 years.

Interview of two BSO team members indicated an awareness that the home's new policy does not integrate the use of the BSO team that is actively used in the home to manage resident's with responsive behaviours, and tools that are actually utilized in the home (related to responsive behaviours). [s.53.(2)(a)]

WN #7: 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 SDM and any other person specified by the resident were immediately notified upon becoming aware of an alleged incident of abuse or neglect of the resident that caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

Related to log #002157:

Review of the home's investigation and interview of staff indicated Staff #109 had received two written complaints on a specified date from Staff #110 & # 111. The complaint letters were regarding allegations of neglect from Resident #15 about Staff #108 and the resident was fearful of Staff #108. The allegation was not reported to the SDM until 13 days later(when Staff #109 submitted a third written complaint, reporting the same). [s.97(1)(a)]

2. Related to log #002312:

At the time of the inspection, the home disclosed to the inspector that the home was currently investigating further allegations of staff to resident abuse related to Staff # 108.

Review of the home's investigation indicated Staff #112 reported an allegation of suspected staff to resident physical abuse 6 days after the incident occurred. The allegation was not reported to the SDM until 8 days after the incident occurred (when Staff #112 submitted a written statement regarding the incident). [s. 97(1)(a)]

WN #8: 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 the appropriate police force was 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.

Related to log # 001441:

Review of the home's investigation, interview of staff and review of Resident #3 health record indicated on a specified date and time, the resident reported "someone came to the room" and sexually assaulted the resident.

Interview of the DNS and review of the health record of Resident #3 indicated the police were notified the day after the allegation was made. [s.98]

2. Related to log # 001522:

Review of the home's investigation, review of health care records for Resident #4 & #5, and interview of staff, indicated there was a suspected incident of resident to resident sexual abuse that occurred on a specified date and time between Resident #4 & #5. Both residents were cognitively impaired and Resident #4 had a history of sexual responsive behaviours towards other residents. Review of the progress notes for Resident #4 indicated on a specified date and time, "the police were notified of the incident that occurred yesterday".[s.98]

3. Related to log # 002174:

A critical incident report (CIR) was received by the Director on a specified date for a resident to resident physical abuse incident. The CIR indicated on the same day and a specified time, Resident #7 was found on the floor their room and had reported to staff the resident had been physically assaulted by Resident #8 resulting in an injury requiring transfer to hospital and significant change in condition. The CIR indicated "called POA of [Resident #7] and does not want police called".

Interview of the DNS indicated "we usually call the family of the recipient of the aggression and if they don't want us to call the police, we don't call them". The police were not called regarding this incident. [s. 98.]

4. Related to log # 002157:

Review of the home's investigation, interview of staff, review of health care records,and interview of the resident indicated on a specified date, Staff #109 received two written complaints (from Staff #110 & #111) alleging improper care and Resident #15 fearful of Staff #108.

Interview of the DNS and DOC indicated the police were not contacted regarding the concerns with Staff #108 towards Resident #15 on the day the first two written complaints were received alleging neglect or 13 days later when a third written complaint was received from Staff # 109 alleging the staff to resident neglect and emotional abuse by Staff # 108 towards Resident #15. The DNS indicated the police were called approximately one month later, after receiving additional allegations of staff to resident abuse by Staff #108 (towards other residents). [s.98.]

5. Related to log # 002312:

At the time of the inspection, the home disclosed to the Inspector an allegation of staff to resident physical abuse that occurred 9 days earlier. The DNS indicated the police were notified 9 days later. [s. 98.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation was commenced immediately.

Related to log # 001940:

Interview of the DNS and DOC indicated a written complaint from a family member of Resident #14 was received on a specified date. There was no client feedback form completed regarding this complaint (as per the home's policy). There was confusion between all managers as to which of the home's "Complaint policy" (new or previous) was to be implemented (despite documented evidence to indicate that the previous complaint policy was still in use at the time the written complaint was received).Interview of the Administrator indicated that although the new ownership

took effect prior to the complaint being received, the new policies had not yet been implemented.

Review of the home's previous complaint policy "Complaint Handling Process-Client Feedback Log" (ADM-QUA-100) indicated:
- on page 1 of 2 under #3."it is the responsibility of the person receiving a concern/complaint to document the information on a Client Feedback Log Form, if a follow up is required. All sections on the form are to be completed promptly".
- under #4. "when all information has been taken, the person receiving the complaint will identify the recommended actions and note in the "actions taken" section of the form, along with names of who will be accountable for these actions".

Review of the home's investigation indicated:
- The written complaint was regarding Resident #14: being denied attendance to specific programs on more than one occasion,dietary concerns, the resident sustaining ongoing unexplained injuries to specified areas, and the family member witnessing a staff member providing rough-handling of the resident on a specified date (resulting in the resident screaming and sustaining an injury to a specified area).
-There was no documented evidence of a "Client Feedback form" completed for this written complaint (alleging improper care and possible physical abuse).
-the home's investigation included investigation into the activation and dietary concerns only.
-the DNS/DOC received 3 internal incident reports (on a specified date)where staff reported 2 injuries to specified areas to Resident #14 of unknown cause; the following month, another injury was sustained to a specified area to Resident #14.
-There was no documented evidence to indicate an investigation was completed into the cause of Resident#14 sustaining "ongoing" injuries to specified areas (prior to the incident that a written complaint was received for) and the 3 internal incident reports.
-the DNS indicated the "investigation" was concluded 13 days after the written complaint was received but the complainant was not contacted by the DNS 2 days later (when a message was left requesting an extension for the investigation). A final response was then provided to the complainant by the DNS (20 days after the written complaint was received) of the final outcome of the investigation and actions taken.
[s.101.(1) 1.]

2. The licensee failed to ensure that a documented record is kept in the home that includes: (a) the nature of each written complaint; (b) the date the complaint was received; (c) the type of action taken to resolved the complaint, including the date the action, time frames for actions to be taken and any follow-up action required.

Related to log # 001940:

Review of the home's investigation and interview of DNS, DOC and Administrator indicated a written complaint was received for Resident #14 on a specified date from the family member.

Interview of the Administrator indicated all complaints received are to be placed in the "complaint binder" along with "client feedback forms"(which indicates who the complaint was from, when the complaint was received and what actions were taken, and what outcome was). The Administrator indicated the complaints received are also tracked electronically by each unit on a complaint log, and based on this entry, trends are determined.

Review of the paper "complaints binder" for a three month period (during the time the complaint letter was received)had a copy of the complaint letter received (but no client feedback form). Review of the "electronic" complaint logs (based on client feed backs) for the month the complain letter was received, had no indication of a written complaint received by a family member alleged staff to resident "rough handling" and sustaining ongoing injuriesof unknown cause. [s.101.(2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the Director received a written complaint with respect to a matter that the licensee reports or reported to the Director, under section 24 of the Act, and a corresponding written report documenting the response the licensee made to the complainant.

Related to log # 001940:

A written complaint was received by the home on a specified date from a family member of Resident #14 regarding witnessed incident of rough-handling towards Resident #14 and ongoing, injuries sustained by Resident #14 of unknown cause.

Interview of the DNS indicated no written response was provided to the complainant or to the Director as the complainant was only notified via telephone (15 days later).

2.Related to log #002270:

The home received a written complaint from the family of Resident #16 on a specified date regarding an incident of staff to resident physical abuse. A copy of the complaint letter alleging staff to resident abuse was not provided to the Director (until six days later). [s.103(1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the report to the Director included the following description of the incident:date and time of the incident.

Related to log # 002157:

A critical incident report (CIR)was received by the Director on a specified date,for a staff to resident abuse/neglect that occurred towards Resident #15. The CIR indicated on the same day, at a specified time, the resident reported to Staff #109 the resident had been experiencing difficulty with Staff #108.

Review of the home's investigation indicated on a specified date (13 days before the Director was notified), Staff #109 had received two written complaints from Staff #110 & #111 with allegations of neglect and emotional abuse from Resident #15 by Staff #108. This information was not provided on the CIR that was submitted to the Director. [s. 104. (1) 1.]

Issued on this 28 day of September 2015 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : LYNDA BROWN (111) - (A1)

Inspection No. / No de l'inspection : 2015_360111_0014 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 001301-14,001441-14,001522-15,001691-15,002174-15,001940-15,002157-15,002270-15, 002312-15 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Sep 28, 2015;(A1)

Licensee / Titulaire de permis : CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc., 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8

LTC Home / Foyer de SLD : Orchard Villa
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Gary Hopkins

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To CVH (No.6) GP Inc. as general partner of CVH (No.6) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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 :

(A1)
The licensee shall prepare, submit and implement a plan for achieving compliance with LTCHA, 2007 s. 19 (1) to ensure all residents are protected from physical and emotional abuse..

The licensee shall ensure the plan includes:

1)The development and implementation of a monitoring process to ensure that:
a) the resident s SDM is immediately notified of every incident of alleged, suspected or witnessed incident of abuse and are notified with 12 hours upon
the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.
b) every alleged, suspected or witnessed incident of physical and emotional abuse of a resident, by a staff member, that the licensee knows of, or that is reported to the licensee, is immediately investigated and appropriate action is taken to ensure the safety of those residents involved (and any other residents who may be vulnerable), are protected from physical and emotional

abuse from staff.
c) the Director is immediately notified if there are reasonable grounds to suspect
the 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.
d)the appropriate police force is immediately notified of any alleged, suspected or
witnessed incident of physical and emotional abuse of a resident that the licensee suspects may constitute a criminal offence.
2) All staff and management to review the home's new policy relating to "Zero Tolerance of Abuse and Neglect", including actions to be taken by any person when a suspicion, allegation or witnessed, incident of abuse neglect has been reported,ensuring awareness of roles and responsibility, and ensuring staff clearly understand who will be responsible for completing the investigation and that the investigation is to be completed immediately, and appropriate actions to be taken as a result of the investigations.
3) Develop and implement a system to monitor and evaluate staff adherence to the Zero Tolerance of Abuse and Neglect Policy.
4) Develop and implement specific measures to be in place when non-adherence to the home's policy and or legislation is identified.
5) The plan should also identify who is responsible for ensuring the completion of
each and every item listed above.

The plan shall be submitted in writing and emailed to LTCH Inspector-Nursing,
Lynda Brown at lynda.brown2@ontario.ca on or before June 30, 2015. The plan
shall identify who will be responsible for each of the corrective actions listed and expected time from for completion.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that Resident # 15, #16 & #17 were protected from physical and/or emotional abuse by the licensee or staff in the home.

Under O.Reg. 79/10, s.2(1) For the purposes of the definition of "abuse" in subsection 2(1) of the Act, "emotional abuse" means, (a) any threatening, insulting,

intimidating or humiliating gestures, actions, behaviour, or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a residents.

Under O.Reg. 79/10, s. 2(1) For the purposes of the definition of "abuse" in subsection 2(10 of the Act, "physical abuse" means, subject to subsection (2),(a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Related to log # 002157:

A critical incident report was received by the Director on a specified date for a staff to resident abuse/neglect that occurred towards Resident #15. The CIR indicated on the same date,the resident reported to Staff #109 the resident "had been experiencing difficulty" with Staff #108.

Review of the home's investigation indicated that 13 days before the CIR was submitted, Staff#109 had received two written complaints (from Staff #110 & #111) regarding allegations of improper care towards Resident #15 by Staff #108, Resident #15 had expressed fear of Staff #108, did not want Staff #108 to provide their care, Resident #15 "was upset and crying", and indicated this staff member "has a history of getting back at staff and residents when complaints about [Staff #108] are made". The actions taken (by Staff #109)indicated "spoke with resident" and informed the resident Staff # 109 would be monitoring Staff #108 for a 2 week period. Thirteen days later, a third written complaint (by Staff #109)was received by the DOC indicating Resident #15 "was asked how things had been going with [Staff #108]". The resident stated Staff #108 "does not speak to me" when providing personal care, the resident "feels sick" when Staff #108 "is going to be on duty for the next 3-4 days", and reported Staff #108 continued to not provide assistance with toileting. Staff #108 was interviewed by DNS & DOC on the same day the third complaint letter was received and was to receive disciplinary action but the DNS indicated it did not occur until further allegations were received.

Interview of Staff #109 by the inspector, indicated that all "client feedback forms" (complaint letters) are forwarded to DOC and DNS. Staff #109 indicated when the first two complaint letters were received (13 days earlier), Staff #108 was not interviewed, did not document the incident on the resident's health record, did not report the complaints to the other staff (to monitor), and did not check on Resident

#15 daily (to ensure no further incidents of emotional abuse occurred and the resident was toileted) until thirteen days later when the resident indicated the concerns continued and escalated.

Interview of Resident #15 indicated the resident was initially upset with Staff #108 (thirteen days earlier) because Staff #108 refused to provide the proper diet to the resident. The resident stated the staff member "made a big scene" in the dining room and left the resident tearful. Resident #15 indicated reporting concerns [to Staff #110 & #111] but expressed regret in reporting as [Staff #108] continued to be emotionally abusive as the staff member continued to provide the resident's personal care.

Interview of the DNS and DOC indicated awareness of written complaints received (13 days prior to submitting the CIR) and awareness of Staff #109 submitting a written complaint letter (regarding concerns with Staff #108 towards Resident #15). The DNS indicated Staff #108 "had previous disciplinary action" for improper care and was currently suspended pending investigation related to another allegation of staff to resident physical abuse towards another resident. The DNS indicated Staff #109 "took action" following the two written complaints and the DNS was unable to interview Staff #108 (after receiving the third complaint letter) because Staff #108 "was on vacation" at that time. The DNS indicated the disciplinary action was to occur following the return of Staff #108 from vacation, but was not completed yet as "other allegations came forward".

Review of the staffing schedule indicated Staff #108 was working on the day the first two written complaints were received, then worked 9 more shifts (which included the day the third complaint letter was received and one day after). Staff #108 did not go on vacation until 16 days after the first two complaint letters were received and 3 days after the third complaint letter was received. Staff #108 continued to work (and did not receive any disciplinary action) for an additional 6 more shifts when the staff member was suspended from duty (pending the home's investigation).

Review of the Staff #108 employee record indicated the staff member had received two prior disciplinary actions for violating "resident's right to dignity" and "violating the policy on employee conduct and behaviour".

Therefore, the licensee failed to ensure that Resident #15 was protected from ongoing emotional abuse by Staff #108 by:
-failing to immediately investigate (when two allegations of emotional abuse were

initially reported), and take immediate action of protecting Resident #15 from further emotional abuse by Staff #108, as action was not taken until two additional allegations were received (by other resident's/staff), as indicated under LTCHA, s.23(1)(a)(b) under WN #4.
-failing to follow the home's prevention of abuse and neglect policy, as Staff #109, DOC, and DNS did not interview all individuals involved (specifically Staff #108) until 13 days later, after the third complaint was received, and continued to allow Staff #108 to provide care to Resident #15 (despite an allegation of emotional abuse), as indicated under LTCHA, s.20(1) under WN #3.
-failing to immediately report an allegation of staff to resident emotional abuse, as the allegations initially made, were not reported to the Director until 13 days later(after the third allegation), as indicated under LTCHA, s.24(1) under WN#5.
-failing to immediately notify the SDM of Resident #15 of allegations of emotional abuse, as the SDM was not notified until after the third allegation was received, as indicated under O.Reg. 79/10, s. 97(1)(a) under WN #7.
-failing to immediately notify the police of allegations of staff to resident emotional abuse as the police were not contacted until after the second allegation was received regarding Resident #15 and Staff #108, as indicated under O.Reg.79/10, s.98 under WN #8. [s. 19.(1)]

2. Related to log #002270:

A critical incident report was received by the Director on a specified date for an allegation of staff to resident physical abuse incident that occurred. The CIR indicated two days before, at a specified time, Resident #16 reported had received physical abuse by Staff #108. Resident #16 complained of pain to a specified area and sustained an injury, as a result.

The home also received a written complaint from the family of Resident #16 (on the same day the incident occurred). A copy of the complaint letter alleging staff to resident abuse was not immediately provided to the Director (until six days later).

Review of the home's investigation indicated on the day of the incident, Staff #112 entered Resident #16 room to assist Staff #108 with a transfer. Staff #112 found the resident "crying and visible upset" but could not understand "what was wrong" due to language barrier. Staff #112 did not report the incident until the home began their investigation (6 days later). Staff #113 indicated on the day of the incident, staff reported (at start of shift) Resident #16 had an injury to a specified area. Staff #108

reported to Staff #113 (later in the shift) that Resident #16 had another injury to a different specified area. Staff #113 assessed the resident at that time, but was unable to determine cause of injury (due to language barrier). Staff #113 waited until approximately 2 hours later (to get a translator to determine cause of injury) when Resident #16 reported (with a translator) that Staff #108 had injured the resident (earlier in the shift) and expressed "I don't like [Staff #108]", and "I am so upset". Staff #113 then reported the incident to Staff #114. Staff #114 then notified the DOC (who instructed Staff # 114) to notify the family, police, physician, and the Director. Staff #108 was also relieved of duty pending an investigation.

Review of Resident #16 progress notes also indicated the day before the allegation was made, staff had reported a large injury was noted to a specified area on the resident of unknown cause. No internal incident report was completed and there was no indication of an investigation to determine the cause of that injury.

Therefore, the licensee failed to ensure that Resident #16 was protected from physical abuse by Staff #108 by:
-failing to provide the resident's care according to resident's plan of care as Staff #108 failed to transfer the resident according to the plan, as indicated under LTCHA, s.6(7) under WN #2.
-failing to follow the home's abuse policy by Staff #112 failing to immediately report suspicion of staff to resident physical abuse, and the home failing to immediately investigating Resident #16 sustaining a large injury to a specified area that occurred the day before the allegation was made, as indicated under LTCHA, s. 20(1) under WN #3.
-failing to provide the Director a copy of a complaint letter received by the home from the family of Resident #16, alleging staff to resident physical abuse, as indicated under O.Reg.79/10, s.103(1) under WN #10. [s. 19. (1)]

3. Related to log #002312:

On a specified date, the home disclosed to the inspector that the home was currently investigating a third allegation of staff to resident abuse (involving Staff #108).

A critical incident report (CIR) was submitted to the Director on a specified date for a staff to resident physical abuse incident that occurred. The CIR indicated Staff #115 reported to Staff #109 (3 days before the CIR was submitted and 5 days before it was reported to Staff #109)"overhearing Resident #17 stating "please stop hurting

me", then overheard Staff #108 stating to Resident #17 "I'm not hurting you" and the resident responded "you are hurting me now". Staff #115 did not provide a written statement of the incident until eight days after the incident occurred.

Review of the home's investigation indicated that the incident actually occurred 6 days before the incident was reported (when Staff #108 was putting Resident #17 to bed) and Staff # 115 overheard the conversation outside the resident's room as the door was left slightly ajar. Staff #109 asked Staff #115 to provide a written statement (when it was reported 6 days later) and also notified the DOC. Staff #115 did not provide the written statement until until 9 days after the incident occurred (and 4 days after reporting it to Staff # 109). There was no indication the SDM, police or the Director was notified, or an investigation (when Staff #109 was first notified), until 9 days later, when the written statement was received.

Review of Staff #108 work schedule indicated the staff member was working on the day the incident was witnessed and not on the day it was reported as occurring on the CIR. Staff #108 was then relieved of duty 2 days after the incident (pending investigation).

Therefore, the licensee failed to ensure that Resident #17 was protected from physical abuse by Staff #108 by:
-failing to follow the home's abuse policy, as staff member failed to immediately report a suspected incident of staff to resident physical abuse, as indicated under LTCHA, s. 20(1) under WN #3.
-failing to notify the SDM (within 12 hours of suspected staff to resident abuse towards Resident #17),as the SDM was not notified until 5 days after the initial report of neglect and emotional abuse, as indicated under O.Reg. 79/10, s.97(1) under WN #7.
-failing to immediately notify the police of a suspected staff to resident abuse, as indicated under O.Reg.79/10, s.98 under WN #8.
-failing to immediately investigate a suspected incident of staff to resident abuse, as Staff #109/DOC/DNS had "reasonable grounds" to suspect abuse on a specified date and did not investigate until 3 days later, as indicated under LTCHA, s.23(1) under WN #4.
-failing to immediately report to the Director, a witnessed staff to resident abuse on a specified date when Staff #109 was first notified, as indicated under LTCHA, s. 24(1) under WN #5. [s. 19. (1)] (111)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

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

Aug 15, 2015(A1)

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

(A1)
The licensee must prepare, submit and implement a plan for achieving compliance with LTCHA, 2007, s. 6 - Plan of Care, specific to, s. 6 (10)(b)(c).

The homes plan shall include:
1) Review and revise the plan of care for Resident #3, #4, #7 & #8 s plan of care (and any other residents demonstrating sexually and physically aggressive responsive behaviours towards other residents), to ensure the plan of care and interventions to manage these responsive behaviours, are implemented, and that the plan of care is reviewed and revised, when no longer necessary or determined to be ineffective is provided to the resident, as indicated in the plan.
2) to ensure there is a process in place to monitor that the resident s are reassessed
and the plan of care is reviewed and revised at least every six months, and at
any other time, when the resident's care needs change; to ensure the plan of care is reflective of resident care needs, related to the identified residents (and any other resident s demonstrating physically aggressive and sexually inappropriate responsive behaviours), towards other residents.

The plan shall be submitted in writing and emailed to LTC Homes Inspector, Lynda Brown at lynda.brown2@ontario.ca on or before June 30, 2015. The plan shall identify who will be responsible for each of the corrective action listed.

Grounds / Motifs :

1. 1. Related to log #002270:

The licensee has failed to ensure the care set out in the plan of care, was provided to Resident #16, as specified in the plan, related to bed mobility and transferring.

A critical incident report (CIR) was received by the Director on a specified date for an allegation of staff to resident abuse/neglect incident that occurred. The CIR indicated that three days earlier, at a specified time, Resident #16 reported had been physically abused by Staff #108.

Review of the plan of care(in place at time of incident)for Resident #16 indicated under transferring & bed mobility indicated the resident was to be transferred safely with assistance of 2 staff and a full mechanical lift, to instruct the resident to bend knees and assist with pushing self up in bed with two staff assistance, and requires 2 staff to get from laying to sitting position.

Review of the home's investigation indicated on a specified date, Staff #112 had entered Resident #16 (to assist Staff #108) with a transfer. When Staff # 112 entered the resident's room, found the resident sitting on side of bed "crying and visible upset".Therefore, the resident had been repositioned (from lying to sitting) on the side of the bed with only the assistance of one staff member and resulting in pain. [s.6.(7)]

2. The licensee has failed to ensure when the resident was reassessed and the plan of care was reviewed, it was revised when the resident's care needs changed, or was no longer necessary, or the care was no longer effective for Resident #4, related to responsive behaviours.

Related to log #001522:

Note:There was previous non-compliance in 2014 related to Resident #4 for resident to resident sexual abuse.

A critical incident report (CIR)was received by the Director on a specified date for a suspected incident of resident to resident sexual abuse. The CIR indicated the incident occurred two days before when Resident #5 was found in Resident #4 room, sitting across from Resident #4, with Resident #4 pants unfastened. Both residents are cognitively impaired. The CIR indicated Resident #4 "has a previous history of sexually inappropriate behaviours". The CIR indicated no injuries to Resident #5. The actions taken by the home to prevent a recurrence included: BSO referral, door alarm to Resident #4 (to alert staff), and placed on every 15 minute checks.

Review of the progress notes for Resident #4 (for an eight month period) indicated:
-on a specified date and time, Resident #18 had wandered into the resident's room (to lay on the bed). The resident was on "every 15 minute checks".
-4 days later, Resident #18 entered the resident's room and the resident grabbed the co-resident(no injuries noted).
-3 days later, an unidentified resident wandered into the resident's room and was

redirected. The resident "Remains on every 15 minute checks".
-the following month, indicated on "every 30 minute checks for aggressive behaviour towards other residents".
-the following month, an unidentified resident was found in the resident's room attempting to hit the resident with a shoe (no injuries noted).
-3 days later, (not two days later as indicated on the CIR) staff witnessed Resident #5 sitting in a wheelchair in Resident #4 room. Resident #4 was sitting in a chair across from the resident with pants zipper was undone. Resident #5 was removed from the room. Staff noted "unaware of exact time last seen" but was last sitting at nursing station and "Every 15 minute checks" were started for 3 days.
-6 days later, BSO indicated "no further incidents or behaviours" but "DOS and every 15 minutes checks started".
-3 days later, staff indicated "spoke to maintenance to put a door alarm on resident's door to alert staff to all who come and go from room". The "door alarm in place and care plan updated".
-8 days later, the resident was relocated to a room closer to nursing station "for closer observation".
-7 days later, the resident was observed removing the yellow wander-guard strip from door, and attempting to wander into other resident's rooms. The resident "was angry" with redirection and threw the wander-guard at staff. Extra staff were called to the unit for assistance. The resident expressed being "upset" with use of door alarm and staff turned off the door alarm. Later in the shift the resident was observed "quickly entering and exiting the room to avoid setting off the door alarm. Remains on every 15 minute checks".
-2 days later, the resident was found hiding the yellow wander-guard.
-11 days later, the BSO noted "resident remains on BSO program, on every 15 minute checks, staff to ensure door alarm and yellow wander-guard is in place".

Observation of Resident #4 (over a two day period)indicated the resident's door was closed and the door alarm was in place and activated. There was no yellow wander guard in place.

Interview of Staff #116 indicated Resident #4 is unpredictable, can be physically & verbally aggressive towards staff and other residents, and has a history of sexually inappropriate behaviour (towards staff and other residents). Staff #116 indicated the resident no longer uses the yellow wander guard as "the resident doesn't understand what it is for and removes it". Staff #116 indicated the resident is on every 30 minutes checks and door alarm in place/activated "unless the resident deactivates it

or demands the door remain open and then staff have to turn it off".

Interview of BSO staff indicated the resident frequently will remove the yellow wander-guard and hide in room but it is to remain in place. The BSO staff indicated the resident always had a door alarm (previous to incident on the CIR) but the resident kept turning it off. The BSO staff indicated a different door alarm was put in place (8 days later) which was placed higher and more difficult for the resident to deactivate.

Review of the plan of care for Resident #4(in place prior to incident on CIR) indicated the resident demonstrated the following responsive behaviours:
1) wandering: staff allow the resident to wander the unit safely, door alarm in place to notify staff (when resident is in and out of the room) and if co-resident's are entering the residents room, staff are to respond promptly, and yellow wander-guard placed at door to prevent co-residents from entering.
3)Socially inappropriate or disruptive (teases other residents, "overly friendly" with specific co-residents (touching, will take them into own room, uses sexual inappropriate words towards staff, exposes/touches own genitals in presence of specific co-residents). Interventions included: staff to re-direct resident to own room if speaking in a sexually inappropriate manner, remove other co-residents who may react or resident may act inappropriate with, initiate behaviour tracking every 15 minutes (for a previous incident of inappropriate touching of a specific resident and exposing genitals, door alarm on door frame, avoid sitting resident next to any female residents if possible, monitor resident if wandering unit and if approaches other specific residents, remove specific resident if resident not able to be redirected, referral to Ontario Shores, monitor groin area for irritation to determine possible cause of exposure of private areas, and remind resident of unacceptable behaviour.

Therefore, the interventions of a door alarm, and yellow wander-guard, that were to be used to manage the responsive behaviours of sexually inappropriate behaviour, were supposed to be already in place (prior to the incident on the CIR and despite being indicated on CIR as actions taken to prevent recurrence), and when those interventions were determined to be no longer necessary or ineffective (as the resident and/or staff would remove/deactivate), the plan of care was not revised until 8 days later (when a new door alarm was applied). The care plan indicated the yellow wander-guard that was to be used (and which the resident continuously removed and continued to remain ineffective) was also not in place over a two day period (to prevent other residents from entering the resident's room). The progress

notes also indicated "a door alarm was not in place" until eight days after the the incident occurred. [s. 6. (10)]

3. Related to log #002174:

A critical incident report was received by the Director on a specified date for a resident to resident physical abuse incident. The CIR indicated on the same day and at a specified time, Resident #7 was found on the floor in own room and had reported to staff the resident "had been kicked" by Resident #8. Resident #7 sustained a an injury requiring transfer to hospital as a result. The long term actions indicated Resident #7 "already had a door alarm in place but was only activated during the night and will now be activated 24/7". Resident #8 "had a door alarm" put in place and both residents were "to be monitored every 15 minutes and already on BSO program".

Review of progress notes for Resident #8 (for a three month period) indicated:
-on a specified date, BSO noted "not showing any aggressive behaviour for 3 weeks so every 15 minute checks discontinued".
-13 days later, the resident was found in Resident #12 room sleeping in the resident's bed. Resident #12 was found sitting in wheelchair in the room.
-4 days later, BSO noted "discontinued from the BSO program due to no documentation of resident having any behaviours".
-10 days later, staff were attempting to redirect the resident out of Resident #13 room but resident became "physically abusive".
-5 days later, Resident #7 was found in own room sitting on the floor complaining of pain and injury to a specified area, requiring transfer to hospital. The resident reported Resident #8 had "kicked the resident" and Resident #8 was found sleeping in Resident #7 bed.
-13 days later, BSO noted "resident monitoring decreased from every 15 minutes to every 30 minutes as behaviours has now decreased".

Review of the care plan for Resident #8 (in place prior to incident on CIR) indicated the following responsive behaviours/interventions:
1) wandering: allow to wander in safe supervised areas of secure unit, seek and determine resident's whereabouts to ensure is safe, determine if any reason for wandering (eg. toileting needs), in BSO program, and respond to door alarms promptly.
2) physically abusive behaviour (unpredictable-will hit out at staff and other

residents). Interventions included: 1:1 staff when needed, redirect from other residents when needed, ensure door alarm is on when in room so staff alerted when the resident leaves the room, on every 15 minute checks for responsive behaviour (but discontinued if no behaviours noted in last 3 weeks).

Observation of Resident #8 room (on a specified date) indicated a staff member entered the resident's room. The staff member deactivated the door alarm and then failed to reactivate the door alarm upon exiting the room.

Review of the plan of care for Resident #7 related to responsive behaviours of wandering also indicated the resident already had a door alarm in place (prior to incident on the CIR) and did not indicate the door alarm was only activated "during the night" as indicated on the CIR.

Therefore, the interventions of a door alarm for Resident #8, (that was to be used to manage the responsive behaviours of physical aggression and wandering)were already in place prior to the incident, (despite what was indicated on CIR as actions taken to prevent recurrence). There was no indication in the progress notes that the door alarm for Resident #8 was activated (on three separate dates) when the resident was wandering into other resident's room. The plan of care for Resident #7 also already had a door alarm that was already in place as an intervention to manage the responsive behaviour of wandering and did not indicate was to be only activated during the night (as indicated on the CIR). The other interventions to manage Resident #8 responsive behaviour(BSO monitoring) was also discontinued despite the resident demonstrating aggressive /wandering behaviours. [s. 6. (10)]

4. Related to log #001441:

A critical incident report(CIR) was received by the Director on a specified date for an allegation by Resident #3 of sexual assault. The CIR indicated the incident occurred two days before at a specified time. In the "description of the occurrence" the resident was assessed (when returned to bed) and indicated "excoriation and swelling" and a small injury was noted to the same area. The resident also reported "someone came into my room" and sexually assaulted the resident.

Interview of Staff #101 indicated Resident#3 “has a history of" displaying and vocalizing inappropriate sexual responsive behaviours.

Interview of Staff #103 stated "I have heard on report in the past that [Resident #3] has displayed and vocalized some inappropriate sexual behaviours".

Interview of BSO team member #104 indicated BSO team was not aware of Resident #3 demonstrating “inappropriate sexual responsive behaviours” until after the allegation (that was made and on CIR) and a referral to BSO was received.

Interview of RAI-Coordinator indicated the plan of care for Resident #3 was revised after the allegation of sexual abuse was made.

Review of the progress notes for Resident #3 indicated:
- on a specified date and time, the resident was calling for help and complained of soreness to a specified area. The resident was assessed and treatment was provided to the reddened area. Staff noted the resident "has habit of" rubbing the specified area "causing redness" and expresses loneliness.
-3 days later, the RPN indicated “during supper, resident complained of soreness” to a specified area. The resident was assessed later that evening (after going to bed). Staff noted excoriation, swelling to the specified area and scant amount of blood. Resident reported "someone came to the room" and sexually assaulted the resident. Resident also stated "it was dark and screamed for help and no one came". No screaming was noted throughout the shift. POA was notified and "note left for MD". Treatment cream applied.
-2 days later, BSO member indicated “resident referred to BSO r/t unusual behaviour of sexually inappropriate comments/yelling in public areas (dining room). The resident has been expressing loneliness, has been reported to be displaying inappropriate sexual responsive behaviours in public areas and asking staff to assist with these behaviours. Staff noted the behaviours have been worsening "over the last 2 weeks”. Diagnostic test completed to rule out infection and placed on every 30 minute checks. Staff to report any unusual/escalated behaviour exhibited by resident and rule out any physical cause (infections, discomfort, etc.). New order received from physician to restart antidepressant (was discontinued), further diagnostic test to rule out infections, and request Nurse Practitioner (NP) to complete an exam to the specified area. The NP completed the exam and indicated the resident reported "has been rubbing" to stop the discomfort that is ongoing. Staff provided specific cleaning instructions to specified area and a new order for treatment cream. Later that evening, police arrived for investigation of incident.
-the following day, the staff documented the resident was yelling out for help and reporting someone was inappropriately touching the resident but no one had entered

the resident's room and remains on every 30 minute checks.
-two days later staff documented the resident remained on behavioural tracking as still vocalizing sexually inappropriate words.

Review of the care plan (was revised post incident)for Resident #3 indicated socially inappropriate or disruptive behaviour: reported to display and vocalize sexually inappropriate behaviours in public areas which was triggered with decrease in antidepressant. Interventions included: rule out possible causes (irritation, itchiness, or discomfort/rule out infection), move resident to private room if displaying sexually inappropriate behaviours, remind/discourage resident of inappropriate comments disrupting other residents, assess symptoms and review medications. Staff to apply barrier treatment cream as ordered, keep skin dry and clean, staff to complete daily skin assessments and report to charge nurse any problems, report to charge nurse any displaying towards self of sexually inappropriate behaviours, notify MD/NP if irritation persists (to assess), and avoid using soap to area.

There was no indication the plan of care was reviewed and revised when the resident's needs/condition changed (re: possible infection as displayed as sexually inappropriate responsive behaviours) as the resident had been exhibiting responsive behaviours (that were not documented) and displaying alteration in skin integrity (as a result of the responsive behaviours) and interventions were not implemented until after the resident expressed "someone came into my room" and sexually assaulted the resident.[s.6.(10)(b)] (111)

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

Aug 15, 2015(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et 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

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 28 day of September 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

Service Area Office /
Bureau régional de services : Ottawa