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

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

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Inspection de soins de longue durée

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Apr 25, 2017;	2017_620126_0001 (A1)	035422-16	Resident Quality Inspection

Licensee/Titulaire de permis

GENESIS GARDENS INC
438 PRESLAND ROAD OTTAWA ON K1K 2B5

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

FOYER ST-VIATEUR NURSING HOME
1003 Limoges Road South Limoges ON K0A 2M0

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

LINDA HARKINS (126) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

As requested by Administrator an extension of compliance due date to complete education with all staff

Issued on this 25 day of April 2017 (A1)

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

Original report signed by the inspector.

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LINDA HARKINS (126) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): Janaury 10, 11, 12, 13, 16, 17, 18, 19, 20, 23, 24, 2017

The following inspections were completed during this Resident Quality Inspection:

Two critical incidents related to fall that resulted in an injury and two critical incidents related to an allegation of resident to resident physical abuse

During the course of the inspection, the inspector(s) spoke with residents, family members, the President of the Family Councils, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the RAI Coordinator and Infection control Officer, the Food Service Attendants, the Food Services Supervisor, the Registered Dietician(RD), the Activity Director (AD), the Assistant Activity Aid (AAA), the Geriatric Psychiatry Outreach nurse, the Assistant Director of Care (ADOC), the Director of Care (DOC) and the Administrator.

The inspectors toured the home and observed resident care being provided, medication administration passes and infection prevention and control practices and several meal services. The inspectors reviewed resident health care records and the resident and family Councils meeting minutes. The inspectors reviewed documentation related to the home's investigations into the above critical incidents and policies related to the home's prevention of abuse programs and

the fall program.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

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

14 WN(s)
4 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 failed to protect resident #025 from sexual abuse by resident #035.

O. Reg. 79/10 s. 2(1) b defines sexual abuse as any non-consensual touching,

behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a person other than a licensee or staff member.

On January 10, 2017 an inspection began for the Resident Quality Inspection for 2017 that identified that resident's #035's has worsening responsive behaviours based on the home's Minimum Data Set (MDS) evaluations from September 2016.

Resident #035 was admitted to the home in 2014 with several medical diagnoses including a neurological disease. Resident #035's MDS assessment dated a specific day of September 2016 indicated mood behaviours of socially inappropriate/disruptive behavioural symptoms that occurred one to three days in last seven days and that this behaviour was not easily altered. Resident #035 was assessed by an external team for behaviours of sexual inappropriate touching of residents in the home on a specific day of April 2016. Resident #035's current plan of care, in place in the resident's chart since May 2016, indicated that the resident is at risk for sexually abusive behaviours. Resident #035's plan of care further indicated that the resident's cognition was poor for orientation/recall related to the neurological disease, confusion and memory loss.

Resident #025 was admitted to the home in 2012 with several medical diagnoses. Resident's current plan of care in the resident's chart dated a specific day of February 2016, indicated resident #025 requires total dependence of two staff for mobility while in bed. Resident #025 is cognitively impaired with short and long term memory loss.

On a specific day of September 2016 resident #035 was witnessed by RPN #107 to be sitting at resident #025's bedside inappropriately touching resident #025 inside the front of the brief.

The home's internal incident report completed by RPN #107 documented that the police were not called as identified in WN #12 of this report.

This report further indicated, that staff need to ensure that resident #035 is to be nowhere near resident #025's room and to place a door barrier across the door as intervention. This intervention was not in place as identified in WN #9 of this report. The home internal incident report was evaluated by the DOC the next day, who added interventions to sit resident #035 in a lazyboy style chair in the room room after supper to assist nursing staff in keeping resident #035 away from resident #025 in the evening as identified as trigger time for resident # 035's inappropriate

actions. This intervention was not added to resident #035's plan of care until four month later, when Inspector #547 brought it to the DOC's attention as identified in WN #9 of this report.

RPN #107 and the DOC indicated to Inspector #547 that they did not report this incident of witnessed resident to resident sexual abuse immediately when they became aware of the incident to the Director of the Ministry of Health and Long-Term Care (MOHLTC) as identified in WN #2 of this report.

On a specific day of January 2017 resident #035 was witnessed by PSW #114 to be sitting at resident #025's bedside inappropriately touching inside the back of the resident #025's brief.

RN #113 did not complete any internal incident report immediately as required by the home's policy and procedures for abuse as identified in WN #7 of this report.

RN #113 did not report this incident to the police as identified in WN #12 of this report.

RN #113 did not report this incident to the Director (MOHLTC) as identified in WN #2 of this report.

The DOC reported this incident report to the Director (MOHLTC) in January 2017, five days after becoming aware of this incident of witnessed resident to resident sexual abuse.

The licensee failed to comply with:
1. LTCHA 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: 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.(Refer to WN #2)

2. LTCHA, 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). (Refer to WN #08)

3. O. Reg 79/10 s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible; and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. (Refer to WN #9)

4. O. Reg 79/10 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. (Refer to WN #11)

5. 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. (Refer to WN #12)

The severity of harm in the above incident was determined to be "actual harm" and the scope was identified as "pattern" as three out of four documented incidents of witnessed sexual abuse was directed towards resident #025 by resident #035 between a specific day in January 2015 and January 2017. [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 O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).
3. The type and level of assistance required relating to activities of daily living. O. Reg. 79/10, s. 24 (2).
4. Customary routines and comfort requirements. O. Reg. 79/10, s. 24 (2).
5. Drugs and treatments required. O. Reg. 79/10, s. 24 (2).
6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions. O. Reg. 79/10, s. 24 (2).
7. Skin condition, including interventions. O. Reg. 79/10, s. 24 (2).
8. Diet orders, including food texture, fluid consistencies and food restrictions. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home and shall include the following:

1. Any risks the resident may pose to himself, including any risk of falling, and interventions to mitigate those risk.
3. The type and level of assistance required relating to activities of daily living.
4. Customary routines and comfort requirements.

The licensee shall ensure that the care plan sets out, the planned care for the resident; and clear directions to staff and others who provide direct care to the resident .

The home as identified that the plan of care refers to the kardex, the care plan, the

resident's flow sheets, the MARS, the TARS, the shift report, any assessment kept in the resident's health care record and a bed side tool located at each resident's bed side.

A Critical Incident was submitted on a specific day of October 2016 to the Ministry of Health and Long Term Care in regards to resident #039 having a fall, three days prior, which resulted in a fracture.

A review of resident #039's health care record was done by Inspector #592. The health care record indicated that resident #039 was admitted in 2016 with several diagnoses. The resident's health care record further indicated that the next day, the following assessment were completed upon admission:

Dental Assessment
Skin Assessment
Physiotherapy Assessment
Initial Admission Nursing Assessment
Fall Assessment
Continence Assessment
Dietary Assessment
Bed Tool Assessment

A review of the Admission Nursing Assessment for resident #039 was done by Inspector #592. The Nursing Assessment indicated that the resident was assessed on a specific day of October 2016 with unsteady gait, dizziness and was identified as suddenly loosing her/his balance when getting up. The Nursing Assessment further indicated that the usual bedtime for the resident was at 1900 hours and that resident #039 was continent. The resident's bed side tool dated a specific day of October 2016 was also reviewed and indicated that resident #039 was requiring assistance of one staff member for transferring.

In a review of resident #039 health care record, Inspector #592 was unable to find a 24-hour admission care plan developed for the resident following the results of the resident Nursing Assessments. The care plan available for the resident was dated a specific day of January 2017.

On January 20, 2017, during an interview, PSW #122 informed Inspector #592 that she was taking care of resident #039 prior to the injury. She further indicated that upon admission, resident #039 was using a wheelchair to mobilize on the unit but

that often resident #039 was trying to get up on her/his own but was too weak, therefore was requiring assistance from staff members. She further indicated to the Inspector that when the incident occurred, resident had tried to get up independently with no assistance. Upon asking PSW #122 about the process on how was information about newly admitted resident given to staff, the PSW indicated to the Inspector that the staff will be informed through the 24 hour nursing report for any specific interventions and that the staff will adapt to the resident. PSW #122 further indicated that if there are any concerns, staff will ask the nurse to clarify resident's need, but that these were communicated verbally, as there was no documentation available other than the progress notes, the 24 hour nursing report and the bed assessment tool located in all the residents’ rooms.

On January 20, 2017, during an interview, PSW #120 indicated to Inspector #592 that she was taking care of resident #039 prior to the injury. She further indicated that upon admission, resident #039 was ambulating independently and was independent with limited assistance. PSW #120 further indicated to the Inspector that upon a new resident admission, the staff will be informed through the 24 hour nursing report and by registered staff if any specific interventions were required. She further indicated that PSW would refer to the resident’s chart if any questions and uses their own judgement for providing the care.

On January 20, 2017, during an interview, RN #119 indicated to Inspector #592 that upon a new resident admission, the registered staff are to assess the resident by completing the admission/assessment form which includes different assessments and communicate any specific interventions verbally at the 24 hour nursing report for four consecutive shifts. RN #119 further indicated that no care plan is developed for the newly admitted residents.A care plan is only available once the RAI coordinator has completed the care plan is made available to staff. She further indicated that she was unable to access any electronic care plan, as it was only the RAI Coordinator who has authorized access.

On January 20, 2017, during an interview, the RAI Coordinator indicated to the Inspector that within 24 hour of a resident's admission, assessments were initialized and left for all staff members to fill out for a length of seven days. She further indicated that after the seven days assessment, the information was reviewed and that a written care plan is to be developed and completed within 21 days of the resident admission. The RAI Coordinator indicated that there no 24-hour admission care plan developed for all the newly admitted resident, until she was done collecting the data obtained from the seven day observations flow

sheets. She further indicated that she was not able to keep up with her assignments, therefore resident #039's care plan was not developed and completed until a specific day of January 2017, eighty nine days after the admission.

On January 20, 2017, during an interview, the ADOC indicated to Inspector #592 that upon admission, resident's assessments were completed and that a bed side tool was developed following the assessments to guide staff members for the resident's transfers. The ADOC indicated that there was no care plan developed for new resident until they were completed and made accessible by the RAI Coordinator.

In addition the licensee has failed to ensure that the resident is reassessed and the care plan is reviewed and revised when the resident's care needs change.

In a review of resident #039's health care record done by Inspector #592, the progress notes indicated that following the return of the resident from the hospital on a specific day in October 2016, the resident had a significant change in his/her physical status. The progress notes indicated that resident #039 was now wearing a cast , requiring 2 person assistance for transfers and was also using a wheelchair to mobilize on the unit. The progress notes further indicated that the resident had poor weight bearing and pivoting and was now requiring pericare.

On January 24, 2017, during an interview, the DOC, indicated to the Inspector that when a resident care needs change, the plan of care will be reviewed to reflect the current need for the resident. She further indicated that resident #039 had a significant change in his/her physical status upon the return from the hospital and that no care plan was reviewed and revised as there was no care plan developed at that time for the resident. The DOC further indicated that the staff were using the home's bed side tool for quick reference to guide them for the type of transfer and that the tool was not updated after the resident came back from the hospital.

In a review of the home's bed side tool, accessible to nursing staff members, there was no indication noted for the type and level of assistance required by resident #039 relating to activities of daily living and the customary routines and comfort requirements. Before and after the resident's fall and injury, the home's bed side tool did not have any indication for any risk that resident #039 may pose to herself/himself, including any risk of falling, and interventions to mitigate those risks.

On January 24, 2017, Inspector # 126 reviewed the health care records for resident's #014, admitted on a specific day of September 2016 and resident # 048, admitted on a specific day of November 2016. The following assessments were completed on admission for both residents: dental, skin, physiotherapy, continence, dietary , bed tool and initial admission nursing assessments.

The severity of harm in the above incident was determined to be "potential harm" and the scope was identified as "widespread" as indicated in the interviews with the nursing staff, that all newly admitted residents did not have a 24 hour care plan developed for each resident. [s. 24. (2)]

Additional Required Actions:

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

WN #3: 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. The licensee has failed to ensure that any alleged, suspected and witnessed incident of resident to resident sexual abuse, that was immediately reported to the licensee, was immediately investigated.

On a specific day of January 2017, PSW #114 immediately reported to RN #113 that she had observed resident #035 seated at resident #025's bedside with the hand inside the back of resident #025's brief.

PSW #114 indicated to Inspector #547 that on that specific day of January 2017, she intervened immediately and had to physically remove resident #035's hand as the resident was not listening to verbal redirection. PSW #114 then went to report this incident to the RN in charge that evening, RN #113.

RN #113 indicated to Inspector #547 that he went to resident #025's room and resident #035 then had his/her hand on the top of resident #025's hip over the resident's brief, again, and RN #113 removed resident #035 from this bedroom and redirected the resident to the lounge. RN #113 indicated to the inspector that he did not complete any internal incident report, investigate the witnessed abuse, or call any police or Substitute Decision Maker (SDM) when this incident immediately occurred. RN #113 indicated that he wrote a progress note in resident #035's file, and a note in the 24 hour shift report book at the end of shift and no other action was taken by the RN.

On January 16, 2017, the DOC indicated to Inspector #547 that she was made aware of this incident of resident to resident abuse on the next morning shift report. The DOC indicated to Inspector #547 that no investigation had been initiated into the alleged incident of resident to resident sexual abuse to date. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that an alleged, suspected and witnessed incident of resident to resident sexual abuse, that was immediately reported to the licensee, was immediately investigated., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 25. Initial plan of care

Specifically failed to comply with the following:

s. 25. (1) Every licensee of a long-term care home shall ensure that,
(a) the assessments necessary to develop an initial plan of care under subsection 6 (6) of the Act are completed within 14 days of the resident's admission; and O. Reg. 79/10, s. 25 (1).
(b) the initial plan of care is developed within 21 days of the admission. O. Reg. 79/10, s. 25 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an initial plan of care is developed within 21 days of admission.

Resident #014, #039 and #048 health care records were reviewed by Inspector #592 and #126.
Resident #014 was admitted on a specific day of September 2016 and the initial plan of care was put in place three months later.
Resident #039 was admitted on a specific day of October 2016 and the initial plan of care was put in place three months later.
Resident #048 was admitted on a specific day of November 2016 and the initial plan of care was not located as of January 2017.

On January 20, 2017, during an interview, the RAI Coordinator indicated to the Inspector that within 24 hours of a resident admission, admission assessments were initialized and left for all staff members to fill out for a period of seven days. She further indicated that after the seven days assessment, the information is reviewed and a plan of care is to be developed within 21 days of the resident admission. The RAI Coordinator indicated that there no plan of care is developed for all the new residents admitted to the home until she has completed collecting the data obtained from the seven day observations flow sheets. She further indicated that she has not been able to keep up with her assignments, therefore resident #014 and #039 plan of care were not developed within the 21 days of their admissions. She further indicated to the Inspector that she was still working on developing resident #048's plan of care. [s. 25. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the initial plan of care is developed within 21 days for all new admitted residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the menu cycle was reviewed by the Residents Council.

The home does have a Resident Council that meet on a quarterly basis. The last meeting was held in October 2016.

On January 16, 2017, the Activity Director(AD) indicated to Inspector #126 that each department was responsible to complete the "multidisciplinary referral" which include information regarding their individual program such as new things, activities and changes. This information is share with the Resident Council. The AD indicated that the Resident Council does not always have group meeting and that they will speak to residents' individually in their rooms because there is not a lot of residents participation to the Resident's Council meeting.

On January 17, 2017, the Food Service Supervisor(FSS) indicated to Inspector #126 that she does not participate at the Resident Council meeting in person as it is expected process that she complete the "multidisciplinary referral" and the information gathered is shared with the Council by the AD. She indicated , that in October 2016 she was instructed by the AD, to meet individually with residents to discuss the menu cycle. To this date, five of 57 residents have been individually consulted about the home menu cycle. The FSS indicated that she did not discuss the menu cycle with all other residents.

On January 17, 2017, the Administrator indicated to Inspector #126 that he was aware that the AD would discussed individually with the residents and that a Resident Council group meeting was not always held will all the residents.

It was documented in the December 16, 2016, Resident Council 's minutes, that the AD and Assistant Activity Aid (AAA) spent between 20-30 minutes visiting several residents individually. Out of 57 residents, 16 residents were visited and information(Christmas Party, Influenza Vaccins..) documented on the "multidisciplinary referral" was given those residents.No information was included in those minutes related to the FSS sharing menu cycle information with the residents.

The menu cycle was not presented to the Residents Council. [s. 71. (1) (f)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the menu cycle was reviewed by the Residents Counclil, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that included appropriate furnishings and equipment in resident dining areas.

During the inspection, Inspector #592 observed four semi-circle dining tables in the main dining room. The remainder of the tables in the main dining room were standard square tables, each seating four residents during the meal service.

During the lunch meal service, January 10, 2017, Inspector #592 observed residents seated in the dining room at the ends of a semi-circle table, however there was inadequate space at the table for these residents therefore they were seated at the end with no allocated table space. Six residents were observed with

no appropriate furniture.

During the lunch meal service, January 12, 2017, Inspector #592 observed residents seated in the dining room at the ends of a semi-circle table, however there was inadequate space at the table for these residents therefore they were seated at the end with no allocated table space. Five residents were observed with no appropriate furniture.

During the breakfast meal service, January 16, 2017, Inspector #592 observed residents seated in the dining room at the ends of a semi-circle table, however there was inadequate space at the table for these residents therefore they were seated at the end with no allocated table space. Four residents were observed with no appropriate furniture.

A review of the seating plan for the main dining room, found that table’s one, two, five and seven were a semi-circle table with the seating plan indicating that seven residents were assigned to each of these tables.

On January 16, 2017, during an interview with the Food Service Supervisor, she indicated to Inspector #592 that she was aware that the lack of furnishing was a concern as it was brought forward on a previous inspection and no action have been taken at this time to address the lack of furnishings.

On the same day, during an interview, the Administrator, indicated to Inspector #592 that lots of issues following the last inspection were resolved in the dining area but that the home did not have the time to focus on the issue with appropriate furnishings and equipment for the residents.

A VPC was issued in September 2016, inspection # 2016_285126_0019 following the RQI inspection. [s. 73. (1) 11.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all resident's have appropriate furnishing and equipment at meat time, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In accordance with s.48 (1), of Regulation 79/10, the licensee shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

A review of the licensee's policy titled “Fall Prevention and Falls Risk Management”, last revised in 2013, indicated under Post Fall Incident the following:

Tab. 4: After assessing the resident and appropriate interventions is taken the registered staff will complete an incident report.

Tab. 6: Update plan of care to ensure that interventions appropriately reflect the residents needs to prevent further falls or injury.

Tab.11: If more than two incidents in the same month, resident will be assessed by PT or OT and physician to rule out any physical problem or medication effect.

Tab.12: DOC or ADOC will review all incident reports and documentation for accuracy of data entry to assure corrective actions are in place and outcomes.

Inspector #592 reviewed the health care record of Resident #038. Resident #038 was admitted to the home in 2015, with multiple diagnoses including dementia and cardiac conditions. The health care record also indicates that resident #038 was using a wheelchair and moving his/her feet to mobilize on the unit.

The health care record further indicates that the resident has had four falls between the periods of November 2016 to December 2016.

A review of the resident's current care plan was done by Inspector #592. The current care plan was dated December 2015 and was last updated in October 2016. The care plan indicated that resident #038 was identified as being at high risk for falls related to cognitive and physical impairment. Interventions identified in the care plan were to provide the resident with the call bed when in bed and to regularly check on the resident. A sensor pad alarm was also noted to be part of the interventions in the past but was removed in June 2016.

On January 18, 2017, during an interview, PSW #110 indicated to Inspector #592 that resident #038 was at high risk for falls because the resident often will not use the call bell for assistance and will transfer independently. She further indicated that the current interventions were to ensure that resident #038 has the call bell within reach and the wheelchair besides the bed to prevent him/her from getting out of bed on his/her own. PSW #110 further indicated to Inspector #592 that she was aware that the resident had frequent falls but that the interventions remain the same as she did not received any other instructions regarding fall prevention interventions.

On January 18, 2016, during an interview, RPN #103, indicated to Inspector #592 that resident #038's falls because the resident is sitting at the edge of the bed and then slides on the floor. RPN # 103, indicated that she was not aware that resident

038 had several falls. She indicated that there was no specific interventions in place to prevent the falls, other than giving the calling bell.

On January 18, 2016, during an interview, the ADOC indicated to Inspector #592 that resident #038 plan of care was last reviewed in October 2016. She further indicated that as part of the home’s policy and program, each time a resident has a fall, the registered staff will complete an incident report which include a follow-up with analysis of factors preceding the fall. The incident report shall include suggestions such as implementing bed rails, bed alarms and interventions will be put in place to prevent further falls. She further indicated to the Inspector that every incident report is reviewed by her or the DOC and are brought forward at the CQI (continuous Quality Improvement) meeting which is held quarterly. During the interview the ADOC indicated to Inspector #592 that resident #038 was stable and was not informed of any fall recently. The resident health care records was reviewed with the presence of the Inspector and the ADOC. The ADOC identified that resident #038 had 4 falls within a short period of time and that she was not made aware, therefore, no interventions and follow-ups were done for that resident. It was also noted by the ADOC and the Inspector that the four incidents reports were signed by the DOC.

On January 18, 2016, during an interview, the DOC indicated that all the incident reports were reviewed by her or the ADOC to assure that corrective actions were in place to prevent further resident falls. She further indicated that she has signed the four incidents but did not implement any interventions to assure corrective actions and minimize resident’s fall. [s. 8. (1) (a),s. 8. (1) (b)]

WN #8: 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 and that it is complied with.

The home's policy titled Preventing, Reporting and Elimination of Abuse related to Residents in the home that was last revised on November 2014. This policy's purpose indicated "The fragile and vulnerable condition of our aging population demands that the standard of care and safety far exceeds the norm".

O.Reg. 79/10, s.2(1) identified the definition of sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member such as another resident in the home.

RPN #107 reported to Inspector #547 on January 13, 2017 that on a specific day of September 2016, RPN #107 observed resident #035 at resident #025's bedside, inappropriately sexually touching resident #025.

RN #113 reported to Inspector #547 on January 19, 2017 that on a specific day of January 2017, PSW #114 observed resident #035 at resident #025's bedside, inappropriately sexually touching resident #025.

This Abuse policy indicated the following:
Staff reporting:
2. The individual to whom the incident has been reported will conduct an inquiry and complete a preliminary written report before going off duty.

On a specific day of January 2017 RN #113 was informed by PSW #114 that resident #035 was sexually inappropriately touching resident #025 inside the brief. RN #113 intervened and removed resident #025 however did not complete any

internal incident report, that is identified in the home as the preliminary written report before going off duty.

RN #113 did not interview PSW #114 or begin any internal incident report as required by this policy.

6.(d) indicated the Ministry of Health will be notified of any incidents of suspected resident abuse at the earliest possible time (critical incident via electronic system)

On January 19, 2016 the DOC indicated to Inspector #547 that no critical incident report was sent to the MOH-LTC via the critical incident electronic system for the incidents of September 2016 and January 2017. The DOC indicated that she was made aware of each incident from the morning 24 hour shift reports, however did not report these to the Director.

The DOC further provided a copy of the home's Critical Incident System Reporting policy with effective date July 2016 that goes with the homes abuse policy for registered nursing staff in the home that indicates the following:

"RN/RPN on duty who is made aware of an incident that must be reported to the Director (MOHLTC) and does not have access to the on-line critical incident reporting system, should report immediately using the on call reporting after hours pager number for the Director (MOHLTC)".

RPN #107 indicated to Inspector #547 that she did not call the Director (MOHLTC) immediately following the incident of September 2016.

RN #113 reported to Inspector #547 that he did not call the Director (MOHLTC) immediately following the incident of January 2017.

On January 19, 2017, the DOC indicated to Inspector #547 that she was made aware of these incidents from the morning 24 hour shift report on the next morning in September 2016 and in January 2017 and did not call the Director (MOHLTC) or complete any incident report to the Director to date as required by this policy.

6.(d) further indicated resident's Substitute Decision-Maker (SDM) to be notified immediately or within 12 hours upon the administrator or designate becomes aware of the incident.

RN #113 reported to Inspector #547 on January 19, 2017 that he did not contact any SDM for resident's #025 or #035 to date. The DOC indicated that she called resident #025 and #035's SDMs five days after the incident occurred.

7. In all cases where sufficient evidence exists to substantiate an allegation of sexual abuse, the Administrator, DOC, ADOC or designate must notify the police.

On January 13, 2017 RPN #107 indicated to Inspector #547 that she did not call the police on that evening of September 2016 and completed an internal incident report that was provided to the DOC the next day, that was documented that the police was not called. RPN #107 indicated to Inspector #547 that she should have called the police but did not.

On January 19, 2017 the DOC indicated to Inspector #547 that the charge RN #113 on that specific day of January 2017 was the designated person to complete the internal incident report and call the police regarding this alleged, suspected incident of sexual abuse of resident #025 by resident #035.

As such, the Licensee's policies regarding: Preventing, Reporting and Elimination of Abuse related to Residents and Critical Incident System Reporting in place in the home when these incidents of alleged, suspected sexual abuse occurred between resident #035 and #025 on a specific day of September 2016 and on a specific day of January 2017 were not complied with. [s. 20. (1)]

WN #9: 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 the person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm, had occurred or may have occurred immediately report the suspicion and the information upon which it was based to the Director.

Resident #025 was admitted to the home in 2012 with several medical diagnoses. The health care record was reviewed and it was noted the following incident reports in resident #025's file.

Internal incident reports were completed for alleged suspected resident to resident sexual abuse of resident #025 by resident #035 on three incidents that occurred between January 2015 and January 2017. The first two incidents were never reported to the Director.

On January 18, 2017 the DOC indicated to inspector #547 that upon review of these incident reports for resident #025 and #046, that no critical incident system report was ever sent to the Director (Ministry of Health and Long-Term Care) as she would stapled it to the incident report and copied it to the resident's chart. The DOC reported the incident of alleged suspected resident to resident sexual abuse of a specific day of January 2017 was reported five days after the incident occurred. The DOC further indicated that the home did not immediately report these suspicions and the information upon which they were based to the Director. [s. 24. (1)]

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

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies that were developed for resident #035 were implemented to respond to this resident when demonstrating responsive behaviours, where possible.

An Incident report was completed on a specific day of September 2016 regarding an incidence of inappropriate sexual abuse towards resident #035. Long term actions documented on this incident report identified to make sure resident #035 is to be kept away from resident #025's room and to place a door barrier across resident #025's bedroom door. Another intervention was to continue to have DOS monitoring every 30 minutes to be aware of resident location. DOC then documented on a specific day of September 2016 a new intervention to sit resident #035 in a lazyboy type chair in the bedroom after supper.

On January 18, 2017 Inspector #547 observed resident #035's DOS monitoring flow sheets for a period of seven day in September 2016 and noted that documentation of q-30 minute monitoring was not completed from 1400-2200 hours on the day of the incident of September 2016.

On January 17, 2016 Inspector #547 interviewed RPN #107 working on that specific day in September 2016 during the 1400-2200 hour shift when this incident occurred and identified a new intervention of utilizing the yellow door barrier across resident #025 doorway to prevent resident #035 from wanting to enter. RPN #107 indicated that she has never seen resident #035 remove door barriers or go underneath them and figured this would be an effective intervention. RPN #107

indicated the door barrier has not been used regularly for resident #025's room to date.

On a specific day of January 2017, resident #025 was inappropriately sexually touched by resident #035 in the bedroom on the evening shift.

Evening PSW #114 indicated to Inspector #547 that resident #025's bedroom doorway did not have any door barrier in place, and that this was rarely ever in place. PSW #114 further indicated that resident #035 was not transferred to a lazyboy type chair after supper most nights. Evening Charge RN #113 indicated that no door barrier was in place to resident #025's room, and that he was not aware that resident #035 was to be transferred to a lazyboy style chair in the room as an intervention for the responsive behaviours.

Inspector #547 reviewed resident #035's health records and noted that interventions developed for resident #035's responsive behaviours in September 2016 were not added to the resident's plan of care.

The DOC noted that the resident's plan of care was not updated with these interventions until January 16, 2017 when this was brought to the DOC's attention by the inspector. [s. 53. (4) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations

Every licensee of a long-term care home shall ensure that,

(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff were advised at the beginning of the evening shift on a specific day of September 2016 of resident #035's responsive behaviours towards nursing staff, that required heightened monitoring because those behaviours posed a potential risk to residents or others.

Resident #035's progress notes indicated on 0600-1400 hour shift on a specific day of September 2016 that resident #035 touched personal support staff between the legs inappropriately and required intervention to stop this activity by RPN #103.

RPN #103 indicated to Inspector #547 on a specific day in January 2017, that she recalled that she went to see the resident and told him/her that this inappropriate sexual behavior was not acceptable. She indicated that she told him/her to stop, and he/she did. Resident #035 does have short term and long term memory loss, so it is hard to know if he/she remembers. At the time when he/she is caught, the resident is aware that it is wrong. When provided explanation, the resident understands and is redirectable. But action re-occurs every few months.

Inspector #547 reviewed the 24 hour report book utilized for shift report in the home for communication purposes to staff coming on the next shift, and no indication of this inappropriate sexual touching for resident #035 was identified for heightened monitoring by staff.

Resident #035 was observed to sexually inappropriately touch resident #025 that same evening, six hours after the initial behaviour was noted with nursing staff. [s. 55. (b)]

WN #12: 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 resident #025's Substitute Decision Makers (SDM) were notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse of the resident.

On a specific day of January 2015 an incident report was completed in the home regarding an incident of sexual abuse. It was documented in this report that resident #035 was observed by PSW #105 to be seated in the wheelchair at resident #025's bedside. Resident #035 was noted to have his hand inside the front of resident #025's brief.

The resident's SDM was informed by the Director of Care, three days after the incident occurred.

On a specific day of March 2016 an incident report was completed in the home regarding an incident of sexual abuse. It was documented in this report that resident #035 was observed by PSW #117 to have a hand in between resident #046's legs while seated in the front lounge of the home. It was further documented that resident #046 was patting resident #025's knee during the incident. PSW #117 immediately separated both residents.

RPN #108 was made aware and completed the incident report for abuse three days after the incident. Resident's SDM was notified of this incident by RN #118,

two days after the incident occurred.

Seven days later an incident of sexual abuse occurred on a specific day in January 2017, an incident report was completed in the home. It was documented in this report that resident #035 was observed by PSW #114 to be seated at resident #025's bedside with the hand inside resident #025's brief .Charge RN #113 was immediately made aware and wrote in resident #035's progress notes about this incident.

Charge RN #113 reported to Inspector #547 on January 18, 2017 that he did not call any resident SDM regarding the incident of January 2017.

The DOC reported to Inspector #547 on January 18, 2017 that she was made aware of the sexual abuse incident of resident #025 the next day with the morning report the incident occurred, as RN #113 documented this incident in the 24 hour shift report book. Resident #025's SDM was notified by the DOC, five days after the incident occurred.

As such, resident #025's SDM's were not notified within 12 hours upon becoming aware of these incidents of sexual abuse. [s. 97. (1) (b)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse of residents that the licensee suspected may have constituted a criminal offences.

Resident #035 was admitted to the home in January 2014 with several medical diagnoses including a neurological disease. Resident #035's plan of care indicated the resident was risk for sexually abusive behaviour. Upon chart review of resident #035's file, four internal incident reports were completed between the period of January 2015 and January 2017 related to incidences of sexual abuse towards female residents in the home. In those four incidents reports, it was documented that the police were not notified.

On January 18, 2017 the DOC indicated to Inspector #547 that the police force was called for the incident of alleged sexual abuse of resident #025 that occurred on a specific day of January 2017, six days after the incident occurred. The DOC further indicated that the police force was not immediately notified for these incidents of alleged, suspected or witnessed incidents of sexual abuse by resident #035. [s. 98.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than three business days, of an incident that caused an injury to a resident for which the resident was taken to a hospital, but whereby the licensee was unable to determine within one business day whether the injury had resulted in a significant change to the resident's health condition.

In accordance with O.Reg, 79/10, s. 107 (7), a significant changes means a major change in the resident's health condition that will not resolve itself without further intervention, impacts on more than one aspect of the resident's health condition and requires an assessment by the interdisciplinary team or revision to the resident's plan of care. (030654-16)

Inspector #592 reviewed the health care records for resident #039. Resident #039 was admitted to the home on a specific day of October 2016. Two days later, resident #039 was found sitting on the floor on the left side of the bed with a blanket wrapped around the legs. The resident was sent to hospital on the same day due to pain. The progress notes indicates that the resident was sent back to the home on the same day with a diagnosis of a fracture resulting in a significant change in resident physical status.

On January 19, 2017, during an interview, the DOC indicated to Inspector #592 that she and the ADOC were the persons responsible to inform and send all the Critical Incident to the Director. She further indicated to the Inspector that resident #039's was sent out to the hospital and has returned on the same day with a diagnosis of fracture resulting in a significant change in her/his daily activities, therefore a critical report was sent to the Director within 10 days. The DOC indicated that she was not aware that the Director had to be informed no later than one business day.

The incident occurred was reported to the Director five days after the incident occurred. [s. 107. (3) 4.]

Issued on this 25 day of April 2017 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LINDA HARKINS (126) - (A1)
Inspection No. / No de l'inspection :	2017_620126_0001 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / Registre no. :	035422-16 (A1)
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 25, 2017;(A1)
Licensee / Titulaire de permis :	GENESIS GARDENS INC 438 PRESLAND ROAD, OTTAWA, ON, K1K-2B5
LTC Home / Foyer de SLD :	FOYER ST-VIATEUR NURSING HOME 1003 Limoges Road South, Limoges, ON, K0A-2M0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Benoit Marleau

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To GENESIS GARDENS INC, 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 :

The licensee shall prepare, submit and implement a plan to ensure the following:

- The members of the management team including registered nursing staff of the home are educated on the home's Preventing, Reporting and Elimination of Abuse-Resident Abuse and Critical Incident System Reporting policies to ensure that all members of the management team and registered nursing staff understand and implement the requirements as required.
- All staff are educated on how to identify and report resident to resident alleged, suspected or witnessed abuse in accordance with their policies
- All members of the management team and registered nursing staff are to be aware of how to document a concise description, assessment and investigation into this reported alleged, suspected or witnessed resident's abuse
- A system is developed whereby the Director of Care and/or delegate is reviewing all documentation and communication from the front line staff at least daily to determine if any alleged, suspected and witnessed resident's abuse has occurred in the home.
- A system is developed whereby when there is reasonable grounds to suspect
that resident's abuse has occurred, the home shall immediately document their investigation and ensure that all legislative requirements have been fulfilled.
- A system is developed whereby when there is a resident with responsive behaviours, that the resident is assessed, interventions are developed and implemented. These interventions are to be documented into the resident plan of care and that the plan of care is reviewed and revised as required.

The plan shall be submitted by February 22, 2017 to Lisa Kluke via fax at 613-569-9670

Grounds / Motifs :

1. 1. The licensee failed to protect resident #025 from sexual abuse by resident #035.

O. Reg. 79/10 s. 2(1) b defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed

towards a resident by a person other than a licensee or staff member.

On January 10, 2017 an inspection began for the Resident Quality Inspection for 2017 that identified that resident's #035's has worsening responsive behaviours based on the home's Minimum Data Set (MDS) evaluations from September 2016.

Resident #035 was admitted to the home in 2014 with several medical diagnoses including a neurological disease. Resident #035's MDS assessment dated a specific day of September 2016 indicated mood behaviours of socially inappropriate/disruptive behavioural symptoms that occurred one to three days in last seven days and that this behaviour was not easily altered. Resident #035 was assessed by an external team for behaviours of sexual inappropriate touching of residents in the home on a specific day of April 2016. Resident #035's current plan of care, in place in the resident's chart since May 2016, indicated that the resident is at risk for sexually abusive behaviours. Resident #035's plan of care further indicated that the resident's cognition was poor for orientation/recall related to the neurological disease, confusion and memory loss.

Resident #025 was admitted to the home in 2012 with several medical diagnoses. Resident's current plan of care in the resident's chart dated a specific day of February 2016, indicated resident #025 requires total dependence of two staff for mobility while in bed. Resident #025 is cognitively impaired with short and long term memory loss.

On a specific day of September 2016 resident #035 was witnessed by RPN #107 to be sitting at resident #025's bedside inappropriately touching resident #025 inside the front of the brief.

The home's internal incident report completed by RPN #107 documented that the police were not called as identified in WN #12 of this report.

This report further indicated, that staff need to ensure that resident #035 is to be nowhere near resident #025's room and to place a door barrier across the door as intervention. This intervention was not in place as identified in WN #9 of this report. The home internal incident report was evaluated by the DOC the next day, who added interventions to sit resident #035 in a lazyboy style chair in the room room after supper to assist nursing staff in keeping resident #035 away from resident #025 in the evening as identified as trigger time for resident # 035's inappropriate actions.

This intervention was not added to resident #035's plan of care until four month later, when Inspector #547 brought it to the DOC's attention as identified in WN #9 of this report.

RPN #107 and the DOC indicated to Inspector #547 that they did not report this incident of witnessed resident to resident sexual abuse immediately when they became aware of the incident to the Director of the Ministry of Health and Long-Term Care (MOHLTC) as identified in WN #2 of this report.

On a specific day of January 2017 resident #035 was witnessed by PSW #114 to be sitting at resident #025's bedside inappropriately touching inside the back of the resident #025's brief.

RN #113 did not complete any internal incident report immediately as required by the home's policy and procedures for abuse as identified in WN #7 of this report.

RN #113 did not report this incident to the police as identified in WN #12 of this report.

RN #113 did not report this incident to the Director (MOHLTC) as identified in WN #2 of this report.

The DOC reported this incident report to the Director (MOHLTC) in January 2017, five days after becoming aware of this incident of witnessed resident to resident sexual abuse.

The licensee failed to comply with:
1. LTCHA 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: 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.(Refer to WN #2)

2. LTCHA, 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). (Refer to WN #08)

3. O. Reg 79/10 s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible; and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. (Refer to WN #9)

4. O. Reg 79/10 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. (Refer to WN #11)

5. 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. (Refer to WN #12)

The severity of harm in the above incident was determined to be "actual harm" and the scope was identified as "pattern" as three out of four documented incidents of witnessed sexual abuse was directed towards resident #025 by resident #035 between a specific day in January 2015 and January 2017. [s. 19. (1)] (547)

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

Jun 09, 2017(A1)

Order # / Ordre no : 002 **Order Type / Genre d’ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks.
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks.
3. The type and level of assistance required relating to activities of daily living.
4. Customary routines and comfort requirements.
5. Drugs and treatments required.
6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions.
7. Skin condition, including interventions.
8. Diet orders, including food texture, fluid consistencies and food restrictions.
O. Reg. 79/10, s. 24 (2).

Order / Ordre :

The licensee shall ensure complete the following:
1. The licensee will immediately developed a 24 hours care plan in writing all new admission as of February 8, 2017, which will be communicated and made available to each staff members.
2. The 24-hour admission care plan should be developed in writing, available to all staff who provide direct care to the resident and shall include the following in addition to the tool presently used at the bed side of each resident:
Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks.
Any risks the resident may pose to others, including any potential behavioral triggers, and safety measures to mitigate those risks. The type of level and assistance required relating to activities of daily living
Customary routines and comfort requirements.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home and shall include the following:

1. Any risks the resident may pose to himself, including any risk of falling, and interventions to mitigate those risk.
3. The type and level of assistance required relating to activities of daily living.
4. Customary routines and comfort requirements.

The licensee shall ensure that the care plan sets out, the planned care for the resident; and clear directions to staff and others who provide direct care to the resident .

The home as identified that the plan of care refers to the kardex, the care plan, the resident's flow sheets, the MARS, the TARS, the shift report, any assessment kept in the resident's health care record and a bed side tool located at each resident's bed side.

A Critical Incident was submitted on a specific day of October 2016 to the Ministry of Health and Long Term Care in regards to resident #039 having a fall, three days prior, which resulted in a fracture.

A review of resident #039's health care record was done by Inspector #592. The health care record indicated that resident #039 was admitted in 2016 with several diagnoses. The resident's health care record further indicated that the next day, the following assessment were completed upon admission:

Dental Assessment
Skin Assessment
Physiotherapy Assessment
Initial Admission Nursing Assessment
Fall Assessment
Continence Assessment
Dietary Assessment
Bed Tool Assessment

A review of the Admission Nursing Assessment for resident #039 was done by

Inspector #592. The Nursing Assessment indicated that the resident was assessed on a specific day of October 2016 with unsteady gait, dizziness and was identified as suddenly loosing her/his balance when getting up. The Nursing Assessment further indicated that the usual bedtime for the resident was at 1900 hours and that resident #039 was continent. The resident's bed side tool dated a specific day of October 2016 was also reviewed and indicated that resident #039 was requiring assistance of one staff member for transferring.

In a review of resident #039 health care record, Inspector #592 was unable to find a 24-hour admission care plan developed for the resident following the results of the resident Nursing Assessments. The care plan available for the resident was dated a specific day of January 2017.

On January 20, 2017, during an interview, PSW #122 informed Inspector #592 that she was taking care of resident #039 prior to the injury. She further indicated that upon admission, resident #039 was using a wheelchair to mobilize on the unit but that often resident #039 was trying to get up on her/his own but was too weak, therefore was requiring assistance from staff members. She further indicated to the Inspector that when the incident occurred, resident had tried to get up independently with no assistance. Upon asking PSW #122 about the process on how was information about newly admitted resident given to staff, the PSW indicated to the Inspector that the staff will be informed through the 24 hour nursing report for any specific interventions and that the staff will adapt to the resident. PSW #122 further indicated that if there are any concerns, staff will ask the nurse to clarify resident's need, but that these were communicated verbally, as there was no documentation available other than the progress notes, the 24 hour nursing report and the bed assessment tool located in all the residents' rooms.

On January 20, 2017, during an interview, PSW #120 indicated to Inspector #592 that she was taking care of resident #039 prior to the injury. She further indicated that upon admission, resident #039 was ambulating independently and was independent with limited assistance. PSW #120 further indicated to the Inspector that upon a new resident admission, the staff will be informed through the 24 hour nursing report and by registered staff if any specific interventions were required. She further indicated that PSW would refer to the resident's chart if any questions and uses their own judgement for providing the care.

On January 20, 2017, during an interview, RN #119 indicated to Inspector #592 that

upon a new resident admission, the registered staff are to assess the resident by completing the admission/assessment form which includes different assessments and communicate any specific interventions verbally at the 24 hour nursing report for four consecutive shifts. RN #119 further indicated that no care plan is developed for the newly admitted residents.A care plan is only available once the RAI coordinator has completed the care plan is made available to staff. She further indicated that she was unable to access any electronic care plan, as it was only the RAI Coordinator who has authorized access.

On January 20, 2017, during an interview, the RAI Coordinator indicated to the Inspector that within 24 hour of a resident's admission, assessments were initialized and left for all staff members to fill out for a length of seven days. She further indicated that after the seven days assessment, the information was reviewed and that a written care plan is to be developed and completed within 21 days of the resident admission. The RAI Coordinator indicated that there no 24-hour admission care plan developed for all the newly admitted resident, until she was done collecting the data obtained from the seven day observations flow sheets. She further indicated that she was not able to keep up with her assignments, therefore resident #039's care plan was not developed and completed until a specific day of January 2017, eighty nine days after the admission.

On January 20, 2017, during an interview, the ADOC indicated to Inspector #592 that upon admission, resident’s assessments were completed and that a bed side tool was developed following the assessments to guide staff members for the resident’s transfers. The ADOC indicated that there was no care plan developed for new resident until they were completed and made accessible by the RAI Coordinator.

In addition the licensee has failed to ensure that the resident is reassessed and the care plan is reviewed and revised when the resident’s care needs change.

In a review of resident #039's health care record done by Inspector #592, the progress notes indicated that following the return of the resident from the hospital on a specific day in October 2016, the resident had a significant change in his/her physical status. The progress notes indicated that resident #039 was now wearing a cast , requiring 2 person assistance for transfers and was also using a wheelchair to mobilize on the unit. The progress notes further indicated that the resident had poor weight bearing and pivoting and was now requiring pericare.

On January 24, 2017, during an interview, the DOC, indicated to the Inspector that when a resident care needs change, the plan of care will be reviewed to reflect the current need for the resident. She further indicated that resident #039 had a significant change in his/her physical status upon the return from the hospital and that no care plan was reviewed and revised as there was no care plan developed at that time for the resident. The DOC further indicated that the staff were using the home's bed side tool for quick reference to guide them for the type of transfer and that the tool was not updated after the resident came back from the hospital.

In a review of the home's bed side tool, accessible to nursing staff members, there was no indication noted for the type and level of assistance required by resident #039 relating to activities of daily living and the customary routines and comfort requirements. Before and after the resident's fall and injury, the home's bed side tool did not have any indication for any risk that resident #039 may pose to herself/himself, including any risk of falling, and interventions to mitigate those risks.

On January 24, 2017, Inspector # 126 reviewed the health care records for resident's #014, admitted on a specific day of September 2016 and resident # 048, admitted on a specific day of November 2016. The following assessments were completed on admission for both residents: dental, skin, physiotherapy, continence, dietary , bed tool and initial admission nursing assessments.

The severity of harm in the above incident was determined to be “potential harm” and the scope was identified as “widespread” as indicated in the interviews with the nursing staff, that all newly admitted residents did not have a 24 hour care plan developed for each resident. [s. 24. (2)] (592)

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

May 09, 2017

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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 25 day of April 2017 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : LINDA HARKINS - (A1)

Service Area Office / Bureau régional de services : Ottawa