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

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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 3, 2016	2016_333577_0008	000046-14, 000494-14, 000884-14, 000954-14, 001378-14, 007796-14, 002787-15, 003410-15, 003665-15, 015035-15, 015763-15, 018675-15, 020743-15, 021114-15, 021192-15, 021420-15	Critical Incident System

Licensee/Titulaire de permis

ORILLIA LONG TERM CARE CENTRE INC.
689 YONGE STREET MIDLAND ON L4R 2E1

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

LEACOCK CARE CENTRE
25 MUSEUM DRIVE ORILLIA ON L3V 7T9

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

DEBBIE WARPULA (577), AMY GEAUVREAU (642), JENNIFER KOSS (616), RYAN GOODMURPHY (638)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 18, 19, 20, 21, 22, 25, 26, 27, 28 and 29, 2016.

The purpose of this inspection was to conduct a Critical Incident inspection related to 37 critical incidents submitted to the Director:
-eight logs regarding staff to resident verbal abuse
- four logs regarding sexual abuse
-thirteen logs regarding staff to resident physical abuse
-four logs regarding responsive behaviours
-seven logs regarding neglect
-one log regarding improper care
-one log regarding medication.

This inspection was conducted concurrently with Complaint inspection #2016_333577_0009.

During the course of the inspection, the inspector(s) toured the resident care areas, observed the provision of care and services to residents, observed interactions between staff and residents, reviewed policies, procedures and programs, various health care records, schedules and training records.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

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

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

- **6 WN(s)**
- **3 VPC(s)**
- **3 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.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A Critical Incident (CI) report was submitted to the Director by the home in August 2015, related to an incident of alleged staff to resident abuse which occurred in July 2015. The Administrator was made aware in July 2015, of the allegations that PSW #100 and PSW #101 did not respond to resident #009's call bell for assistance. The home's investigation determined that the allegations of abuse were unfounded.

During an interview with the Administrator (AD) and the Director of Care (DOC), they reported to Inspector #616 that the allegations of staff to resident abuse was not reported immediately. [s. 24. (1)]

2. A CI report was submitted to the Director in October 2014, related to staff to resident verbal abuse which occurred in October 2014.

During a record review of the home's investigation notes, Inspector #577 found further incidences which were not reported by the home to the Director, as required by the legislation, as follows:

-a day in October 2014, PSW #104 refused to answer call bells and made derogatory comments about residents.

-another day in October 2014, PSW #104 made inappropriate comments to RN #102 about residents. Another resident was calling for assistance on the call bell and PSW #104 stated, "I am not answering that, I just got them off the toilet five minutes ago";

-another day in October 2014, resident #044 wandered into the dining room at lunch hour and their pants were wet and needed to be changed. PSW #104 responded, "I know they are soaked, I noticed it before lunch. Evenings always change them when they first come in";

-another day in October 2014, the investigation notes indicated that PSW #103 reported to the DOC that PSW #104 refused to dress resident #045 and reported they can't stand the resident. PSW #103 further reported that PSW #104 refused to toilet resident #046 because the resident was heavy, and stated "It's too much work"; and witnessed PSW #104 being argumentative with resident #047.

Under O. Reg. 79/10, neglect is defined as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

A review of the home's policy titled "Resident Rights, Care and Services - Abuse - Zero Tolerance -Staff Acknowledgement" revised March 23, 2015, defined "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and included inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Within the policy, it indicated that "upon receiving a report of resident abuse or neglect, the Administrator or Director of Care will file a written report of the results of the investigation with the Director at the Ministry of Health and Long-Term Care within ten days of the home becoming aware of the alleged, suspected or witnessed incident of abuse or neglect.

During an interview with the DOC they reported that it was the expectation of the home that residents were protected from abuse and neglect and that they did not report these allegations to the Ministry. They further confirmed that through investigation, they could not substantiate the allegations, the home did not report neglectful care prior to investigation, and that it did not fit the decision tree. [s. 24. (1)]

3. A CI report was submitted to the Director in June 2015, related to staff to resident verbal abuse. In the report, resident #019 had reported to the day shift Charge Nurse that PSW #106 entered their room to answer the call bell and stated "Why do you always ring your call bell, you are impatient". The report also indicated that PSW #106 used a 'snarly' tone and it upset the resident.

A review of the home's policy titled, "Resident Rights, Care and Services – Abuse" revised date March 26, 2015, indicated that the home was to have completed an internal investigation during any suspected or confirmed allegation of abuse, immediately notify the MOHLTC and initiate a CIS report.

During an interview with the DOC they confirmed that the report was submitted late and could not recall why it was reported late. They further reported that it was the expectation of the home that they submitted reports to the Director immediately. [s. 24. (1)]

4. A CI report was submitted to the Director in April 2016, where resident #001 had displayed inappropriate responsive behaviour toward a cognitively impaired female resident #037.

A review of the clinical record of resident #001 revealed that they had a history of inappropriate responsive behaviours towards other residents dating back to February 2015, and seven incidents where resident #001 exhibited inappropriate responsive behaviours towards residents #002 and #024 in April 2016.

A review of the home's policy titled, "Resident Rights, Care and Services – Abuse" revised date March 26, 2015, indicated that the home was to have completed an internal investigation during any suspected or confirmed allegation of abuse, immediately notify the MOHLTC and initiate a CIS report.

The DOC confirmed that these incidents were not reported to the Director. [s. 24. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with.

A CI report was submitted to the Director in February 2014, regarding staff to resident verbal abuse. In the report, resident #018 had reported to RPN #105 that they were wet during the night. RPN #105 stated to the resident, "Are you trying to get another staff member fired?", which caused the resident to believe their concern warranted termination of staff. The report also indicated that PSW #112 reported this incident to the DOC one day following the incident.

A review of the home's investigation notes revealed the following:

-in February 2014, a letter from PSW #112 indicated that they overheard RPN #105 state to the resident, "Why don't I call the front office and have them all fired";

-in February 2014, during an interview with PSW #116 they indicated that they overheard the resident tell RPN #105 that they were cold and the staff at night don't change them. RPN #105 stated to the resident, "Are you trying to get another staff member fired?";

-in February 2014, during an interview with RPN #105 they indicated that they stated to the resident, "Well we'll just fire them";

A review of the investigation notes revealed a disciplinary letter from the home to RPN #105 dated February 2014. The letter revealed that "the concerns related to the statement towards the resident were intimidating and that they suggested the resident's concerns warranted staff termination. The statement was considered abusive, leaving the resident feeling chastised".

During an interview with the DOC they stated that this incident was reported to management one day after the occurrence and it was the expectation of the home that staff report any form of abuse and/or neglect immediately. The home's letter to RPN #105 dated February 2014, confirmed verbal abuse. [s. 20. (1)]

2. A CI report was submitted to the Director in April 2014, for a staff to resident abuse/neglect incident that occurred in April 2014. The home could not confirm the specific date of the alleged incident.

In the report, in April 2014, resident #004 reported to an employee of the home that PSW #123 was continually rough during the provision of care. The Acting DOC and Acting Co-DOC confirmed this allegation with resident #004.

A review of the home's policy titled, "Resident Rights, Care and Services – Abuse" revised date March 26, 2015, indicated that the home was to have completed an internal investigation during any suspected or confirmed allegation of abuse.

During an interview with Inspector #616 on April 26, 2016, the DOC confirmed that these allegations were not investigated as required by the home's policy "Residents Rights, Care and Services - Abuse" revised March 26, 2015. [s. 20. (1)]

3. A CI report was submitted to the Director in November 2015, regarding staff to resident alleged abuse that occurred in November 2015. In the report, resident #026's family member had reported to the DOC and Life Enrichment Coordinator #110 that they witnessed Activity Aide #111 bend over to hug the resident and make inappropriate sexual remarks to the resident.

A review of the home's policy titled "Resident's Rights, Care and Services - Abuse - Zero Tolerance - Staff Acknowledgement" revised date March 23, 2015, defined sexual abuse as any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that was directed towards a resident by a licensee or staff member.

A review of the investigation notes from November 2015, revealed that the DOC interviewed resident #026 and the resident indicated that they had asked that staff member for a hug and to call them a specific name and that the resident did not feel it was inappropriate.

A review of the home's letter dated November 2015, to Activity Aide #111 indicated that they were to review the home's code of conduct policy and to always maintain a professional relationship with all residents while providing care. As a result of the investigation, Activity Aide #111 received discipline concerning their inappropriate conduct towards a male resident. [s. 20. (1)]

4. A CI report was submitted to the Director by the home in December 2015, related to an incident of alleged staff to resident abuse/neglect in December 2015. The details of the incident were documented in an email received by the home in December 2015. The email indicated that on the date of the incident, resident #010 did not have their call bell within reach, had not received continence care, and safety checks had not been completed by staff during the night shift.

Inspector #616 reviewed the home's investigation records which revealed PSW #119 had confirmed that they had not checked the resident's call bell to ensure that it had been within the resident's reach during the night, and they had not performed hourly safety checks on the resident. As a result, during this shift, the resident had been incontinent in their bed, had been unable to alert staff for assistance, and had remained in bed for approximately four hours until the day staff observed the resident's condition and provided the required care.

A review of the home's policy titled "Resident Rights, Care and Services - Abuse - Zero Tolerance -Staff Acknowledgement" revised March 23, 2015, defined "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and included inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A progress note in December 2015, documented that the resident was found crying in their bed as a result of the incontinence episode, they had been unable to reach their call bell, and that staff had not checked on them for an extended period of time.

During an interview with resident #010 on April 27, 2016, they shared their experience with Inspector #616, and openly expressed embarrassment of the situation.

A review of the home's letter dated December 2015, to PSW #119 indicated that they were to review the home's code of conduct policy.

The Administrator verified that the resident had been neglected in this incident. [s. 20. (1)]

5. A CI report was submitted to the Director in April 2016, related to an incident of staff to resident verbal abuse that occurred in March 2016. The report indicated that PSW #122 had made inappropriate comments when responding to resident #002’s call bell.

A review of the home's policy titled "Resident Rights, Care and Services - Abuse - Zero Tolerance - Staff Acknowledgement" revised March 23, 2015, indicated that they had implemented a zero-tolerance policy that takes all appropriate actions to address the prevention, reporting and elimination of abuse and neglect of residents. The policy defined 'zero-tolerance' as 'allowing no exceptions, tolerating no abusive or neglectful behaviour and required strict compliance and enforcement'.

A review of the investigation notes revealed the following:

In April 2016, the notes indicated that PSW #122 stated to the DOC, “Sometimes things have to be said, you have to be stern with the residents", in reference to their response given to the resident.

A review of the home's letter to the employee dated April 2016, indicated that their verbal response to the resident should have been worded differently.

Inspector #577 conducted an interview with the DOC on April 28, 2016. They stated that it was the expectation of the home expectation that all staff speak respectfully to all residents and as a result of the investigation, PSW #122 received discipline as result of their conduct. [s. 20. (1)]

6. A CI report was submitted to the Director in June 2015, related to staff to resident verbal abuse. In the report, resident #019 had reported to the day shift Charge Nurse in June 2015, that PSW #106 entered their room to answer the call bell and stated “Why do you always ring your call bell, you are impatient”. The report also indicated that the PSW used an angry tone and it upset them.

A review of the home's policy titled "Resident Rights, Care and Services - Abuse - Zero Tolerance - Staff Acknowledgement" revised March 23, 2015, indicated that they had implemented a zero-tolerance policy that takes all appropriate actions to address the prevention, reporting and elimination of abuse and neglect of residents. The policy defined 'zero-tolerance' as 'allowing no exceptions, tolerating no abusive or neglectful behaviour and required strict compliance and enforcement'.

A review of the home's investigation notes revealed the following:

In June 2015, during an interview with PSW #117 they reported that they could hear PSW #106 yelling at the resident and the resident told PSW #106 that they were tired of them yelling at them.

In June 2015, during an interview with RN #118 they reported that the resident rang the call bell and PSW #106 yelled at them, stating that "They rang the call bell too much and that they were impatient".

A review of the home's letter to the employee dated June 2015, indicated that the employee was required to review the home's policy on code of conduct and develop a learning plan prior to returning to work.

Inspector #577 conducted an interview with the DOC on April 28, 2016, and they stated that it was the expectation of the home that all staff speak respectfully to all residents and confirmed that as a result of the investigation, PSW #106 received discipline. [s. 20. (1)]

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.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A CI report was submitted to the Director in April 2016, where resident #001 had displayed inappropriate responsive behaviour toward a cognitively impaired female resident #037.

A review of the clinical record for resident #001 revealed that they had a history of inappropriate responsive behaviours towards other residents dating back to February 2015. An external partner was consulted at that time and recommended interventions to manage the inappropriate responsive behaviours of resident #001. Their report stated to re-refer the resident should the behaviours change or escalate.

A further review of the clinical record for resident #001 revealed seven incidents where the resident exhibited inappropriate responsive behaviours towards residents #002 and #024 in April 2016.

A record review revealed a note written by the DOC which was faxed in April 2016, to the physician for resident #001 which indicated the resident's inappropriate responsive behaviours and that resident #001 was to have been on Dementia Observation System (DOS) charting to monitor escalations in the inappropriate responsive behaviours of resident #001.

A review of the plan of care dated March 2016, for resident #001 revealed that the DOS charting was to be completed to monitor the resident's inappropriate responsive behaviours as well as specific time checks when the resident was in certain areas in order to protect other residents from the inappropriate responsive behaviours of resident #001.

Review of the clinical records revealed that DOS charting had been initiated in February 2016, for seven days and that the DOS charting was not fully completed six of the seven days or 85 per cent of the time.

A review of the specific time checks revealed that the intervention had been initiated in August 2015, and there was no completed documentation after August 2015, during any instance that resident #001 was in certain areas.

A review of the home's policy titled, "Resident Rights, Care and Services – Abuse" revealed that the home promoted zero tolerance regarding resident abuse and that any suspected or confirmed allegations of abuse would have been reported immediately to the Administrator, DOC or charge Nurse immediately and that suspected or confirmed allegations of abuse would have been acted upon by all team members.

Further review of the home's policy revealed that the home was to have completed an internal investigation during any suspected or confirmed allegation of abuse, immediately notify the MOHLTC and initiate a CIS report.

Inspector #638 conducted an interview with the DOC on April 27, 2016, and they revealed that the only record of DOS charting completed in 2016, occurred in February 2016, for seven days and there were no other records of DOS charting for resident #001. The DOC confirmed that there were no documented specific time checks after August 2015, for resident #001 during times when they were in certain areas with residents and confirmed that there was no means of identifying if this intervention had been followed. They further reported that the home had initiated a new physician referral in April 2016, after six additional incidents of inappropriate responsive behaviours had occurred. The DOC further revealed that the home's internal investigation for the incident in April 2016, between resident #001 and resident #002 was not initiated until one day later and the internal investigation was not completed. The internal investigations for the incidents that occurred on two other days in April 2016, was not initiated until three days later. The DOC went on to confirm that none of these incidents were reported to the Director as per the home's policy.

The home did not protect all residents from the inappropriate responsive behaviours of resident #001 and it was the expectation of the home that all residents were protected from abuse by anyone. [s. 19. (1)]

2. A CI report was submitted to the Director in August 2015, related to staff to resident abuse. The report indicated that in August 2015, PSW #107 and RN #108 witnessed PSW #109 pulling a sweater out of resident #020's hands and yelling at the resident to sit down.

A review of the home's investigation notes revealed the following:

-in August 2015, during an interview with PSW #107 they indicated that PSW #109 was

witnessed to be pulling a sweater out of the residents hands, both the PSW and the resident were tugging back and forth, and the PSW was yelling loudly, "Let go now" "Go sit down", and the resident was visibly upset.

A review of the employee's file was conducted by Inspector #577 and found prior conduct and discipline for using inappropriate language and neglectful care.

During an interview with the DOC they stated that it was the expectation of the home that all staff speak respectfully to all residents and confirmed that PSW #109 was terminated from the home for verbal abuse of resident #020. [s. 19. (1)]

3. A CI report was submitted to the Director in October 2014, related to staff to resident verbal abuse which occurred in October 2014. The report indicated that PSW #104 had been loud and verbally aggressive towards resident #003 during a meal. They specifically told resident #003 to make a choice about their meal and PSW #104 became loud and aggressive towards the resident when they did not make a choice.

Under O. Reg. 79/10, verbal abuse is defined as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's well-being, dignity or self-worth, that is made by anyone other than a resident".

A review of the home's policy titled "Resident's Rights, Care and Services - Abuse" revised date March 26, 2015, defined verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's well-being, dignity or self-worth, that is made by anyone other than a resident".

A review of the home's policy titled, "Resident Rights, Care and Services – Abuse" revealed that the home promoted zero tolerance regarding resident abuse and that any suspected or confirmed allegations of abuse would have been reported immediately to the Administrator, DOC or charge Nurse immediately and that suspected or confirmed allegations of abuse would have been acted upon by all team members.

A review of the progress notes dated October 2014, indicated that this incident occurred during a meal service, witnessed and documented by RN #102, who also admitted to management that they did not report this immediately.

A review of the home's letter to the employee dated November 2014, indicated that PSW #104 was required to review the home's code of conduct, abuse policy and duty to report and protect prior to returning to work.

During an interview with the DOC they confirmed that it was the expectation of the home that all residents were protected from abuse and neglect and as a result of the investigation, PSW #104 received discipline concerning their conduct toward resident #003. They further confirmed that RN #102 reported the incident of verbal abuse to management three days later, not immediately, as indicated in their policy. [s. 19. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Two Critical Incident (CI) reports were submitted to the Director related to allegations of staff to resident abuse. Resident #009 was the resident involved in both of the reports.

A CI report was submitted by the home in August 2015, related to an allegation that PSW #100 and PSW #101 did not respond to resident #009's call bell for assistance, which

occurred in July 2015. The home could not confirm the specific date of occurrence and the Administrator was made aware in July 2015.

A CI report was submitted by the home in March 2015, related to an allegation that RN #113 physically abused resident #009 in March 2015.

The home's CI investigations determined the allegations of staff to resident abuse were unfounded in both incidents.

Inspector #616 reviewed the investigation records for both incidents with the AD and the DOC.

The home's investigation into the first CI report revealed that the resident was known to frequently ring their call bell. It was documented in the interviews with both of the PSW staff involved, that they did not "run as quickly" and would take longer to assist the resident when they rang.

The home's investigation into the other CI report that involved RN #113, documented that the RN stated to the resident that they rang their call bell excessively, needed to stop and no physical abuse was verified to have occurred.

During the interview with the AD and the DOC on April 29, 2016, they verified that in both incidents, the resident had not been treated with courtesy and respect. [s. 3. (1) 1.]

2. A CI report was submitted to the Director by the home in July 2015, related to an allegation of resident neglect by staff. The report identified that resident #012 had not been provided with continence care by PSW #114 and PSW #115 in July 2015.

During an interview on April 29, 2016, with the AD and the DOC, Inspector #616 reviewed the investigation records related to this incident. Although the home's investigation determined the allegation of neglect was unfounded, the resident's interviews, and a progress note in July 2015, documented that resident #012 expressed having felt "belittled" and "was a nuisance for asking for incontinence care" from the staff.

The AD and the DOC both verified the resident had not been treated with courtesy, respect, and dignity related to the provision of incontinence care by staff. [s. 3. (1) 1.]

3. A CI report was submitted to the Director in February 2016, related to an incident of alleged staff to resident neglect in February 2016. The report indicated that resident #011 had requested to be toileted during a meal and PSW #120 refused to toilet resident at the time of request and was later incontinent.

A review of the home's investigation notes revealed the following:

In February 2016, the resident interview revealed that PSW #120 did not want to take the time to take the resident to the toilet. They were toileted prior to the meal, the resident was returned to their room as they had refused their meal and rang the call bell stating they had to return to the toilet. The resident was told by staff that they needed two staff to help them transfer and was later incontinent.

In February 2016, a staff interview with PSW #120 revealed that they toileted the resident before the meal. The resident did not eat their meal and returned to their room. Ten minutes later, the resident called for assistance to the bathroom and PSW #120 explained to the resident that they were just toileted and did not toilet resident upon their request.

During an interview with the DOC they stated that it was the expectation of the home that all residents were toileted upon request and that resident #011 was not toileted by staff and was later incontinent. [s. 3. (1) 3.]

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 resident #009, #012 and all other residents are treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity; and to ensure that resident #011 and all other residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A CI report was submitted to the Director by the home in December 2015, related to an incident of alleged staff to resident abuse/neglect in December 2015. The details of the incident were documented in an email received by the home in December 2015. In the email, resident #010 did not have their call bell within reach, had not received continence care, and safety checks had not been completed by staff during the night shift.

Inspector #616 reviewed the home's investigation records which revealed that PSW #119 had confirmed that they had not checked the resident's call bell to ensure that it had been within the resident's reach during the night, and they had not performed hourly safety checks on the resident. As a result, during this shift, the resident had been incontinent in their bed and had been unable to alert staff for assistance.

A review of the resident's care plan in effect at the time of the incident noted that the call bell was to be clipped to pillow (within reach) when in bed.

A progress note dated December 2015, documented that the resident was found crying in their bed as a result of the incontinence episode, they had been unable to reach their call bell, and that staff had not checked on them for an extended period of time. The resident's care plan in effect at the time of the incident noted that the call bell was to be clipped to pillow (within reach) when in bed.

The AD verified that the call bell had not been within reach as per the resident's plan of care at the time of this incident and should have been. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, specifically in regards to resident #010, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse by anyone that the licensee knew of, or that was reported was immediately investigated.

A CI report was submitted to the Director in March 2014, related to allegations of staff to resident abuse which occurred in September 2013. The allegations of abuse by PSW #121 to resident #032 were described in a written letter received by the home in March 2014.

Inspector #616 reviewed the amended CI report submitted by the home in March 2014, which indicated that a meeting was scheduled with PSW #121 in March 2014, and that further actions may be warranted based on outcome of pending interview. A record review of PSW #121's employee file did not provide any reference to the documented meeting that was scheduled as per the CI report. A review of the PSW #121's staff record did not include any reference related to this incident.

During an interview with the DOC, they verified they were unable to provide investigation records pertaining to this incident and could not confirm an immediate investigation had occurred as there was no documentation of an interview or investigation with the alleged staff. [s. 23. (1) (a)]

2. A CI report was submitted to the Director in April 2014, for a staff to resident abuse/neglect incident that occurred in April 2014. The home could not confirm the specific date of the alleged incident. In the report, on a day in April 2014, resident #004 reported to an employee of the home that PSW #122 was continually rough during the provision of care. The Acting DOC and Acting Co-DOC confirmed this allegation with resident #004.

Inspector #616 requested records from the DOC to review this staff to resident abuse investigation. The DOC verified they were unable to locate records that verified the home's investigation, response, or that appropriate action had been taken related to this incident. [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 every alleged, suspected or witnessed incident of abuse by anyone that the licensee know's of, or that is reported is immediately investigated; and to ensure that appropriate action is taken in response to every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee know's of, or that is reported to the licensee., to be implemented voluntarily.

Issued on this 4th day of October, 2016

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

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

Ministére de la Santé et des Soins de longue durée

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

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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBBIE WARPULA (577), AMY GEAUVREAU (642), JENNIFER KOSS (616), RYAN GOODMURPHY (638)
Inspection No. / No de l'inspection :	2016_333577_0008
Log No. / Registre no:	000046-14, 000494-14, 000884-14, 000954-14, 001378-14, 007796-14, 002787-15, 003410-15, 003665-15, 015035-15, 015763-15, 018675-15, 020743-15, 021114-15, 021192-15, 021420-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 3, 2016
Licensee / Titulaire de permis :	ORILLIA LONG TERM CARE CENTRE INC. 689 YONGE STREET, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	LEACOCK CARE CENTRE 25 MUSEUM DRIVE, ORILLIA, ON, L3V-7T9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tracy Muchmaker

To ORILLIA LONG TERM CARE CENTRE 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) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The licensee shall:

a) ensure all registered and non-registered staff are trained to identify and report all alleged, suspected and witnessed incidents of abuse immediately to the Director

b) develop and implement a monitoring system to ensure that abuse is reported as required by this section

Grounds / Motifs :

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

A CI report was submitted to the Director in April 2016, where resident #001 had displayed inappropriate responsive behaviour toward a cognitively impaired female resident #037.

A review of the clinical record of resident #001 revealed that they had a history of inappropriate responsive behaviours towards other residents dating back to February 2015, and seven incidents where resident #001 exhibited inappropriate responsive behaviours towards residents #002 and #024 in April 2016.

A review of the home's policy titled, "Resident Rights, Care and Services – Abuse" revised date March 26, 2015, indicated that the home was to have completed an internal investigation during any suspected or confirmed allegation of abuse, immediately notify the MOHLTC and initiate a CIS report.

The DOC confirmed that these incidents were not reported to the Director. [s. 24. (1)]

(577)

2. A CI report was submitted to the Director in June 2015, related to staff to resident verbal abuse. In the report, resident #019 had reported to the day shift Charge Nurse that PSW #106 entered their room to answer the call bell and stated "Why do you always ring your call bell, you are impatient". The report also indicated that PSW #106 used a 'snarly' tone and it upset the resident.

A review of the home's policy titled, "Resident Rights, Care and Services – Abuse" revised date March 26, 2015, indicated that the home was to have completed an internal investigation during any suspected or confirmed allegation of abuse, immediately notify the MOHLTC and initiate a CIS report.

During an interview with the DOC they confirmed that the report was submitted late and could not recall why it was reported late. They further reported that it was the expectation of the home that they submitted reports to the Director immediately. [s. 24. (1)]

(577)

3. A CI report was submitted to the Director in October 2014, related to staff to resident verbal abuse which occurred in October 2014.

During a record review of the home's investigation notes, Inspector #577 found further incidences which were not reported by the home to the Director, as required by the legislation, as follows:

-a day in October 2014, PSW #104 refused to answer call bells and made derogatory comments about residents.

-another day in October 2014, PSW #104 made inappropriate comments to RN #102 about residents. Another resident was calling for assistance on the call bell and PSW #104 stated, "I am not answering that, I just got them off the toilet five minutes ago";

-another day in October 2014, resident #044 wandered into the dining room at lunch hour and their pants were wet and needed to be changed. PSW #104 responded, "I know they are soaked, I noticed it before lunch. Evenings always change them when they first come in";

-another day in October 2014, the investigation notes indicated that PSW #103 reported to the DOC that PSW #104 refused to dress resident #045 and reported they can't stand the resident. PSW #103 further reported that PSW #104 refused to toilet resident #046 because the resident was heavy, and stated "It's too much work"; and witnessed PSW #104 being argumentative with resident #047.

Under O. Reg. 79/10, neglect is defined as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

A review of the home's policy titled "Resident Rights, Care and Services - Abuse - Zero Tolerance -Staff Acknowledgement" revised March 23, 2015, defined "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and included inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Within the policy, it indicated that "upon receiving a report of resident abuse or neglect, the Administrator or Director of Care will file a written report of the results of the investigation with the Director at the Ministry of Health and Long-Term Care within ten days of the home becoming aware of the alleged, suspected or witnessed incident of abuse or neglect.

During an interview with the DOC they reported that it was the expectation of the home that residents were protected from abuse and neglect and that they did not report these allegations to the Ministry. They further confirmed that through investigation, they could not substantiate the allegations, the home did not report neglectful care prior to investigation, and that it did not fit the decision tree. [s. 24. (1)]
(577)

4. A Critical Incident (CI) report was submitted to the Director by the home in August 2015, related to an incident of alleged staff to resident abuse which occurred in July 2015. The Administrator was made aware in July 2015, of the allegations that PSW #100 and PSW #101 did not respond to resident #009's call bell for assistance. The home's investigation determined that the allegations of abuse were unfounded.

During an interview with the Administrator (AD) and the Director of Care (DOC), they reported to Inspector #616 that the allegations of staff to resident abuse was not reported immediately. [s. 24. (1)]

Non-compliance had been previously issued under inspection 2014_298557_0023, including a VPC and under inspection 2013_109153_0018, including a VPC.

The decision to issue this compliance order was based on the scope which affected four residents, the severity which indicates minimal harm or potential for actual harm and the compliance history which despite previous non-compliance (NC) issued including two VPCs, NC has continued with this area of legislation. (616)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 14, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall:

a) re-train all staff on the home's written policies to promote zero tolerance of abuse and neglect of residents including, but not limited to, the roles of each staff member in identifying, responding to and reporting abuse and neglect

b) maintain a record of re-training provided including dates, times, attendees, trainers and material taught

Grounds / Motifs :

1. The licensee has failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with.

A CI report was submitted to the Director in June 2015, related to staff to resident verbal abuse. In the report, resident #019 had reported to the day shift Charge Nurse in June 2015, that PSW #106 entered their room to answer the call bell and stated "Why do you always ring your call bell, you are impatient". The report also indicated that the PSW used an angry tone and it upset them.

A review of the home's policy titled "Resident Rights, Care and Services - Abuse - Zero Tolerance - Staff Acknowledgement" revised March 23, 2015, indicated that they had implemented a zero-tolerance policy that takes all appropriate actions to address the prevention, reporting and elimination of abuse and neglect of residents. The policy defined 'zero-tolerance' as 'allowing no

exceptions, tolerating no abusive or neglectful behaviour and required strict compliance and enforcement'.

A review of the home's investigation notes revealed the following:

In June 2015, during an interview with PSW #117 they reported that they could hear PSW #106 yelling at the resident and the resident told PSW #106 that they were tired of them yelling at them.

In June 2015, during an interview with RN #118 they reported that the resident rang the call bell and PSW #106 yelled at them, stating that "They rang the call bell too much and that they were impatient".

A review of the home's letter to the employee dated June 2015, indicated that the employee was required to review the home's policy on code of conduct and develop a learning plan prior to returning to work.

Inspector #577 conducted an interview with the DOC on April 28, 2016, and they stated that it was the expectation of the home that all staff speak respectfully to all residents and confirmed that as a result of the investigation, PSW #106 received discipline. [s. 20. (1)]
(577)

2. A CI report was submitted to the Director in April 2014, for a staff to resident abuse/neglect incident that occurred in April 2014. The home could not confirm the specific date of the alleged incident.

In the report, in April 2014, resident #004 reported to an employee of the home that PSW #123 was continually rough during the provision of care. The Acting DOC and Acting Co-DOC confirmed this allegation with resident #004.

A review of the home's policy titled, "Resident Rights, Care and Services – Abuse" revised date March 26, 2015, indicated that the home was to have completed an internal investigation during any suspected or confirmed allegation of abuse.

During an interview with Inspector #616 on April 26, 2016, the DOC confirmed that these allegations were not investigated as required by the home's policy "Residents Rights, Care and Services - Abuse" revised March 26, 2015. [s. 20.

(1)]
(577)

3. A CI report was submitted to the Director by the home in December 2015, related to an incident of alleged staff to resident abuse/neglect in December 2015. The details of the incident were documented in an email received by the home in December 2015. The email indicated that on the date of the incident, resident #010 did not have their call bell within reach, had not received continence care, and safety checks had not been completed by staff during the night shift.

Inspector #616 reviewed the home's investigation records which revealed PSW #119 had confirmed that they had not checked the resident's call bell to ensure that it had been within the resident's reach during the night, and they had not performed hourly safety checks on the resident. As a result, during this shift, the resident had been incontinent in their bed, had been unable to alert staff for assistance, and had remained in bed for approximately four hours until the day staff observed the resident's condition and provided the required care.

A review of the home's policy titled "Resident Rights, Care and Services - Abuse - Zero Tolerance -Staff Acknowledgement" revised March 23, 2015, defined "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and included inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A progress note in December 2015, documented that the resident was found crying in their bed as a result of the incontinence episode, they had been unable to reach their call bell, and that staff had not checked on them for an extended period of time.

During an interview with resident #010 on April 27, 2016, they shared their experience with Inspector #616, and openly expressed embarrassment of the situation.

A review of the home's letter dated December 2015, to PSW #119 indicated that they were to review the home's code of conduct policy.

The Administrator verified that the resident had been neglected in this incident.

[s. 20. (1)]
(577)

4. A CI report was submitted to the Director in November 2015, regarding staff to resident alleged abuse that occurred in November 2015. In the report, resident #026's family member had reported to the DOC and Life Enrichment Coordinator #110 that they witnessed Activity Aide #111 bend over to hug the resident and make inappropriate sexual remarks to the resident.

A review of the home's policy titled "Resident's Rights, Care and Services - Abuse - Zero Tolerance - Staff Acknowledgement" revised date March 23, 2015, defined sexual abuse as any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that was directed towards a resident by a licensee or staff member.

A review of the investigation notes from November 2015, revealed that the DOC interviewed resident #026 and the resident indicated that they had asked that staff member for a hug and to call them a specific name and that the resident did not feel it was inappropriate.

A review of the home's letter dated November 2015, to Activity Aide #111 indicated that they were to review the home's code of conduct policy and to always maintain a professional relationship with all residents while providing care. As a result of the investigation, Activity Aide #111 received discipline concerning their inappropriate conduct towards a male resident. [s. 20. (1)]

(577)

5. A CI report was submitted to the Director in April 2016, related to an incident of staff to resident verbal abuse that occurred in March 2016. The report indicated that PSW #122 had made inappropriate comments when responding to resident #002's call bell.

A review of the home's policy titled "Resident Rights, Care and Services - Abuse - Zero Tolerance - Staff Acknowledgement" revised March 23, 2015, indicated that they had implemented a zero-tolerance policy that takes all appropriate actions to address the prevention, reporting and elimination of abuse and neglect of residents. The policy defined 'zero-tolerance' as 'allowing no exceptions, tolerating no abusive or neglectful behaviour and required strict

compliance and enforcement'.

A review of the investigation notes revealed the following:

In April 2016, the notes indicated that PSW #122 stated to the DOC, "Sometimes things have to be said, you have to be stern with the residents", in reference to their response given to the resident.

A review of the home's letter to the employee dated April 2016, indicated that their verbal response to the resident should have been worded differently.

Inspector #577 conducted an interview with the DOC on April 28, 2016. They stated that it was the expectation of the home expectation that all staff speak respectfully to all residents and as a result of the investigation, PSW #122 received discipline as result of their conduct. [s. 20. (1)]
(577)

6. A CI report was submitted to the Director in February 2014, regarding staff to resident verbal abuse. In the report, resident #018 had reported to RPN #105 that they were wet during the night. RPN #105 stated to the resident, "Are you trying to get another staff member fired?", which caused the resident to believe their concern warranted termination of staff. The report also indicated that PSW #112 reported this incident to the DOC one day following the incident.

A review of the home's investigation notes revealed the following:

-in February 2014, a letter from PSW #112 indicated that they overheard RPN #105 state to the resident, "Why don't I call the front office and have them all fired";

-in February 2014, during an interview with PSW #116 they indicated that they overheard the resident tell RPN #105 that they were cold and the staff at night don't change them. RPN #105 stated to the resident, "Are you trying to get another staff member fired?";

-in February 2014, during an interview with RPN #105 they indicated that they stated to the resident, "Well we'll just fire them";

A review of the investigation notes revealed a disciplinary letter from the home to

RPN #105 dated February 2014. The letter revealed that "the concerns related to the statement towards the resident were intimidating and that they suggested the resident's concerns warranted staff termination. The statement was considered abusive, leaving the resident feeling chastised".

During an interview with the DOC they stated that this incident was reported to management one day after the occurrence and it was the expectation of the home that staff report any form of abuse and/or neglect immediately. The home's letter to RPN #105 dated February 2014, confirmed verbal abuse. [s. 20. (1)]

Non-compliance had been previously issued under inspection 2013_109153_0018, including a VPC.

The decision to issue this compliance order was based on the scope which affected six residents, the severity which indicated minimal harm or potential for actual harm and the compliance history which despite previous non-compliance (NC) issued a VPC, NC has continued with this area of legislation.
(577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 14, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that residents #002, #020, #024 and #003, and any other resident of the long-term care home are protected from abuse by anyone and that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Grounds / Motifs :

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

A CI report was submitted to the Director in October 2014, related to staff to resident verbal abuse which occurred in October 2014. The report indicated that PSW #104 had been loud and verbally aggressive towards resident #003 during a meal. They specifically told resident #003 to make a choice about their meal and PSW #104 became loud and aggressive towards the resident when they did not make a choice.

Under O. Reg. 79/10, verbal abuse is defined as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's well-being, dignity or self-worth, that is made by anyone other than a resident".

A review of the home's policy titled "Resident's Rights, Care and Services - Abuse" revised date March 26, 2015, defined verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's well-being, dignity or self-worth, that is made by anyone other than a resident".

A review of the home's policy titled, "Resident Rights, Care and Services – Abuse" revealed that the home promoted zero tolerance regarding resident abuse and that any suspected or confirmed allegations of abuse would have been reported immediately to the Administrator, DOC or charge Nurse immediately and that suspected or confirmed allegations of abuse would have been acted upon by all team members.

A review of the progress notes dated October 2014, indicated that this incident occurred during a meal service, witnessed and documented by RN #102, who also admitted to management that they did not report this immediately.

A review of the home's letter to the employee dated November 2014, indicated that PSW #104 was required to review the home's code of conduct, abuse policy and duty to report and protect prior to returning to work.

During an interview with the DOC they confirmed that it was the expectation of the home that all residents were protected from abuse and neglect and as a result of the investigation, PSW #104 received discipline concerning their conduct toward resident #003. They further confirmed that RN #102 reported the incident of verbal abuse to management three days later, not immediately, as indicated in their policy. [s. 19. (1)]
(577)

2. A CI report was submitted to the Director in August 2015, related to staff to resident abuse. The report indicated that in August 2015, PSW #107 and RN #108 witnessed PSW #109 pulling a sweater out of resident #020's hands and yelling at the resident to sit down.

A review of the home's investigation notes revealed the following:

-in August 2015, during an interview with PSW #107 they indicated that PSW #109 was witnessed to be pulling a sweater out of the residents hands, both the PSW and the resident were tugging back and forth, and the PSW was yelling loudly, "Let go now" "Go sit down", and the resident was visibly upset.

A review of the employee's file was conducted by Inspector #577 and found prior conduct and discipline for using inappropriate language and neglectful care.

During an interview with the DOC they stated that it was the expectation of the

home that all staff speak respectfully to all residents and confirmed that PSW #109 was terminated from the home for verbal abuse of resident #020. [s. 19. (1)]

(577)

3. A CI report was submitted to the Director in April 2016, where resident #001 had displayed inappropriate responsive behaviour toward a cognitively impaired female resident #037.

A review of the clinical record for resident #001 revealed that they had a history of inappropriate responsive behaviours towards other residents dating back to February 2015. An external partner was consulted at that time and recommended interventions to manage the inappropriate responsive behaviours of resident #001. Their report stated to re-refer the resident should the behaviours change or escalate.

A further review of the clinical record for resident #001 revealed seven incidents where the resident exhibited inappropriate responsive behaviours towards residents #002 and #024 in April 2016.

A record review revealed a note written by the DOC which was faxed in April 2016, to the physician for resident #001 which indicated the resident's inappropriate responsive behaviours and that resident #001 was to have been on Dementia Observation System (DOS) charting to monitor escalations in the inappropriate responsive behaviours of resident #001.

A review of the plan of care dated March 2016, for resident #001 revealed that the DOS charting was to be completed to monitor the resident's inappropriate responsive behaviours as well as specific time checks when the resident was in certain areas in order to protect other residents from the inappropriate responsive behaviours of resident #001.

Review of the clinical records revealed that DOS charting had been initiated in February 2016, for seven days and that the DOS charting was not fully completed six of the seven days or 85 per cent of the time.

A review of the specific time checks revealed that the intervention had been initiated in August 2015, and there was no completed documentation after

August 2015, during any instance that resident #001 was in certain areas.

A review of the home's policy titled, "Resident Rights, Care and Services – Abuse" revealed that the home promoted zero tolerance regarding resident abuse and that any suspected or confirmed allegations of abuse would have been reported immediately to the Administrator, DOC or charge Nurse immediately and that suspected or confirmed allegations of abuse would have been acted upon by all team members.

Further review of the home's policy revealed that the home was to have completed an internal investigation during any suspected or confirmed allegation of abuse, immediately notify the MOHLTC and initiate a CIS report.

Inspector #638 conducted an interview with the DOC on April 27, 2016, and they revealed that the only record of DOS charting completed in 2016, occurred in February 2016, for seven days and there were no other records of DOS charting for resident #001. The DOC confirmed that there were no documented specific time checks after August 2015, for resident #001 during times when they were in certain areas with residents and confirmed that there was no means of identifying if this intervention had been followed. They further reported that the home had initiated a new physician referral in April 2016, after six additional incidents of inappropriate responsive behaviours had occurred. The DOC further revealed that the home's internal investigation for the incident in April 2016, between resident #001 and resident #002 was not initiated until one day later and the internal investigation was not completed. The internal investigations for the incidents that occurred on two other days in April 2016, was not initiated until three days later. The DOC went on to confirm that none of these incidents were reported to the Director as per the home's policy.

The home did not protect all residents from the inappropriate responsive behaviours of resident #001 and it was the expectation of the home that all residents were protected from abuse by anyone. [s. 19. (1)]

Non-compliance had been previously issued under inspection 2016_334565_0004, including a VPC.

The decision to issue this Compliance order was based on the scope which affected four residents, the severity which indicated actual harm or risk and a compliance history which despite previous non-compliance (NC) issued a VPC,

NC has continued.
(638)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 14, 2016

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
Ontario, ON
M5S-2B1
Fax: 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
Ontario, ON
M5S-2B1
Fax: 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 3rd day of October, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Debbie Warpula

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