Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 22, 2020	2020_836766_0009 (A1)	010880-20, 012711-20, 012713-20, 014058-20	Complaint

Licensee/Titulaire de permis

2063412 Ontario Limited as General Partner of 2063412 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Creedan Valley Care Community
143 Mary Street CREEMORE ON L0M 1G0

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

Amended by KATY HARRISON (766) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

This report has been revised to reflect an extension to the CDD. The Complaint inspection, #:2020_836766_0009 was completed on July 20-24, 27, 2020.
A copy of the revised report is attached.

Issued on this 22nd day of October, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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Creedan Valley Care Community
143 Mary Street CREEMORE ON L0M 1G0

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

Amended by KATY HARRISON (766) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 20-27, 2020

The following intakes were completed within this complaint inspection;

Log #010880-20, related to re-admission of resident from hospital and concerns regarding plan of care

Log #014058-20, related to the home interfering in resident relationships and a leak in the ceiling

Log #012711-20, Follow up to compliance order #004, 2020_781729_0005 related to bathing

Log #012713-20, Follow up to compliance order #006, 2020_781729_0005 related to Infection Prevention and Control practices

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Care Partner (CPP), Office Manager, Scheduling Coordinator, Housekeeper, RAI Coordinator/Infection Control Lead (RAIC/ICL), Resident Relations Coordinator (RRC), Maintenance Manager, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW), Agency staff, residents and family members.

The inspectors also toured resident home areas, observed resident care provision, Infection Control practices, meal service, resident staff interaction; reviewed relevant clinical records, policies, procedures, incident reports, Critical Incident Report and staff training records pertaining to the inspection. Interviews were conducted with residents, staff and family members.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services

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

5 WN(s)
4 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 229. (4)	CO #006	2020_781729_0005	766
O.Reg 79/10 s. 33. (1)	CO #004	2020_781729_0005	155

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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:
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

A complaint was received by the Ministry of Long-Term Care pertaining to resident #008 and resident #009 who had been prevented by the home from having a relationship.

Resident #008 asked inspector #766 what their rights were and if they were

allowed to have a relationship with resident #009. Resident #008 stated that they didn't understand why the home would say they couldn't have a relationship with resident #009 if they both wanted it. The resident understood consent and the need for both of them to consent to the relationship

.

The progress notes showed that on a certain date resident #008 was upset and tearful at times as they were concerned about the situation and the actions taken; namely that staff separated residents #008 and #009 as they were observed to be intimate with each other. A review of the progress notes for resident #009 showed that on a certain date the resident was upset because they were told they couldn't have a relationship with resident #008.

The home submitted a Critical Incident (CI) #2633-000020-20 related to sexual abuse. The report stated that an agency Personal Support Worker (PSW) observed two residents in the hallway kissing and holding hands.

2. (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" means, 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.

The homes' investigation determined through witness statements that both residents consented to the kiss and were aware of their actions.

The Lichtenberg Tool for Assessing Sexual Capacity to Consent was completed for residents #008 and #009 and comments made from both residents showed that the kiss was consensual in the moment. However, according to the home's policy if your Mini Mental State Examination (MMSE) is 14 or less you are unable to consent. Resident #009's MMSE was less than 14.

During an interview with resident #009 they said they understood what consent meant and felt they should be able to have a relationship if they wanted one. The resident stated that if they no longer wanted the relationship, they would be comfortable telling staff, and the co-resident, that the relationship was over.

Staff indicated that both resident #008 and #009 could consent in the moment.

The progress notes and care plan for both residents indicated that staff were encouraged to keep the residents apart. This was confirmed during staff

interviews with PSW #107. Resident and staff interviews confirmed consent in the moment and a review of the relevant documentation, including progress notes, assessments and incident reports showed that both resident #008 and resident #009 were consenting in the moment.

The licensee failed to ensure that resident #008 and resident #009 right to form friendships and relationships and to participate in the life of the long-term care home was respected.

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 / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

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

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident, the SDM, if any, and the

designate of the resident/SDM was provided the opportunity to participate fully in the development and implementation of the plan of care.

The Ministry of Long Term Care received a complaint that resident #004 was sent to hospital for reasons related to not taking their medication. The SDM said they were not informed that resident #004 had not been taking their medication.They felt that had they been notified at the time that resident #004 was refusing their medications they could have assisted the staff in getting the resident to take their medication and avoided the need for the resident to be hospitalized. SDM #126 shared that they had informed the staff of their concerns.

Review of resident 004's eMAR showed that in a particular month resident #004 refused a certain medication on 21 of the 26 days (80.7 per cent of the time).

Review of resident #004's progress notes showed the following:

After reviewing the seven communication notes only two were related to the resident not taking medication and both calls to the SDM took place early in the month in question.

Resident Relations Coordinator #123 shared that during a care conference SDM #126 expressed concerns about resident #004 refusing their medication and they had looked into the concerns. The completed Complaint Record showed that in the month in question resident #004 took their medication 3/20 times, that the Doctor was aware of the resident refusing medication and discussed this with the SDM. Resident Relations Coordinator, #123 said they were not sure if medication refusals were discussed during the calls with the SDM.

SDM #127 said they had no idea medication was refused 21 of the 26 days. SDM #126 and #127 shared that if they had known resident #004 was not taking their medications they would have arranged to be available on the phone to encourage the resident to take their medication.

RN #110 shared that resident #004 was admitted to hospital for reasons related to not taking their medication. RN #110 said they had spoken to SDM #127 at least once a week advising them that they had a lot of challenges with resident #004 but were unsure whether they spoke about medication.

The licensee failed to ensure that the resident, the SDM, if any, and the designate

of the resident/SDM was provided the opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)]

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 resident, the residents' substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the residents' plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #004 had their weight monitored and recorded monthly.

Review of resident #004's weights recorded in Point Click Care showed that resident #004 was weighed in May, 2020. The next weight recorded for resident #004 was in July, 2020, which showed the resident had lost weight.

RPN #120 and RN #110 shared that residents were to be weighed between the first and the tenth of each month and the weight was to be recorded in Point Click Care in the weights and vitals section.

Director of Dietary Services #122 and Executive Director #100 acknowledged that residents were to be weighed monthly and that resident #004 was not weighed during the month of June 2020.

The licensee failed to ensure that resident #004 was weighed during the month of June 2020. [s. 68. (2) (e) (i)]

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 a weight monitoring system to measure and record each residents weight on admission and monthly thereafter, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. **A change of 5 per cent of body weight, or more, over one month.**
2. **A change of 7.5 per cent of body weight, or more, over three months.**
3. **A change of 10 per cent of body weight, or more, over 6 months.**
4. **Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.**

Findings/Faits saillants :

1. The licensee failed to ensure that resident #006 was assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated when resident #006 had a documented weight loss greater than five per cent of their body weight over one month.

Review of resident #006's weight recorded in Point Click Care showed that resident #006 experienced a weight loss over a one month period that was greater than five per cent of the resident's body weight in one month. The resident was re-weighed twice and dietary referral completed.

Review of resident #006's assessments in point click care and progress notes by the Registered Dietitian showed that resident #006 had not been assessed by the Registered Dietitian for a couple of months.

Director of Dietary Services #112 reviewed their weight variance reports and noted that the weight change for resident #006 was not noted on the report.

Executive Director #100 reviewed resident #006's Point Click Care records and acknowledged that resident #006 had not been assessed for the weight loss of greater than five per cent of their body weight in one month.

The licensee failed to ensure that resident #006 was assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated when resident #006 had a documented weight loss greater than five per cent of their body weight over one month. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 residents with a change of five percent body weight over one month are assessed using an interdisciplinary approach, and that actions are taken and that outcomes are evaluated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Findings/Faits saillants :

1. The licensee failed to comply with the following requirement of the LTCHA: it is a condition of every license that the licensee shall comply with every order made under the Act.

On June 8, 2020, compliance order (CO) #004 from inspection number 2020_781729_0005 (A1) was issued under O.Reg 79/10, s.33(1) that stated:

The licensee must be compliant with s.33 (1) of O. Reg 79/10.

Specifically, the licensee must:

a) Ensure that residents #004, #008, #014 and all other residents are bathed by the method of their choice at a minimum twice per week.

b) Ensure that the residents #004, #008, #014 and all other residents' plan of care clearly states their bathing preference. Any deviation for their bathing preference shall be documented in the residents clinical record at time of the deviation.

c) Ensure that staff member #113 and all other nursing and personal care staff receive training on the use of the shower chair provided for showering residents and ensure that the training on the use of the shower chair is added to all nursing and personal care staff orientation checklists.

The compliance date was July 7, 2020.

The licensee completed step a) and b) but failed to complete step c).

Review of the Sienna Senior Living RPN orientation checklist and Sienna Senior Living RN orientation checklist did not include training on the use of the shower chair.

Executive Director #100 and Compliance Manager #118 agreed that the RPN and RN orientation checklists did not include training on the use of the shower chair.

The licensee failed to comply with part c) of compliance order #004 made under the act. [s. 101. (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 the licensee comply with the Act, the Local Health System Integration Act, 2006, The comittment to the failure of the Medicare Act, 2004, the Regulations, and every directive issued, order made, or agreement entered into under this Act and those Acts, to be implemented voluntarily.

Issued on this 22nd day of October, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by KATY HARRISON (766) - (A1)
Inspection No. / No de l'inspection :	2020_836766_0009 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	010880-20, 012711-20, 012713-20, 014058-20 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 22, 2020(A1)
Licensee / Titulaire de permis :	2063412 Ontario Limited as General Partner of 2063412 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Creedan Valley Care Community 143 Mary Street, CREEMORE, ON, L0M-1G0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Chantal Carriere

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To 2063412 Ontario Limited as General Partner of 2063412 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 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. 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.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee must be compliant with LTCHA Act s.3. (1) 18.

Specifically the licensee must;

a) ensure that resident #008 and resident #009 have the right to form friendships and relationships and to participate in the life of the long-term care home.

b) review and revise the homes policy, Sexual Expressions and Intimacy, VII-G10.10, to ensure that the policy is based on current research, evidence and best practice.

c) ensure that staff are educated on any changes made to the Sexual Expressions and Intimacy policy. A record of the education including date, staff names and education content should be kept in the home.

Grounds / Motifs :

1. A complaint was received by the Ministry of Long-Term Care pertaining to resident

#008 and resident #009 who had been prevented by the home from having a relationship.

Resident #008 asked inspector #766 what their rights were and if they were allowed to have a relationship with resident #009. Resident #008 stated that they didn't understand why the home would say they couldn't have a relationship with resident #009 if they both wanted it. The resident understood consent and the need for both of them to consent to the relationship.

The progress notes showed that on a certain date resident #008 was upset and tearful at times as they were concerned about the situation and the actions taken; namely that staff separated residents #008 and #009 as they were observed to be intimate with each other. A review of the progress notes for resident #009 showed that on certain date the resident was upset because they were told they couldn't have a relationship with resident #008.
The home submitted a Critical Incident (CI) #2633-000020-20 related to sexual abuse. The report stated that an agency Personal Support Worker (PSW) observed two residents in the hallway kissing and holding hands.

2. (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" means, 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.

The homes' investigation determined through witness statements that resident #008 had asked resident #009 for a kiss and they kissed in the hallway, on the lips. Both residents consented to the kiss and were aware of their actions.

The Lichtenberg Tool for Assessing Sexual Capacity to Consent was completed for residents #008 and #009 and comments made from both residents showed that the kiss was consensual in the moment. However, the most recent Mini Mental State Examination (MMSE) score for resident #009 was 11/30. The homes policy stated anyone with an MMSE score of 14 or less was unable to give consent.

During an interview with resident #009 they said they understood what consent meant and felt they should be able to have a relationship if they wanted one. The resident stated that if they no longer wanted the relationship, they would be

comfortable telling staff, and the co-resident, that the relationship was over. The resident said the relationship with resident #008 had developed over a few months.

PSW #107 said they believed resident #009 could consent in the moment and the resident would say something if they did not want the attention. RPN #116 said they felt that resident #009 could decide in the moment if it was OK to hold hands and have a kiss with resident #008.

The progress notes for resident #009 showed that direction was given to ensure that resident #009 and resident #008, were kept away from one another until further notice. Staff were encouraged to keep resident #009 and resident #008 apart.

The care plan for both residents stated that staff were to intervene if they got too close and separate them. This was confirmed during staff interviews with PSW #107, who stated, everyone's been told to keep them apart by management. RRC #123, confirmed that if the residents were getting physical, the staff were supposed to separate them.

Resident and staff interviews confirmed consent in the moment and a review of the relevant documentation, including progress notes, assessments and incident reports showed that both resident #008 and resident #009 were consenting in the moment.

The licensee failed to ensure that resident #008 and resident #009 right to form friendships and relationships and to participate in the life of the long-term care home was respected

The severity of this issue was determined to be a level 2 as there was minimal risk or harm to the residents. The scope of the issue was a level 2 as it related to two of the three residents reviewed. The home had a level 2 history of previous non-compliance to a different sub-section of the Act.

(766)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 20, 2020(A1)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

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

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

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

Issued on this 22nd day of October, 2020 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by KATY HARRISON (766) - (A1)

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

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Service Area Office / Bureau régional de services : Central West Service Area Office