Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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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
May 14, 2021	2021_751649_0004 (A1) (Appeal\Dir#: n/a)	022976-20, 023014-20, 024722-20, 001043-21, 001883-21, 002107-21	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

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

Norfinch Care Community
22 Norfinch Drive North York ON M3N 1X1

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

Amended by JULIEANN HING (649) - (A1)(Appeal\Dir#: n/a)

Amended Inspection Summary/Résumé de l'inspection modifié

To remove the first point in Compliance Order (CO)#001.

Issued on this 14th day of May, 2021 (A1)(Appeal\Dir#: n/a)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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Amended by JULIEANN HING (649) - (A1)(Appeal/Dir# n/a)

Amended 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): February 19, 22, 23, 24, 25, 26, March 2, 3, 4, 5, 7 (off-site), 8, 9, 10, and 22 (off-site), 2021.

The following intakes were completed during this Critical Incident System (CIS) Inspection:

Logs #022976-20 and #002107-21 related to plan of care.

Logs #024722-20 and #001883-21 related to duty to protect.

Log #023014-20 related to prevention of abuse and neglect.

Log #001043-21 related to a communicable disease outbreak in the home.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Directors of Care (ADOCs), Director of Resident Programs (DRP), Physicians, Nurse Managers (NMs), Nurse Manager/ Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RNs), Registered Dietitian (RD), Physiotherapist (PT), Resident and Family Experience (RFE), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Recreation Aide (RA), Housekeepers, and residents.

During the course of the inspection the inspector observed staff to resident interactions, conducted resident observations, reviewed residents' clinical records, staffing schedules, and reviewed policy and procedures.

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

9 WN(s)
4 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	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care of two residents collaborated with each other.

A review of the home's policy #VII-F-10.10, titled Responsive Behaviours Management, with a current revision date of November 2020 directed the nurse as follows:
1.If a resident has a known history of responsive behaviours on move in, initiate a BSO-DOS monitoring and Responsive Behavioural Referral to screen for potential risk and assist in developing the plan of care to minimise risk to self/others.
2.Conduct and document an assessment of the resident experiencing responsive behaviours that may include:
- completing behavioural assessments based on the resident need, including but not limited to: Behavioural Assessment Tools (BAT), Depression Scale, Mini-mental Cohen-Mansfield Aggression Inventory, PIECES
-Coach frontline team members about interventions identified on the plan of care and strategize with them on additional interventions required or on the effectiveness of interventions
-evaluate the effectiveness of a planned intervention on the plan of care addressing specific responsive behaviours.
3.Complete an electronic Responsive Behaviour Referral to the internal Behavioural Support Lead/ Designate:
-When there is a new, worsening, or change in responsive behaviours
-Upon move in of a resident with identified responsive behaviour(s) that poses a risk to themselves or others.

A review of a resident's assessments indicated that no Responsive Behavioural Referral was completed at the time of admission even though their behavioural

assessment tool indicated that they exhibited responsive behaviours.

According to the resident's progress notes several incidents of sexual abuse occurred of them inappropriately touching other residents' private areas on different occasions.

The physician documented in the resident’s progress notes that they were not acting inappropriately recently, even though three incidents of sexual abuse had previously occurred.

According to one of the resident's progress notes, the DOC had spoken with resident’s family member who consented to an external referral, but wanted to wait a couple of weeks to determine the effectiveness of an identified medication. The DOC confirmed that the referral was not sent.

There was an interdisciplinary care conference attended by a Nurse Manager, Registered Dietitian, Recreation Assistant, and ADOC, who is a co-lead for the home’s responsive behaviour program. The main issue identified was medication compliance. There was no mention in this interdisciplinary care conference of the resident’s inappropriate sexual behaviours despite documentation of several incidents.

An incident of sexual abuse occurred involving another resident. The other resident reported to the nurse that the resident had gone into their room while they were in bed, and asked them to perform an inappropriate act. According to the incident note the physician was not immediately notified. The incident was reported to the registered nurse who documented that they reported the incident to the on-call manager. This incident was not reported to the Ministry, and there was no documentation of any follow-up action taken in regards to the resident's inappropriate sexual behaviours.

The physician documented when they became aware of the above incident to remove the resident’s mobility device overnight. This intervention was updated in the resident's care plan. No other action was taken.

The physician ordered an external referral in the fall of 2020. The resident's family declined after the first consultation therefore the service was cancelled.

According to a PSW the resident was very touchy with the staff. They told the

inspector that the resident did not like anyone going into their room even though residents wandered on the unit. They witnessed the resident going into another resident's room and confirmed that the resident had not mistakenly gone to the other resident`s room, but that it was intentional. The resident touched the other resident and they yelled. They acknowledged being aware that the resident would inappropriately touch other residents. The PSW told the inspector that they had never removed the resident's mobility device at night and was not aware of this intervention.

A PSW told the inspector that the resident likes to touch other residents. According to the PSW if the resident saw you looking at them, they would not demonstrate this behaviour, but if by chance they were spotted exhibiting this behaviour, they would deny it. When the resident was asked to lower their voice, they will raise their voice louder. The PSW admitted they did not read the care plan and had been using their own approach with the resident.

The RPN told the inspector that the resident touches residents and staff inappropriately. The resident will go into other resident rooms deliberately. There was no trigger for the resident's behaviour and that another identified behaviour occurred mostly at nights. In response to a different identified behaviour they had been using an identified intervention to distract them.

A RPN told the inspector that the resident had touched another resident's private area in the hallway. They asked the resident if they had done what the other resident had alleged and they denied it. The nurse acknowledged being aware of the resident's behaviour of inappropriately touching other residents and staff, but was not certain if they had informed management about this incident. They did not immediately consider what happened between the two residents as sexual abuse.

The same RPN witnessed another incident of sexual abuse involving another resident. The other resident came out of their room and was fixing their mobility device, when the resident went behind them and touched them inappropriately. They asked the resident what they were doing, to which the resident responded with the use of profanities. The RPN alleged giving a verbal report of the incident to the charge nurse but was unable to recall who. There was no documentation by the RPN that the two incidents were reported to the charge nurse.

The RN who was the in-charge nurse when the two incidents had occurred could not recall being informed about them. They explained that when something was

reported to them, they usually documented and confirmed that they had not documented on the two incidents. They confirmed after reading the progress notes that sexual abuse had occurred, and had to be reported to the Ministry of Long-Term Care (MLTC) immediately. The RN pointed out that there was no documentation by the RPN that they had reported the two incidents to them.

A RPN told the inspector that the resident exhibited an identified responsive behaviour and that this behaviour occurs at any time and was not specific to a trigger. The resident would exhibit another type of responsive behaviour and when asked to reduce this behaviour it would get louder. They had been using a specific intervention to distract the resident which they had found to be effective. When the resident was approached and asked to stop their behaviour it escalated more. They had been using two identified interventions for several months.

A Responsive Behavioural Referral was sent to the ADOC related to the resident's responsive behaviours.

The ADOC acknowledged being aware of the referral and told the inspector that they had ruled out other possible causes for the resident's responsive behaviours. They had missed the follow-up on the resident's sexually inappropriate behaviour.

The resident was ordered an identified medication which was discontinued six months later, due to a side effect. No other medications were ordered to help with the resident’s inappropriate sexual behaviours. At the time that the identified medication was discontinued the physician ordered an external referral, the DOC confirmed that this referral was not sent.

The resident’s care plan did not indicate that they exhibited an identified responsive behaviour, and that when asked to reduce this behaviour it would get louder.

The ADOC told the inspector that the resident’s behaviours were unpredictable, and they needed to be referred to an external source, and reassess by the home's physician. In response to action taken to protect residents, they told the inspector that the resident required 1:1 monitoring. They confirmed that the home no longer used the BAT referral as was indicated in their policy. They acknowledged several incidents of sexual abuse had occurred and home's failure to take action.

The DOC co-lead of the home's responsive behaviour program also indicated that the resident's behaviours were unpredictable. They identified several triggers for the resident and admitted to dropping the ball for this resident. The incidents that occurred on several different occasions were reviewed with the DOC and they implemented a 1:1 staff for monitoring the resident during the inspection. Some of the above information was shared with the DOC and they acknowledged a gap in collaboration among staff.

Sources: resident's clinical record, home's policy #VII-F-10.10, titled Responsive Behaviours Management with revision date of November 2020, interview with DOC, and other staff. [s. 6. (4)]

2. A resident returned to the home Coronavirus (COVID-19) positive after spending time in hospital.

The resident's progress notes were reviewed and indicated that they repeatedly reported feeling unwell but no action was taken by the home to collaborate with the physician about the resident's health condition. The resident sustained a fall and was transferred to hospital and passed away.

The PT acknowledged that they had not told the nurse about the resident's discomfort, only about another medical concern, they assumed that the other medical concern was causing the discomfort but did not clarify this with the resident.

The resident's primary physician was away from work for a few days during the above mentioned period and coverage was being provided by several other physicians. All the physicians including the resident's primary physician denied being informed of the resident's change in health status.

The DOC and other staff acknowledged that there was a lack of collaboration between nursing, and the physician when the resident reported feeling unwell; and that the resident's Substitute Decision-Maker (SDM) had not been informed of the change in the resident's health status.

Sources: resident's health records, staffing schedule, interview with DOC and other staff. [s. 6. (4) (a)]

Additional Required Actions:

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

(A1)(Appeal/Dir# n/a)
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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

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

A review of the home's policy #VII-G-10.00 titled Prevention of Abuse and Neglect of a Resident with a current revision date of April 2019, stated that the home has a zero tolerance policy for resident abuse and neglect. The policy indicates under abuse definitions that any non-consensual touching, behaviour, or remarks or a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or team member constitutes sexual abuse.

As a result of the resident's involvement in an incident their clinical records were reviewed, and several incidents of sexual abuse were identified by the inspector.

The DOC confirmed that five incidents of resident to resident sexual abuse were not reported to the MLTC. No action was taken in regards to the home's policy that directed staff to assess the resident's safety, emotional and physical well-being, inform the SDM immediately, and the Executive Director (ED) or designate to initiate an investigation. They also confirmed that there was no documentation that one of the alleged victim's SDM was informed of an incident of sexual abuse.

Sources: residents clinical records, home's policy #VII-G-10.00 titled Prevention of Abuse and Neglect of a Resident with a current revision date of April 2019, and interview with DOC. [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 five residents were protected from physical abuse.

Under O. Reg. 79/10, for the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, subject to section (2), the use of physical force by a resident that causes physical injury to another resident.

The home submitted a Critical Incident System (CIS) report related to an incident of resident to resident physical abuse that occurred between two residents. According to the CIS report and interview with the nurse who discovered the incident told the inspector that they heard a resident yelling, and found another resident on the floor in their room with the resident standing over them. The resident found on the ground was cognitively intact and told the nurse that the other resident had gone into their room, and when asked to leave became aggressive. As a result of this incident, the resident sustained an area of altered skin integrity, and verbalized pain to another body area. The resident was later diagnosed with a injury as a result of this altercation. Physical abuse was confirmed by the home’s staff.

Sources: residents’ health records, CIS report, interview with DOC, and other staff. [s. 19. (1)]

2. The home submitted a CIS report related to an incident of resident to resident physical abuse that occurred between two residents. One resident accidentally scratched the other resident and the resident slapped them on the face.

According to the PSW there was a program/activity in progress, and while serving the nourishment they heard a noise and a resident came to them and showed them that they were bleeding. The resident stated that another resident had scratched them. The PSW told the inspector that one of the residents admitted to hitting the other resident on the face. The PSW did not actually witness what had

happened between the two residents, and only became aware of the incident when the resident came to them and showed them they were bleeding.

According to the RA they were having a program/activity when the nourishment cart arrived, as a result the program was stopped. The RA left the area while the nourishment was being served and was at the nursing station when they heard a PSW screaming and attended to see what was happening. They saw a resident trying to get to another resident and a PSW was between the two residents. They did not see the resident scratch the other resident.

The physician had ordered 1:1 staff monitoring for the resident who sustained the scratch, after the first incident mentioned above where they had gone into another resident's room and caused them to have an injury. At the time of this incident the resident did not have a 1:1 staff. Physical abuse was confirmed by the home's staff.

The home had submitted another CIS report, related to an incident of resident to resident physical abuse between the resident who sustained the scratch and another resident. According to this report the other resident had sustained an injury as a result of their interaction with this resident. At the time of the incident the resident did not have a 1:1 staff which was ordered by the physician after the first incident mentioned above where they had gone into another resident's room and caused them to have an injury.

Sources: residents' health records, CIS report, interview with DOC, and other staff. [s. 19. (1)]

3. The home submitted a CIS report related to an incident of resident to resident physical abuse that occurred between two residents. According to the CIS report and staff interview they heard the resident calling out and the other resident was holding onto the resident and pulling. The staff told the inspector that they heard the resident who was holding onto the other resident using profanities and making verbal threats to them. As a result of this incident the resident sustained an injury. The home's staff confirmed that physical abuse had occurred.

Sources: residents' health records, CIS report, interview with DOC, and other staff. [s. 19. (1)]

4. The licensee has failed to ensure that five residents were protected from sexual

abuse.

In accordance with the definition identified in section 2(1) of the Regulation 79/10 “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.

As a result of an incident of resident to resident physical abuse, this resident clinical records were reviewed, and several incidents of sexual abuse were identified by the inspector.

Inspector #649 made several observations of the resident's responsive behaviours.

One of the alleged residents remembered an incident of another resident coming into their room and asked them to perform an inappropriate act. They told the inspector that the same resident had touched their private area during another incident, and they had reported it to the nurse. There was no documentation of this alleged incident, and when the nurse was asked about this they denied being told.

The Physician documented in the resident’s progress notes that they were not acting inappropriately recently, even though three incidents of sexual abuse had occurred.

After a review of the above mentioned sexual incidents with the DOC they implemented a 1:1 staff for monitoring the resident during the inspection, to protect other residents' safety.

Sources: residents' health records, interview with DOC, interview with the resident and other staff. [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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that three residents who exhibited altered skin integrity were assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

The resident sustained an area of altered skin integrity. A referral was not made to the RD for the resident's injury therefore the resident was not assessed. The wound healed approximately 10 days later.

Sources: Review of one resident's health records, interview with DOC, and other staff. [s. 50. (2) (b) (iii)]

2. The resident sustained an area of altered skin integrity that required a dressing. A referral was not made to the RD for the resident's injury therefore the resident was not assessed. The inspector was unable to find any documentation of when the injury healed.

Sources: Review of one resident's health records, interview with ADOC, and other staff. [s. 50. (2) (b) (iii)]

3. The resident sustained an area of altered skin integrity. A referral was not made to the RD for resident's injury therefore the resident was not assessed. The most recent weekly skin and wound assessment completed, did not indicate the status of the injury. The previous assessment indicated that the injury was improving.

Sources: Review of one resident's health records, interview with DOC, and other staff. [s. 50. (2) (b) (iii)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

Inspector #649 observed the medication cart on a home area unlocked. The RPN went into a resident's room, the resident's door was partially closed, therefore the medication cart was not visible to the RPN when they were in the resident's room. A resident was observed sitting outside of their room in their mobility device in close proximity to the unlocked medication cart.

The RPN acknowledged that the medication cart should have been locked when they left it unattended.

Sources: Inspector #649's observations and interview with RPN. [s. 129. (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 drugs are stored in an area or a medication cart, that is secure and locked, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to two residents in accordance with the directions for use specified by the prescriber.

The resident verbalized pain after an incident of physical abuse involving another resident. Documentation indicated that the resident had moderate pain, as a result of this incident. No pain medication was administered to the resident when they verbalized pain despite having a physician’s order for analgesic.

The ADOC confirmed that no pain medication was administered to the resident when they reported pain.

Sources: one resident's health records, and interview with ADOC, DOC, and other staff. [s. 131. (2)]

2. The resident sustained an injury due to an incident between them and another resident. They were assessed and indicated mild pain post incident. No pain medication was administered to the resident when there was documentation of pain despite having a physician’s order for analgesic.

The home’s staff confirmed that no pain medication was administered to the resident when there was documentation of pain.

Sources: one resident's health records, interview with DOC, and other staff. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

The following observations were made by Inspector #649 related to the home's infection prevention and control program (IPAC).

-A Housekeeper was observed inside a resident's room without a gown; they told the inspector that they were told by a manager that they are not required to wear a gown as they were not in close contact with the resident. According to the PSW it had been 14 days at the time of the observation since they had not been wearing a gown when going into resident rooms, despite signage on the resident's door indicating they were on droplet/contact precautions. The RPN and NM both confirmed that the Housekeeper was told not to wear a gown when going into a resident's room on droplet/contact precautions.

-A Housekeeper and PSW were observed inside a resident's room without a gown. There was signage posted on resident's door indicating they were on droplet/contact precautions. The PSW confirmed that they had not been wearing a gown when care was being provided to the resident.

These observations were brought to the ADOC`s attention who is the home's IPAC Lead and the DOC. The DOC told the inspector that there had been some miscommunication between the home and the Public Health Unit related to the PPE practices.

Sources: Inspector #649's observations, interview with DOC and other staff. [s. 229. (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 all staff participate in the implementation of the program, to be implemented voluntarily.

WN #8: 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:
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. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to, 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.

Inspector #649 observed the screen on the medication cart on a home area open, and an identified resident's personal health information was visible. A resident was observed sitting outside of their room in their mobility device in close proximity to the electronic-medication administration record (e-MAR) screen on the medication cart.

The RPN acknowledged that the e-MAR screen should not have been left open when left unattended.

Sources: Inspector #649's observations, interview with DOC and other staff. [s. 3. (1) 11. iv.]

WN #9: 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.
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, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm to the resident was immediately reported to the Director.

The home submitted a CIS report related to an incident of resident to resident physical abuse that occurred between two residents, while they were attending a program. A resident accidentally scratched the other resident on the arm, and the resident slapped the other resident on the face. This incident was reported to the Ministry after hours number two days late.

Sources: Review of the CIS report, interview with DOC, and other staff. [s. 24. (1) 2.]

Issued on this 14th day of May, 2021 (A1)(Appeal/Dir# n/a)

[redacted]

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 JULIEANN HING (649) - (A1) (Appeal/Dir# n/a)
Inspection No. / No de l'inspection :	2021_751649_0004 (A1)(Appeal/Dir# n/a)
Appeal/Dir# / Appel/Dir#:	n/a (A1)
Log No. / No de registre :	022976-20, 023014-20, 024722-20, 001043-21, 001883-21, 002107-21 (A1)(Appeal/Dir# n/a)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 14, 2021(A1)(Appeal/Dir# n/a)
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, Markham, ON, L3R-0E8
LTC Home / Foyer de SLD :	Norfinch Care Community 22 Norfinch Drive, North York, ON, M3N-1X1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gajany Sivalingam

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 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

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. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

(A1)(Appeal/Dir# n/a)
The licensee must be compliant with s. 6 (4) of the LTCHA.

Specifically, the licensee must:

1. Retrain all registered staff on the home's Responsive Behaviours Management policy #VII-F-10.10.
The home must maintain a documentation record of the education and training provided, including the dates of when the education was provided, who provided the education, and signed staff attendance records.

2. Implement a documented process to ensure that the physician is immediately informed of all incidents of sexual abuse involving the resident.

3. Ensure all Geriatric Mental Health Outreach Team (GMHOT) and Behavioural Supports Ontario (BSO) referrals are processed in a timely manner.

4. Maintain a documented system to ensure that all frontline staff (PSWs) are kept up to date on the interventions in the resident's care plan including any

revisions.

5. Implement a process to ensure all allegations of sexual abuse are immediately reported to management of the home.

6. Update the resident's care plan with interventions that have been identified by staff to be effective in managing their responsive behaviours. Provide an opportunity for staff to meet and discuss the resident's care plan interventions on all shifts.
The home must maintain documentation of discussions, including the dates and times, staff signed attendance, and outcome of the discussions.

7. Implement a process to ensure the ADOC and the DOC (co-leads of the home's responsive behaviour program) are informed about all allegations of sexual abuse involving the resident and any other resident.
The home must maintain documentation of action taken, date of action, and outcome of action taken.

8. When a resident and any other resident experiences a change in health status there should be collaboration between nursing staff and the physician.

Grounds / Motifs :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care of two residents collaborated with each other.

A review of the home's policy #VII-F-10.10, titled Responsive Behaviours Management, with a current revision date of November 2020 directed the nurse as follows:
1.If a resident has a known history of responsive behaviours on move in, initiate a BSO-DOS monitoring and Responsive Behavioural Referral to screen for potential risk and assist in developing the plan of care to minimise risk to self/others.
2.Conduct and document an assessment of the resident experiencing responsive behaviours that may include:
- completing behavioural assessments based on the resident need, including but not limited to: Behavioural Assessment Tools (BAT), Depression Scale, Mini-mental Cohen-Mansfield Aggression Inventory, PIECES
-Coach frontline team members about interventions identified on the plan of care and

strategize with them on additional interventions required or on the effectiveness of interventions
-evaluate the effectiveness of a planned intervention on the plan of care addressing specific responsive behaviours.
3.Complete an electronic Responsive Behaviour Referral to the internal Behavioural Support Lead/ Designate:
-When there is a new, worsening, or change in responsive behaviours
-Upon move in of a resident with identified responsive behaviour(s) that poses a risk to themselves or others.

A review of a resident's assessments indicated that no Responsive Behavioural Referral was completed at the time of admission even though their behavioural assessment tool indicated that they exhibited responsive behaviours.

According to the resident's progress notes several incidents of sexual abuse occurred of them inappropriately touching other residents' private areas on different occasions.

The physician documented in the resident's progress notes that they were not acting inappropriately recently, even though three incidents of sexual abuse had previously occurred.

According to one of the resident's progress notes, the DOC had spoken with resident's family member who consented to an external referral, but wanted to wait a couple of weeks to determine the effectiveness of an identified medication. The DOC confirmed that the referral was not sent.

There was an interdisciplinary care conference attended by a Nurse Manager, Registered Dietitian, Recreation Assistant, and ADOC, who is a co-lead for the home's responsive behaviour program. The main issue identified was medication compliance. There was no mention in this interdisciplinary care conference of the resident's inappropriate sexual behaviours despite documentation of several incidents.

An incident of sexual abuse occurred involving another resident. The other resident reported to the nurse that the resident had gone into their room while they were in bed, and asked them to perform an inappropriate act. According to the incident note

the physician was not immediately notified. The incident was reported to the registered nurse who documented that they reported the incident to the on-call manager. This incident was not reported to the Ministry, and there was no documentation of any follow-up action taken in regards to the resident's inappropriate sexual behaviours.

The physician documented when they became aware of the above incident to remove the resident's mobility device overnight. This intervention was updated in the resident's care plan. No other action was taken.

The physician ordered an external referral in the fall of 2020. The resident's family declined after the first consultation therefore the service was cancelled.

According to a PSW the resident was very touchy with the staff. They told the inspector that the resident did not like anyone going into their room even though residents wandered on the unit. They witnessed the resident going into another resident's room and confirmed that the resident had not mistakenly gone to the other resident`s room, but that it was intentional. The resident touched the other resident and they yelled. They acknowledged being aware that the resident would inappropriately touch other residents. The PSW told the inspector that they had never removed the resident's mobility device at night and was not aware of this intervention.

A PSW told the inspector that the resident likes to touch other residents. According to the PSW if the resident saw you looking at them, they would not demonstrate this behaviour, but if by chance they were spotted exhibiting this behaviour, they would deny it. When the resident was asked to lower their voice, they will raise their voice louder. The PSW admitted they did not read the care plan and had been using their own approach with the resident.

The RPN told the inspector that the resident touches residents and staff inappropriately. The resident will go into other resident rooms deliberately. There was no trigger for the resident's behaviour and that another identified behaviour occurred mostly at nights. In response to a different identified behaviour they had been using an identified intervention to distract them.

A RPN told the inspector that the resident had touched another resident's private

area in the hallway. They asked the resident if they had done what the other resident had alleged and they denied it. The nurse acknowledged being aware of the resident's behaviour of inappropriately touching other residents and staff, but was not certain if they had informed management about this incident. They did not immediately consider what happened between the two residents as sexual abuse.

The same RPN witnessed another incident of sexual abuse involving another resident. The other resident came out of their room and was fixing their mobility device, when the resident went behind them and touched them inappropriately. They asked the resident what they were doing, to which the resident responded with the use of profanities. The RPN alleged giving a verbal report of the incident to the charge nurse but was unable to recall who. There was no documentation by the RPN that the two incidents were reported to the charge nurse.

The RN who was the in-charge nurse when the two incidents had occurred could not recall being informed about them. They explained that when something was reported to them, they usually documented and confirmed that they had not documented on the two incidents. They confirmed after reading the progress notes that sexual abuse had occurred, and had to be reported to the Ministry of Long-Term Care (MLTC) immediately. The RN pointed out that there was no documentation by the RPN that they had reported the two incidents to them.

A RPN told the inspector that the resident exhibited an identified responsive behaviour and that this behaviour occurs at any time and was not specific to a trigger. The resident would exhibit another type of responsive behaviour and when asked to reduce this behaviour it would get louder. They had been using a specific intervention to distract the resident which they had found to be effective. When the resident was approached and asked to stop their behaviour it escalated more. They had been using two identified interventions for several months.

A Responsive Behavioural Referral was sent to the ADOC related to the resident's responsive behaviours.

The ADOC acknowledged being aware of the referral and told the inspector that they had ruled out other possible causes for the resident's responsive behaviours. They had missed the follow-up on the resident's sexually inappropriate behaviour.

The resident was ordered an identified medication which was discontinued six months later, due to a side effect. No other medications were ordered to help with the resident's inappropriate sexual behaviours. At the time that the identified medication was discontinued the physician ordered an external referral, the DOC confirmed that this referral was not sent.

The resident's care plan did not indicate that they exhibited an identified responsive behaviour, and that when asked to reduce this behaviour it would get louder.

The ADOC told the inspector that the resident's behaviours were unpredictable, and they needed to be referred to an external source, and reassess by the home's physician. In response to action taken to protect residents, they told the inspector that the resident required 1:1 monitoring. They confirmed that the home no longer used the BAT referral as was indicated in their policy. They acknowledged several incidents of sexual abuse had occurred and home's failure to take action.

The DOC co-lead of the home's responsive behaviour program also indicated that the resident's behaviours were unpredictable. They identified several triggers for the resident and admitted to dropping the ball for this resident. The incidents that occurred on several different occasions were reviewed with the DOC and they implemented a 1:1 staff for monitoring the resident during the inspection. Some of the above information was shared with the DOC and they acknowledged a gap in collaboration among staff.

Sources: resident's clinical record, home's policy #VII-F-10.10, titled Responsive Behaviours Management with revision date of November 2020, interview with DOC, and other staff. [s. 6. (4)]

(649)

2. A resident returned to the home Coronavirus (COVID-19) positive after spending time in hospital.

The resident's progress notes were reviewed and indicated that they repeatedly reported feeling unwell but no action was taken by the home to collaborate with the physician about the resident's health condition. The resident sustained a fall and was transferred to hospital and passed away.

The PT acknowledged that they had not told the nurse about the resident's discomfort, only about another medical concern, they assumed that the other medical concern was causing the discomfort but did not clarify this with the resident.

The resident's primary physician was away from work for a few days during the above mentioned period and coverage was being provided by several other physicians. All the physicians including the resident's primary physician denied being informed of the resident's change in health status.

The DOC and other staff acknowledged that there was a lack of collaboration between nursing, and the physician when the resident reported feeling unwell; and that the resident's Substitute Decision-Maker (SDM) had not been informed of the change in the resident's health status.

Sources: resident's health records, staffing schedule, interview with DOC and other staff. [s. 6. (4) (a)]

An order was issued based on the following factors:
Severity: One or more residents experienced actual harm or risk of harm.

Scope: The scope of the non-compliance was identified as a pattern because one resident was identified with responsive behaviour and a second resident with a change in health condition, both were not collaborated on.

Compliance history: The licensee was previously found to be in non-compliance with different sections of the legislation in the past 36 months.
(649)

Aug 24, 2021

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

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

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: 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 must be compliant with s. 20. (1) of the LTCHA 2007.

Specifically, the licensee must:
1. Retrain all registered staff on the home's policy titled Prevention of Abuse & Neglect of a Resident (policy #VII-G.10.00 with current revision date of April 2019), related to their roles, responsibilities and definitions of abuse. The training should include scenarios of sexual abuse so as to reinforce staff understanding and identification of such incidents.

The home must maintain a documentation record of the education and training material content, including the dates the education was provided, who provided the education, and signed staff attendance records.

Grounds / Motifs :

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

A review of the home's policy #VII-G-10.00 titled Prevention of Abuse and Neglect of a Resident with a current revision date of April 2019, stated that the home has a zero tolerance policy for resident abuse and neglect. The policy indicates under abuse definitions that any non-consensual touching, behaviour, or remarks or a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or team member constitutes sexual abuse.

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

As a result of the resident's involvement in an incident their clinical records were reviewed, and several incidents of sexual abuse were identified by the inspector.

The DOC confirmed that five incidents of resident to resident sexual abuse were not reported to the MLTC. No action was taken in regards to the home’s policy that directed staff to assess the resident's safety, emotional and physical well-being, inform the SDM immediately, and the Executive Director (ED) or designate to initiate an investigation. They also confirmed that there was no documentation that one of the alleged victim's SDM was informed of an incident of sexual abuse.

Sources: residents clinical records, home’s policy #VII-G-10.00 titled Prevention of Abuse and Neglect of a Resident with a current revision date of April 2019, and interview with DOC. [s. 20. (1)]

An order was issued based on the following factors:

Severity: Three and more residents experienced sexual abuse indicating actual harm.

Scope: The scope of the non-compliance was identified as a pattern because five out of seven residents experienced sexual abuse.

Compliance history: The licensee was found to be non-compliant with S. 20. (1) of O. Reg 79/10 in the past 36 months, and a Compliance Order (CO) was issued to the home on July 22, 2019 on inspection report #2019_759502_0016 with a compliance due date of August 12, 2019.

(649)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Aug 24, 2021

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: 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 must be compliant with s. 19. (1) of the LTCHA 2007.

Specifically, the licensee must:
1. Ensure that all residents including the five residents mentioned below are protected from physical abuse.
2. Ensure that all residents including the five residents mentioned below are protected from sexual abuse.

Grounds / Motifs :

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

1. The licensee has failed to ensure that five residents were protected from physical abuse.

Under O. Reg. 79/10, for the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, subject to section (2), the use of physical force by a resident that causes physical injury to another resident.

The home submitted a Critical Incident System (CIS) report related to an incident of resident to resident physical abuse that occurred between two residents. According to the CIS report and interview with the nurse who discovered the incident told the inspector that they heard a resident yelling, and found another resident on the floor in their room with the resident standing over them. The resident found on the ground was cognitively intact and told the nurse that the other resident had gone into their room, and when asked to leave became aggressive. As a result of this incident, the resident sustained an area of altered skin integrity, and verbalized pain to another body area. The resident was later diagnosed with a injury as a result of this altercation. Physical abuse was confirmed by the home’s staff.

Sources: residents’ health records, CIS report, interview with DOC, and other staff. [s. 19. (1)]

(649)

2. The home submitted a CIS report related to an incident of resident to resident physical abuse that occurred between two residents. One resident accidentally scratched the other resident and the resident slapped them on the face.

According to the PSW there was a program/activity in progress, and while serving the nourishment they heard a noise and a resident came to them and showed them that they were bleeding. The resident stated that another resident had scratched them. The PSW told the inspector that one of the residents admitted to hitting the other resident on the face. The PSW did not actually witness what had happened between the two residents, and only became aware of the incident when the resident came to them and showed them they were bleeding.

According to the RA they were having a program/activity when the nourishment cart arrived, as a result the program was stopped. The RA left the area while the nourishment was being served and was at the nursing station when they heard a PSW screaming and attended to see what was happening. They saw a resident trying to get to another resident and a PSW was between the two residents. They did not see the resident scratch the other resident.

The physician had ordered 1:1 staff monitoring for the resident who sustained the scratch, after the first incident mentioned above where they had gone into another resident's room and caused them to have an injury. At the time of this incident the resident did not have a 1:1 staff. Physical abuse was confirmed by the home's staff.

The home had submitted another CIS report, related to an incident of resident to resident physical abuse between the resident who sustained the scratch and another resident. According to this report the other resident had sustained an injury as a result of their interaction with this resident. At the time of the incident the resident did not have a 1:1 staff which was ordered by the physician after the first incident mentioned above where they had gone into another resident's room and caused them to have an injury.

Sources: residents' health records, CIS report, interview with DOC, and other staff. [s. 19. (1)]
(649)

3. The home submitted a CIS report related to an incident of resident to resident physical abuse that occurred between two residents. According to the CIS report and staff interview they heard the resident calling out and the other resident was holding onto the resident and pulling. The staff told the inspector that they heard the resident who was holding onto the other resident using profanities and making verbal threats to them. As a result of this incident the resident sustained an injury. The home's staff confirmed that physical abuse had occurred.

Sources: residents' health records, CIS report, interview with DOC, and other staff. [s. 19. (1)] (649)

4. The licensee has failed to ensure that five residents were protected from sexual abuse.

In accordance with the definition identified in section 2(1) of the Regulation 79/10 "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.

As a result of an incident of resident to resident physical abuse, this resident clinical records were reviewed, and several incidents of sexual abuse were identified by the inspector.

Inspector #649 made several observations of the resident's responsive behaviours.

One of the alleged residents remembered an incident of another resident coming into their room and asked them to perform an inappropriate act. They told the inspector that the same resident had touched their private area during another incident, and they had reported it to the nurse. There was no documentation of this alleged incident, and when the nurse was asked about this they denied being told.

The Physician documented in the resident's progress notes that they were not acting inappropriately recently, even though three incidents of sexual abuse had occurred.

After a review of the above mentioned sexual incidents with the DOC they implemented a 1:1 staff for monitoring the resident during the inspection, to protect other residents' safety.

Sources: residents' health records, interview with DOC, interview with the resident and other staff. [s. 19. (1)]

An order was issued based on the following factors:

Severity: Three and more residents experienced physical and sexual abuse that resulted in actual harm.

Scope: The scope of the non-compliance was identified as a pattern because four out of six residents experienced physical abuse and five out of seven residents experienced sexual abuse.

Compliance history: The licensee was found to be non-compliant with S. 19. (1) of LTCHA, 2007 S.O. 2007, c.8, in the past 36 months, and a Compliance Order (CO) was issued to the home on July 22, 2019 on inspection report #2019_759502_0016 with a compliance due date of August 12, 2019.
(649)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 24, 2021

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 14th day of May, 2021 (A1)(Appeal/Dir# n/a)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by JULIEANN HING (649) - (A1)
(Appeal/Dir# n/a)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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