Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 3, 2016	2016_226192_0022	015967-16	Critical Incident System

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH CARE, LONDON
268 Grosvenor Street P.O. Box 5777 LONDON ON N6A 4V2

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

Mount Hope Centre for Long Term Care
21 GROSVENOR STREET P.O. BOX 5777 LONDON ON N6A 1Y6

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

DEBORA SAVILLE (192), SHARON PERRY (155)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 26, 27, 30, 31, June 1, 2 and 3, 2016.

This Critical Incident Inspection was completed in relation to allegations of abuse by a Registered Practical Nurse (RPN) who had been employed by the home.

The evidence gathered was based primarily on information gathered and incidents that occurred in 2014.

During the course of the inspection, the inspector(s) spoke with residents, family members, private duty care giver, the Director, Vice President accountable for Mount Hope, Coordinators, Administrative Assistant, Long-term Care Support Specialists, Point Click Care User Support, Registered Practical Nurses, Personal Care Providers, Registered Nurses, Unifor Chair Person, Human Resources Consultant and a Human Resources Assistant.

The inspector(s) reviewed medical records, incident reports, staff schedules, abuse allegations, investigation notes, policy and procedure, email records, training records, job descriptions. employment records, complaint logs, and communication with Substitute Decision Makers.

The following Inspection Protocols were used during this inspection:
Medication
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

- **10 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **9 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written policy that promoted zero tolerance of abuse and neglect of residents and that it was complied with.

The Director of the home received allegations of abuse and neglect directed toward residents of the home, by a staff member of the home.

The licensee's policy titled Abuse and Neglect of Residents: Zero Tolerance, dated as revised July 2014, stated:
A) "When any incident of alleged, witnessed or suspected abuse or neglect of a resident occurs, it is mandatory that the person who becomes aware of the abuse report the incident immediately to the Registered Nurse who will notify the Coordinator or Clinical-

on-Call."

Interview with Registered Nurses (RN) #120 and #122, who were the most responsible person and in charge of the home during a specified time, confirmed knowledge of the allegations of abuse and stated that they were aware of the allegations for approximately 12 months before the allegations were reported to the home's Director #100. Interview with Personal Care Provider #123 and PCP #128 confirmed that they had reported the allegations to RN's #120 and #122 regularly throughout the 12 month period, and that they were not aware of any action taken with regard to the allegations.

Registered Nurses #120 and #122 failed to notify the Coordinator or Clinical-on-Call as outlined in the policy.

B) "The Coordinator of Resident Care will fully investigate any alleged, witnessed or suspected abuse immediately. This may be done by interviewing all relevant parties, examining documentation or other evidence, or by directing a designate to do so."

"The Coordinator/Clinical-on-Call or designate was to ask staff or others who had witnessed or had knowledge of the incident to provide individual statements."

"The residents were to be interviewed by the Coordinator/Clinical-on-Call or designate and a written statement obtained whenever possible."

The Director of the home received allegations of abuse within the home. An investigation into the allegations was initiated by the home, however record review and interview with Director #100 and Coordinator #102 identified that not all allegations of abuse were included in the investigation, and not all residents identified in the allegation were interviewed. Resident #006 was not interviewed until twenty-three days after the Director of the home received the allegation of abuse; resident #005 was not interviewed until seventeen days after the Director of the home received the allegation of abuse. Director #100 stated that the home was unable to find notes related to some interviews that had been recorded as having being completed. No written statements from residents or additional staff named in the allegations were obtained by the home.

Staff members identified in the allegation as having knowledge related to the incidents, including Registered Practical Nurse (RPN) #126 and Personal Care Provider #110 had not been interviewed by the home as part of their investigation. RPN #126 confirmed in interview that the home had not at any time conducted an interview with regard to their

knowledge of the allegations.

Review of the home's investigation notes failed to identify that specified allegations had been investigated.

Once becoming aware of the allegations of abuse and neglect the Coordinator of Resident Care failed to fully investigate the alleged, witnessed or suspected abuse by interviewing all relevant parties and examining documentation or other evidence. The Coordinator/Clinical-on-Call failed to include individual statements from staff or others who had witnessed or had knowledge of the alleged incidents of abuse and neglect and not all residents identified in the allegation were interviewed or provided opportunity to provide a written statement as outlined in the policy.

C) "Where any alleged, witnessed or suspected abuse constitutes a potential for criminal charges, the police were to be notified immediately and in every instance, by the Director or by the Coordinator of Resident Care."

Review of investigation notes and interview with Director #100 and Coordinator #102 confirmed that the police were not notified of the allegations of neglect and abuse received on a specified date by the Director of the home.

The Director or the Coordinator of Resident Care failed to notify the police of alleged, witnessed or suspected abuse that constituted a potential for criminal charges as outlined in the home's policy.

D) "A capable resident was to be asked who they would like informed about an incident of abuse and for an incapable resident, the incident was to be disclosed to the Substitute Decision Maker along with information about whether or not the resident suffered any injuries or other consequences as a result of the incident."

Record review and interview with Director #100 identified that none of the residents named in the allegation received communication that an allegation of abuse had been received and an investigation initiated. Designated residents were deceased at the time of the allegation and no communication to families was undertaken. At the conclusion of the investigation ten residents failed to receive the disclosure letter used by the home to communicate the results of the investigation.

Interview with Coordinator #100 confirmed that resident's or their SDM's were not notified

of the allegation of abuse and neglect and not all residents were notified at the conclusion of the investigation as outlined in the home's policy.

E) "Anyone who reports an incident of alleged, witnessed or suspected abuse was to be protected from retaliation. Incidents of retaliation were to be reported to the Director or Coordinator of Resident Care."

Resident #003 complained to Registered Practical Nurse (RPN) #126 on a specified date, alleging that RPN #133 withheld requested medication and had made a comment upsetting to the resident. RPN #126 confirmed in interview that this complaint was received from resident #003 and reported to Registered Nurses (RN) #113 and #120. RN #120 stated in interview that she had spoken to RPN #133 about the allegations.

Interview with Personal Care Provider (PCP) #123 confirmed that they had witnessed RPN #133 confront resident #003 about the allegations. PCP #123 indicated that the resident looked at them with fear in their expression.

Resident #003 was not protected from the actions of RPN #133 after RPN #133 was informed of the allegations made against them and the incident was not reported to the Director of the home for two days.

F) "Failure of a staff member to report alleged, witnessed or suspected abuse or neglect of a resident constitutes a serious infraction of the policy."

Interview with Personal Care Providers #123 and #128, and Registered Nurses (RN) #120 and #122 identified that the RN's who were the most responsible person in the home at the time of the alleged incidents, were aware of the allegations of verbal and sexual abuse of residents for a period of approximately one year before the allegations were brought to the attention of the Director of the home and an investigation was conducted.

Staff including PCP's, RPN's and RN's were aware of the alleged, witnessed or suspected abuse or neglect of residents and failed to report the alleged, witnessed and suspected abuse or neglect of residents as required in the policy.

Interview with Director #100 and Coordinator #102 identified no action was taken with staff who had failed to report abuse for a period of approximately one year.

The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

The scope of this issue was a pattern. The severity of the issue was determined to be a level three with actual harm or risk to residents. The home did have a history of non-compliance with the Abuse Policy. Non-compliance was issued under s. 20 on May 13, 2014, as a WN, December 7, 2015 as a VPC; and January 5, 2016, as a VPC. Non-compliance with the abuse policy was also issued under s.8(1)b on May 13, 2014, as a CO and September 26, 2014, as a linked CO. [s. 20. (1)]

3. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contained an explanation of the duty under section 24 to make mandatory reports.

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

Under the Act, the Director means the person appointed under section 175 as the Director.

The home's policy titled Abuse and Neglect of Residents: Zero Tolerance dated as revised December 2015, and confirmed with Director #100 to be the current policy stated;

When any incident of alleged, witnessed or suspected abuse (of all types) or neglect of a resident occurs, it is mandatory that the person who becomes aware of the abuse report the incident immediately to the Registered Nurse (RN); the RN will then ..
Monday to Friday, 8:00 - 4:00, call the Coordinator

In the evening, at night, or on weekends, the building RN informs the Clinical-on-Call Include all such incidents on the 24-hour summative report.

The Director, Long Term Care or designate is required by law to immediately report any alleged, witnessed or suspected abuse or neglect of a resident that caused harm or the potential for harm, to the local office of the Ministry of Health and Long Term Care.

If the person committing the abuse is the person who directs the work of the person who needs to report the alleged, witnessed, or suspected abuse, the report should be made to the person one leadership level above.

Interview with Director #100 and Coordinator #102 identified that Personal Care Providers would be expected to report alleged, witnessed or suspected abuse to Registered Practical Nurses, who would be expected to report to Registered Nurses, who would report to the Coordinator or Clinical-on-Call.

Interview with Personal Care Providers within the home identified that they would not feel confident that reports of alleged, witnessed or suspected abuse would be reported to management if first reported to Registered Practical Nurses or Registered Nurses in the home. No Personal Care Provider or Registered Practical Nurse interviewed during this inspection identified their responsibility in reporting alleged, witnessed or suspected abuse to the Director as appointed by the Minister of Health.

The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contained an explanation of the duty under section 24 to make mandatory reports.

The scope of this issue was a pattern. The severity of the issue was determined to be a level three with actual harm or risk to residents. The home did have a history of non-compliance with this sub-section of the regulation. The Abuse Policy not meeting all requirements of the legislation was issued September 4, 2013 as a VPC and May 13, 2014 as a WN. [s. 20. (2) (d)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 003 – The above written notification is also being referred to the Director for further action by the Director.

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

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

Findings/Faits saillants :

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

A) The plan of care for resident #024 indicated under Bed Mobility that registered staff were to assess the resident for pain and administer pain relieving medication before turning and repositioning the resident to increase comfort during the procedure. Under Pain Management the plan indicated that staff were to administer pain medication as per the physicians orders and acknowledge the resident's pain and discomfort.

An allegation of abuse and neglect identified that during the provision of care while turning and repositioning the resident, PCP #123 observed RPN #133 pull resident #024 over to the bed rail causing resident #024 pain and the resident asked who was touching them. On a specified date resident #024 was in pain and when this was brought to RPN #133's attention the concern was dismissed.

An allegation of abuse and neglect identified that a specified resident called to request analgesic. RPN #133 responded to PCP #128 that the resident had been repositioned instead of providing them with analgesic. The resident again requested analgesic, none was provided. PCP #128 stated that at this time the resident was experiencing an increase in pain.

The medical record identified that the specified resident had pain and other symptoms and was unable to find a comfortable position. The record indicated the nurse was unable to administer analgesic to the resident due to maximum amounts of the medication in a 24 hour period. Review of the Medication Administration Record (MAR) identified that the resident had received less than the maximum amount of the medication. As necessary medication ordered by the physician for the relief of pain was not administered to the resident.

A second PCP confirmed that the specified resident had pain. Review of the MAR identified that as necessary medication was available to have been administered to the resident. Interview with Registered Nurse (RN) #120 identified that it would have been the expectation that when the resident's pain was not managed, the RN would have been notified, a pain assessment completed and the physician contacted.

The licensee failed to ensure that the specified resident received pain relieving medication as prescribed by the physician and before being turned and repositioned as identified in the plan of care.

B) The plan of care for a specified resident indicated under Bed Mobility that the resident assisted with the turning process by grasping the bed rails on turns.

Interview with Personal Care Provider (PCP) #123 confirmed that when providing care to the resident staff had to be very gentle and allow the resident to roll independently, due to the residents pain. PCP #123 confirmed having observed Registered Practical Nurse (RPN) #133 pull the resident over to the bed rail, not allowing the resident to roll independently and causing the resident pain. Interview with PCP #123 identified that she had observed RPN #133 do this routinely when they had worked together.

The licensee failed to ensure that a specified resident was turned and repositioned in a manner consistent with the care set out in the plan of care.

C) The plan of care for a specified resident, under Altered Vision indicated that staff were to announce themselves when approaching the resident or entering the resident's room and explain all care provided.

PCP #123 stated that during the provision of care, on three occasions RPN #133 provided a name other than their own when the resident questioned who was providing care that caused the resident pain.

The licensee failed to ensure that care set out in the plan of care was provided for a specified resident as identified in the plan. [s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan was no longer necessary.

The plan of care for resident #009, indicated under constipation that resident #009 preferred to use medications and that staff were to give specified medication at a specified time to promote a regular bowel movement.

On a specified date, the physician requested that the medication time be changed due to concerns about skin breakdown and disruption of resident #009's activities of daily living. The Medication Administration record was reviewed and had been updated to reflect this change.

Interview with resident #009, identified that further changes to the medication schedule had occurred. Interview with Registered Practical Nurse (RPN) #126 confirmed the resident's statement.

RPN #126 reviewed the current plan of care with Inspector #192 and confirmed that the plan of care was not reflective of the current care being received by the resident.

The licensee failed to ensure that the plan of care was reviewed and revised with a change in the residents care needs.

The scope of this issue was isolated. The severity of the issue was determined to be a level three with actual harm or risk to residents. The home did have a history of non-compliance with this sub-section of the regulation. Non-compliance was issued August 28, 2013 as a VPC; April 22, 2014, as a VPC; May 13, 2014, as a WN; August 13,

2014, as a VPC; January 6, 2015, as a VPC; June 9, 2015, as a VPC; and January 2016 as a VPC. [s. 6. (10) (b)]

Additional Required Actions:

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Under s.30(1) the required pain program must have relevant policies and procedures developed and implemented.

Under regulation s.48(1)4 the licensee is required to ensure that a pain management program is developed and implemented.

The home's policy titled Pain: Assessment and Management indicated;
A) "When orders existed for as necessary pharmacological interventions, the nurse was to offer medication to the resident according to the frequency of the order".

On a specified date, the progress notes for resident #024 indicated that the resident was in pain. Review of the Progress Notes identified that Registered Practical Nurse #133 had recorded they were unable to administer analgesic. Review of the Medication Administration Record (MAR) identified that there was an order for as necessary medication that had not been provided.

The order for as necessary analgesic for resident #024 was changed on a specified date, allowing the resident to have specified medication when required. The analgesic was documented as being given once on two specified dates and was recorded as being ineffective on both occasions.

In spite of ongoing pain, as necessary medication was not provided to resident #024 as prescribed by the physician.

B) "Nurses were to evaluate daily, residents who were at risk of pain, for the presence of pain. Unexpected or intense pain, especially of sudden onset, must be immediately evaluated by a Registered Nurse."

Resident #024 was identified in assessment to have moderate to severe pain daily. Progress notes indicated that resident #024 complained of pain that was becoming increasingly intense.

Interview with Registered Nurse (RN) #120 (who had been working at the time) confirmed that any registered staff member could complete a pain assessment. Where a resident had uncontrolled pain, it would be the expectation that the RN would be called, a pain assessment completed and the physician notified. RN #120 indicated she had not been notified of resident #024's unrelieved pain.

The licensee failed to ensure that the Pain Assessment and Management Policy was complied with when resident #024's pain was not reassessed and as necessary medication was not provided.

The scope of this issue was isolated. The severity of the issue was determined to be a level three with actual harm or risk to residents. The home did have a history of non-compliance with this sub-section of the regulation. Non-compliance was issued September 4, 2013, as a CO; April 22, 2014, as a VPC; May 13, 2014, as a linked CO; September 26, 2014, as a linked CO; January 14, 2015, as a VPC; September 28,

2015, as a VPC; December 7, 2015, as a VPC; and January 15, 2016 as a VPC. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

DR # 004 – The above written notification is also being referred to the Director for further action by the Director.

WN #4: 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 residents were protected from abuse and neglect by the licensee or staff in the home.

Resident #009 was ordered a medication to be administered daily as specified.

Personal Care Provider (PCP) #128 stated that she had been told by Registered Practical Nurse (RPN) #133 that the medication had not been given as prescribed on a specified date. RPN #133 indicated to PCP #123 that she had gone through the steps as if giving the medication but had not given the medication. RPN #126 and Registered Nurse (RN) #122, who was the most responsible person in the home at the time, were made aware of RPN #133's actions.

PCP #123 stated that on three occasions, they had observed RPN #133 go through the steps as if giving the medication, without giving the ordered medication. PCP #123 indicated that RPN #133 believed the resident did not require the medication and failed to provide the ordered medication. PCP #123 confirmed in interview that registered staff including the RN who was the most responsible person in the building at the time, were made aware of the actions of RPN #133.

RPN #133 place resident #009 at risk, when they failed to administer the ordered medication as prescribed.

The licensee failed to protect resident #009 from neglect when registered staff aware of RPN #133's actions failed to report these potentially harmful actions, allowing RPN #133 to place resident #009 at risk on at least three additional occasions. [s. 19. (1)]

2. The licensee has failed to ensure that residents were protected from abuse by anyone and neglect by the licensee or staff in the home.

A) Resident #024 was identified in the plan of care to have pain.

Pain Assessment completed on a specified date, identified the resident to have pain daily and received analgesic routinely and as necessary.

Review of the progress notes identified that resident #024 was in pain. The resident was complaining of additional symptoms. The progress note indicated that the resident was not able to receive further analgesic as they had received their maximum amount.

Review of the Medication Administration Record, confirmed with Registered Practical Nurse #126, identified that the resident had received less than their maximum amount and had an as necessary order for analgesic that could have been given.

Interview with Registered Nurse (RN) #120 identified that it would be the expectation for a resident with uncontrolled pain to be assessed by the RN and the physician would be called to address the residents pain. RN #120 identified that Registered Practical Nurse #133, who was providing care to resident #024, seldom called for assistance from the RN. Review of the Medication Administration Record and Progress notes failed to identify that resident #024 had their pain reassessed by the RN and that they were provided prescribed analgesic when in pain.

The licensee failed to protect resident #024 from neglect by RPN #133 when required analgesic was not provided to relieve pain.

B) Personal Care Provider (PCP) #123 reported that resident #024 was in pain. When PCP #123 communicated this to RPN #133, the RPN dismissed the resident's pain. During interview PCP #123 confirmed that resident #024 was observed to be in pain and

stated "that night it was not right - no other stood out like that".

Review of the Medication Administration Record, identified that the resident had a physician order for as necessary medication for pain relief. There was no as necessary medication documented as provided in the Medication Administration Record. Interview with RN #120, identified that they had not been notified of the residents pain, no assessment was completed and that the physician could have been called to address the resident's pain.

Review of the progress notes for resident #024 identified that the resident was having pain and voiced that medication was being helpful on a specified date. Documentation over the next twenty-four hours demonstrated an exacerbation in the residents pain and a plan to implement alternative pain management including repositioning and distraction via music and await follow-up with the physician. Resident #024 was assessed by the physician the following day and recorded the resident as having pain with even a gentle graze of the skin.

Resident #024 had a further change in condition and was sent to hospital. The resident never returned to the home.

Review of the medical record identified that there was no assessment by a Registered Nurse when resident #024 exhibited pain over a specified four day period. Record review and interview with RN #120, confirmed that no pain assessment was completed during this time.

RPN #133 failed to provide resident #024 as necessary analgesic as prescribed by the physician and registered staff of the home failed to assess resident #024's changing condition.

C) Resident #024 was identified in the plan of care to have; pain and required two staff for mobility, but was to be allowed to participate in the turning process.

Personal Care Provider #123 identified that during the provision of care Registered Practical Nurse #133 would pull resident #024 over toward her, causing the resident pain.

The licensee failed to ensure that resident #024 was protected from abuse and neglect by the licensee or staff of the home when RPN #133 withheld as necessary medication

and used unnecessary physical force that caused resident #024 pain, during the provision of care . [s. 19. (1)]

3. The licensee failed to ensure that residents were protected from emotional abuse and were not neglected by the licensee or staff.

A) Personal Care Provider (PCP) #123 stated that during a specified time, resident #014 was in pain. PCP #123 indicated that RPN #133 would ignore resident #014 or would go into resident #014's room and tell the resident that they were going to help and then provide direction to the PCP to adjust the resident's environment and would leave the room. Resident #014 would continue to express that they were in pain.

Record review revealed that resident #014 received analgesic routinely for pain. Resident #014 also had an order for as needed medication for pain. Review of the Medication Administration Record (MAR) and Progress Notes identified that Registered Practical Nurse #133 did not administer any as needed medication to resident #014 over the specified two month period. The last time that Registered Practical Nurse #133 gave resident #014 as needed medication was two months earlier and it was noted to be effective. Record review showed that other RPN's had recorded that resident #014 received as needed medication and that it was effective in relieving resident #014's pain.

PCP #123 shared that resident #014 complained of pain on three out of five of the shifts per week that they worked. PCP #123 shared that RPN #133 would say environmental factors caused the pain or would rub cream on the designated area and would tell the resident that everything was good. PCP #123 shared that they had informed the Registered Nurse, who was the most responsible person in the home at the time, of this when it occurred. RN #120 shared that they were told by PCP #123 that RPN #133 was not giving residents their pain medications. RN #120 said that RPN #133 always had an excuse for why they did not give the medications.

RPN #126 shared that resident #014 would complain of pain. RPN #126 shared that resident #014 was always willing to take medication offered for pain.

The licensee failed to ensure that resident #014 was protected from neglect when RPN #133 failed to provided prescribed analgesic to address resident #014's pain.

B) Personal Care Provider #123 stated that on a specified date, when PCP #123 and RPN #133 went in to assist resident #014 on rounds, resident #014 had been incontinent

and RPN #133 made insulting and humiliating comments to resident #014.

Record review showed that PCP #123 and RPN #133 worked together on the floor where resident #014 resided and confirmed that on the specified date the resident had been incontinent.

PCP #123 shared that RPN #133 would make insulting and humiliating comments to resident #014 at any time when resident #014 had been incontinent. PCP #123 shared that they would tell the Registered Nurse, who was the most responsible person in the home at that time, what RPN #133 had said to resident #014.

The licensee failed to protect resident #014 from insulting and humiliating comments made by RPN #133. [s. 19. (1)]

4. The licensee failed to protect residents from emotional and sexual abuse by anyone.

Personal Care Provider #123 stated that on specified date and time, PCP #123 and RPN #133 went to assist resident #001. As PCP #123 and RPN #133 were changing resident #001, RPN #133 made non-consensual remarks of a sexual nature and insulting comments to resident #001 and laughed.

PCP #123 told the inspector that RPN #133 made non-consensual remarks of a sexual nature and insulting comments to resident #001. PCP #123 shared that resident #001 would not pay any attention to RPN #133. PCP #123 shared that they told the Registered Nurse, who was the most responsible person in the home, at the time, what RPN #133 had said to resident #001.

The licensee failed to protect resident #001 from non-consensual remarks of a sexual nature and insulting comments made by RPN #133. [s. 19. (1)]

5. The licensee failed to protect residents from emotional and sexual abuse by anyone.

Personal Care Provider #123 stated that on a specified date and time, resident #002 rang for assistance. RPN #133 told PCP #123 to "hold up, I'll grab the pills now and come with you". Upon entering resident #002's room, RPN #133 made an insulting comment to resident #002. PCP #123 stated she found this very disturbing.

PCP #110 shared that she witnessed RPN #133 make non-consensual remarks of a

sexual nature when giving resident #002 their medication. PCP #110 shared that they had reported this to the Coordinator that worked at the home prior to Coordinator #102.

PCP #123 shared that when RPN #133 and PCP #123 were in resident #002's room together, RPN #133 made non-consensual remarks of a sexual nature and insulting comments to resident #002. PCP #123 stated that they reported this to the Registered Nurse, who was the most responsible person in the home, at the time.

The licensee failed to protect resident #002 from non-consensual remarks of a sexual nature and insulting comments made by RPN #133. [s. 19. (1)]

6. The licensee failed to protect residents from emotional and sexual abuse by anyone.

A) Personal Care Provider #123 stated that on a specified date, when PCP #123 and RPN #133 were providing care to resident #004 it was noted that the resident's brief was undone. RPN #133 while standing over resident #004, would make non-consensual remarks of a sexual nature and would laugh. PCP #123 shared that when resident #004 was found with the brief undone RPN #133 would say the same comment. RPN #133, several times had made insulting comments to resident #004, and had participated in non-consensual touching of a sexual nature.

The licensee failed to protect resident #004 from non-consensual remarks and touching of a sexual nature, and insulting comments from RPN #133.

B) Personal Care Provider #128 stated that on a specified date and time, RPN #133 made non-consensual comments of a sexual nature to PCP #128 about resident #004.

Record review revealed that RPN #133 worked on the specified dates with PCP #128 and PCP #123. These shifts were worked on the area where resident #004 resided.

PCP #123 shared that when resident #004 was incontinent they would pull on the front of their brief. When RPN #133 would go in and change resident #004 insulting comments and non-consensual comments of a sexual nature would be made. PCP #123 shared that resident #004 would just smile when RPN #133 made the comments and would not verbalize. PCP #123 also demonstrated how RPN #133 would touch resident #004. PCP #123 shared that they would tell the Registered Nurse, who was the most responsible person in the home at the time, what RPN #133 had said and done to resident #004.

PCP #128, stated that they were disgusted by comments made to resident #004.

The licensee failed to protect resident #004 from non-consensual remarks of a sexual nature and non-consensual touching by RPN #133. [s. 19. (1)]

7. The licensee failed to protect residents from emotional and sexual abuse by anyone.

Personal Care Provider #123 and #128 stated that when resident #013 would ring to request assistance, RPN #133 would touch resident #013's without consent and would make insulting comments.

Record review revealed that RPN #133 worked on the area where resident #013 resided. Record review revealed that resident #013 required the assistance of one staff.

PCP #123 shared that resident #013 would laugh and this resulted in RPN #133 repeating the actions more. PCP #123 shared that they reported this to RN #120 and RN #122, who were the most responsible person in the home at the time, when it happened.

PCP #128 shared that RPN #133 would touch resident #013 without consent, on a regular basis. PCP#128 shared that resident #013 did not comment as they were confused.

The licensee failed to protect resident #013 from non-consensual touching and insulting comments made by RPN #133. [s. 19. (1)]

8. The licensee failed to protect residents from physical, emotional and sexual abuse by anyone.

Personal Care Provider #123 stated that RPN #133 would make insulting comments to resident #005. Resident #005 would look up at PCP #123 with an embarrassed expression on their face. RPN #133 would touch resident #005's without consent when they provided care to resident #005.

PCP #123 stated that RPN #132 questioned why resident #005 was not provided analgesic in a manner that did not exacerbate the residents pain. RPN #132 said that resident #005 complained that they had to lie in pain until the next shift came in because

when resident #005 asked RPN #133 for analgesic, the way RPN #133 gave the medication caused an increase in pain. PCP #123 stated that if resident #005 complained to RPN #133, RPN #133 would make belittling comments to the resident.

The allegation of abuse stated that on a specified date and time RPN #133 was observe touching resident #005 in a sexual manner without consent.

Review of a specified Medication Administration records revealed that resident #005 received as needed medication. It is noted that none of these doses were administered by RPN #133.

Record review showed that RPN #133 and PCP #128 were working on the area of the home where resident #005 resided on the specified date.

When resident #005 was asked by Inspector #155 if any staff member had treated them roughly, resident #005 responded there had been. When asked if they would explain resident #005 shared that the staff would come in and tell them that they had to have this medication and that they had to take it. When asked if they knew the name of the staff resident #005 shared RPN #133's name. Resident #005 said that they felt that RPN #133 was trying to force them to do what they wanted. When asked if anyone ever yelled at them or had been rude to them, resident #005 shared that RPN #133 had been. When Inspector #155 asked resident #005 if RPN #133 ever touched them without consent, resident #005 replied yes. Resident #005 shared that they asked RPN #133 why they did that and RPN #133 would not respond. When asked if RPN #133 ever made insulting comments resident #005 shared that yes RPN #133 had done that quite a few times. When asked if RPN #133 ever gave them analgesic, resident #005 shared that they did not recall the name of the pain medication as they had had a lot of pain. Resident #005 shared that they would tell RPN #133 not to give it in a particular manner and RPN #133 would not comply. When asked what RPN #133 would do if resident #005 asked for pain medication, resident #005 shared that RPN #133 would tell me that I could not have it right now. When asked if RPN #133 would do anything to help relieve resident #005's pain, resident #005 stated that they could not remember RPN #133 doing anything to make it better.

PCP #123 shared that all the staff were aware that resident #005 had pain. PCP #123 said that resident #005 had asked RPN #132 about changing the time of the pain medications but resident #005 required them at a specified time. PCP #123 shared that RPN #133 on rounds would make insulting comments to resident #005. PCP #123

recalled that resident #005 would reply with a specified response. PCP #123 shared that they reported the comments to Registered Nurse #120 and #122 who were the most responsible person in the home at the time.

PCP #128 shared that RPN #133 would touch resident #005 without consent. PCP #128 shared that she could see resident #005's face and they looked embarrassed but resident #005 never made any comments when they were present.

RN #120 shared that PCPs #123 and #128 would tell them of RPN #133's behaviour and comments made to residents. RN #120 said that complaints of RPN #133's behaviour started after RPN #133 got the specified full time position. RN #120 shared that they did not discuss the concerns with anyone other than the PCP's reporting them. RN #120 shared that they did not report the concerns to anyone.

RPN #132 shared that resident #005 had expressed to RPN #132 when giving medication that they were glad she was on. RPN #128 said that resident #005 said that RPN #133 always caused an increase in discomfort when giving the medication. RPN #128 told resident #005 to tell RPN #133 not to do that. RPN #132 did not report this to anyone.

The licensee failed to protect resident #005 from abuse and neglect, including actions that exacerbated the resident's pain, non-consensual touching and insulting comments made by RPN #133 [s. 19. (1)]

9. The licensee failed to protect residents from emotional and physical abuse by

anyone. The allegation of abuse received by the home stated the following:

A) On a specified date and time resident #003 was sitting on the side of their bed when PCP #123 and RPN #133 went into the room to check on the resident. Resident #003 required assistance. RPN #133 in a harsh, condescending tone made comments of a belittling and degrading nature. PCP #123 indicated that resident #003 seemed to be very agitated and asked RPN #133 for medication which was denied by RPN #133. Resident #003 was up and down most of that shift, very restless.

The licensee failed to protect resident #003 from comments of a belittling and degrading nature made by RPN #133.

B) On a specified date, resident #003 requested that RPN #133 provide a specified medication. RPN #133 refused to provide the medication as requested.

The licensee failed to protect resident #003 from neglect when medication was withheld by RPN #133.

C) On a specified date, resident #003 asked for medication. PCP#123 went to resident's #003 room with RPN #133 because RPN #133 had mentioned to PCP #123 that RN #120 had approached RPN #133 with a complaint from resident #003. Upon entering the room RPN #133 confronted resident #003 about the allegation. Resident #003 looked at PCP #123 with fear in their expression and responded to RPN #133. RPN #133 made threatening, insulting and intimidating comments to resident #003.

Review of a specified Medication Administration Record (MAR) revealed that on the specified date, RPN #133 signed for medication 46 minutes after resident #003 had requested the medication.

Review of progress notes revealed that on a specified date resident #003 inquired of RPN #126 when a specified medication could be given. RPN #126 wrote a note in resident #003's medical record that said, resident approached writer and was upset and was questioning about the time they may receive their medication. Resident explained that they rang call bell to request medication and the nurse had said they must wait. Resident was very upset and wondering why nurse had refused to give the medication when they rang call bell and requested.

Review of progress notes revealed that on the following date, RPN #133 wrote a note in resident #003's medical record that said resident rang requesting medication and documented an increase in confusion for resident #003.

Review of progress notes revealed that the same date, resident #003 had been seen by their physician and there was no mention that the resident was confused and the plan was to continue with current treatment.

Review of the home's investigation notes revealed a copy of an email sent from RPN # 126 to Coordinator of Resident Care #102 on a specified date reporting resident #003's allegation of withholding medication and insulting, threatening and intimidating comments made to resident #003. The email also stated that resident #003 was very unhappy and felt nervous about ringing the call bell and did not like the way RPN #133 approached or

provided care to them.

During interview resident #003 shared they lived in their current room for about 3 years. When asked if anyone had ever yelled or been rude to them resident #003 shared, just one person did not yell but was very sarcastic. Resident #003 was able to clearly articulate the specific incidents involving RPN #133. Resident #003 stated I was bullied, I know more than one episode of sarcasm, if she came into my room I would expect to be put down. When the next shift came on or when she was not on I felt free to ask for what I needed.

RN #120 was shown the email from RPN #126 sent to Coordinator of Resident Care #102. RN #120 recalled that they spoke with RPN #133 regarding allegations in the email. RN #120 shared that RPN #133 played down the situation and that there was no record of this conversation. RN #120 shared that they did not report the alleged incident or conversation to anyone, including management.

PCP #123 shared that they reported a specified incident involving resident #003 to RN #120 (the most responsible person in the home) at the time.

The licensee failed to protect resident #003 from threatening, insulting and intimidating comments made by RPN #133. [s. 19. (1)]

10. he licensee failed to ensure that residents were protected from sexual, emotional and physical abuse by anyone and free from neglect by the licensee or staff in the home.

A) In the allegation of abuse and neglect, Personal Care Provider (PCP) #123 stated that when Registered Practical Nurse (RPN) #133 was assisting with the provision of care for resident #015, while PCP #123 was adjusting an incontinence brief for resident #015, the resident inquired about their care. RPN #133 responded, with a non-consensual sexual comment.

PCP #123 identified in interview that Registered Nurses #120 and #122, who were the most responsible person in the home at the time, were made aware of comments made by RPN #133 to resident #015.

PCP #123 during interview conducted by the home, identified that comments like this occurred on three out of five nights that PCP #123 worked with RPN #133.

The licensee failed to protect resident #015 from remarks of a sexual nature made by RPN #133.

B) In the allegation of abuse and neglect, PCP #123 indicated that on a specified dates and each shift worked with RPN #133, when resident #025 was incontinent RPN #133 participated in non-consensual touching and made remarks of a sexual nature and insulting comments to resident #025, and laughed.

PCP #123 confirmed in interview, that Registered Nurse #120, who was the most responsible person in the home at the time, was aware of the comments and actions toward resident #025 from RPN #133. PCP #123 indicated that these comments were reported to the Registered Nurses and Registered Practical Nurses all the time.

Interview with PCP #123 conducted by the home, confirmed that comments were made by RPN #133 to resident #025.

In an allegation of abuse and neglect, PCP #128 indicated that on a specified date RPN #133 made insulting comments to resident #025.

Interview with PCP #128 conducted by the home, indicated that on occasion resident #025 would make a specified comment to RPN #133.

Interview with RPN #133 conducted by the home, confirmed that the RPN had stated, where the resident would be able to hear, an insulting comment.

The licensee failed to protect resident #025 from non-consensual touching and remarks of a sexual nature and insulting comments made by RPN #133.

C) In an allegation of abuse and neglect PCP #123 indicated that RPN #133 would make remarks of a sexual nature and insulting comments to resident #029, then laughed.

Interview with PCP #123 conducted by the home, confirmed the statements made and identified that comments were made on more than one occasion.

Interview with PCP #123 confirmed that PCP #123 had witness the comments made by RPN #133 to resident #029.

Interview with RPN #133 conducted by the home, confirmed comments made in the

presence of resident #029.

The licensee failed to protect resident #029 from non-consensual remarks of a sexual nature and insulting comments.

D) In an allegation of abuse and neglect PCP #123 indicated that RPN #133 would make non-consensual remarks of a sexual nature to resident #018 and then laugh.

Interview with PCP #123 confirmed that incidents of abuse were reported to Registered Nurses #120 and #122, who were the most responsible person in the home at the time.

The licensee failed to protect resident #018 from non-consensual remarks of a sexual nature made by RPN #133.

E) In an allegation of abuse and neglect PCP #123 indicated that RPN #133 made insulting comments and participated in non-consensual touching of a sexual nature with resident #020.

Interview with PCP #123 indicated that RN's #120 and #122, who were the most responsible person in the home at the time, were made aware of the allegations of abuse.

The licensee failed to protect resident #020 from non-consensual touching and insulting comments made by RPN #133.

F) In an allegation of abuse and neglect PCP #123 indicated that every shift RPN #133 would speak to resident #022 in a rude, sarcastic manner.

Interview with resident #022 conducted by the home, indicated that RPN #133 told the resident that staff don't have time to assist the resident to the bathroom and to do it in their pants and then they would clean it up.

Interview with PCP #123, indicated that RPN #133 would respond to resident #022 making insulting and humiliating comments.

Interview with PCP #123 and #128 confirmed that they had observed RPN #133 speak sarcastically to resident #022 and that RN's #120 and #122 were aware of the comments made to resident #022.

The licensee failed to protect resident #022 from insulting, humiliating comments made by RPN #133.

G) In an allegation of abuse and neglect, PCP #123 indicated that RPN #133 made humiliating comments and participated in non-consensual touching of resident #017.

Interview with PCP #123 conducted by the home, identified that resident #017 would become easily agitated and over stimulated by RPN #133 's non-consensual touching.

Interview with PCP #123 identified that RPN #133's non-consensual touching of resident #017 was forced onto the resident, without resident #017 having opportunity to react.

The licensee failed to protect resident #017 from non-consensual touching and humiliating comments made by RPN #133.

H) In an allegation of abuse and neglect PCP #123 indicated that when care was provided to resident #026, the resident would at times be observed to have their hands in their brief. RPN #133 made non-consensual sexual and humiliating comments to resident #026.

In interview conducted by the home, PCP #123 indicated that these comments made her feel sick to her stomach, dirty and grossed out. PCP #123 also indicated that the incidents had been reported to Registered Nurses including RN #120, who would have been the most responsible person in the home at the time.

During interview PCP #123 stated that RPN #133 participate in non-consensual touching of resident #026 when care was being provided. PCP #123 also confirmed that the incidents had been reported to registered nursing staff.

Interview with RPN #133 conducted by the home, confirmed that RPN #133 had made comments to resident #026.

The licensee failed to protect resident #026 from non-consensual touching and insulting comments made by RPN #133.

I) In an allegation of abuse and neglect, PCP #123 indicated that seven specified residents were routinely touched in a sexual manner without consent of the resident by

RPN #133.

Interview with PCP #123 and #128 confirmed observation of RPN #133 touching the specified residents and others in a specified manner during the provision of care.

The licensee failed to protect residents #005, #007, #016, #018, #020, #023, and #028 from non-consensual touching by RPN #133.

J) In an allegation of abuse and neglect PCP #128 indicated RPN #133 was observed to force care onto resident #027. Resident #027, who was unable to verbalize, turned their head away and tried to push RPN #133's hands away. Resident #027 was making sounds to indicate they were unhappy.

Interview with PCP #128, conducted by the home, indicated that resident #027 was not confused and knew what they wanted and didn't.

PCP #128 indicated in interview that she had reported the incident; she believed the incident had been reported to a Registered Nurse.

The licensee failed to ensure that resident #027 was protected from physical force and intimidating remarks made by RPN #133. [s. 19. (1)]

11. n allegation of abuse and neglect indicated that on a routine basis Personal Care Provider (PCP) #123 would enter resident #006's room with Registered Practical Nurse (RPN) #133. It was known to staff that resident #006 was apprehensive about the outcome of care and would respond verbally, when care was about to be provided. PCP
#123 stated that RPN #133 would reply to resident #006 in an insulting and threatening manner.

The allegation also indicated that resident #006 would at times be involved in specified activities which RPN #133 would prevent the resident from participating in. The resident would indicate they wished the activity to continue and RPN #133 would respond "oh, well!, That's too bad!"

PCP #123 indicated that the comments to resident #006 had been reported to registered nurses at the time. PCP #123 indicated that resident #006 enjoyed participating in the specified activity.

Interview with PCP #128 conducted by the home, indicated that resident #006 would verbalize anticipation of care being provided on a daily basis and that RPN #133 was observed to respond with a threatening comment.

During interview PCP #128 stated that she had witnessed RPN #133 make the above statements to resident #006.

The licensee failed to protect resident #006 from threatening, insulting remarks made by RPN #133. [s. 19. (1)]

12. he licensee failed to protect residents from sexual abuse by anyone.

An allegation of abuse and neglect indicated that while standing at resident #008's bedroom door, RPN #133 made comments of a sexual nature about a resident of the home to PCP #123 and RN #122 and laughed.

Interview with PCP #123 identified that RPN #133 was witnessed to have said the above comment, where the resident would have been able to have heard the comment.

During an interview conducted by the home RPN #133 stated that they may have made a comment to RN #122 and PCP #123. When asked how do you think that would make resident #008 feel, RPN #133 responded "very degraded".

The licensee failed to protect resident #008 from non-consensual remarks of a sexual nature made by RPN #133.

The scope of this issue was a pattern. The severity of the issue was determined to be a level three with actual harm or risk to residents. The home did have a history of non-compliance with this sub-section of the regulation. Non-compliance was issued February 19, 2014, as a VPC. [s. 19. (1)]

Additional Required Actions:

DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur immediately reported the suspicion and the information upon which it was based to the Director: 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.

The home received allegations of abuse and neglect of residents of the home over a specified period of time.

Allegations of physical and emotional abuse of resident #024 were reported to Registered Nurse (RN) #120, sexual abuse of resident #008 was witnessed by RN #122; and an allegation of abuse of resident #005 was reported by the resident to RPN #132.

Registered Nurses #120 and #122 were the most responsible person in the home at the time of the incidents.

Interview with PCP #123 conducted by the home, identified that PCP #123 had reported witnessed abuse involving resident #024 to RN #120 on at least two occasions, and that

RN #122 was present when sexual comments were made with regard to resident #008.

Interview with RPN #126 identified that when resident #003 complained to her on a designated date, she reported the incident to RN #113 and sent an email to Coordinator #102. Record review and interview identified that the email sent to Coordinator #102 was not received until two days following the allegation of abuse by resident #003.

Record review and interview identified that PCP #123 witnessed RPN #133 approach resident #003 and confront resident #003 about the complaint made to RPN #126. PCP #123 identified that resident #003 looked at her with fear in their expression and attempted to defend the allegations made. By not taking immediate action on the specified date, resident #003 was allowed to be again verbally abused by RPN #133.

Interview with Director #100 and Coordinator #102 confirmed that the Director as appointed under the Long-term Care Homes Act (LTCHA) was not immediately notified of the complaint of verbal abuse from resident #003, involving RPN #133. The allegations involving resident #003 were reported to the Director LTCHA two days after the allegation was made by resident #003.

Interview with Personal Care Provider #123 and #128, identified that allegations of abuse were reported to RN #120 and #122 when they occurred. PCP #123 state during the interview that she would report these things in a "mortified way" and stated "she gets away with this". PCP #123 also indicated that she expected the RN's would do something. PCP #128 stated in interview that she was hoping that by reporting to the Registered Nurses "something would happen. What was happening was what I was afraid of, I was telling and nothing happened." I was "afraid to go to management and nothing would be done, I still had to report to her."

Interview with RN #120 confirmed that PCP #123 and PCP #128 communicated allegations of staff to resident abuse by RPN #133 to RN #120, starting shortly after RPN #133 took a designated full time line. RN #120 stated that nothing was done with the information provided by PCP's #123 and #128 alleging abuse and neglect of residents by RPN #133, the information was not reported to management or the Director LTCHA. RN #120 stated “we kept quiet about it and we should not have".

During a telephone interview with RN #122 it was identified that RPN #133 had on one occasion asked RN #122 to preform a sexual act on a specified resident. RN #122 confirmed that incidents of abuse and neglect should have been reported immediately

and that the incident had not been reported to the Director or anyone else.

The home's policy titled Abuse and Neglect of Residents: Zero Tolerance, indicated that "when any incident of alleged, witnessed or suspected abuse (of all types) or neglect of a resident occurred, it was mandatory that the person who became aware of the abuse report the incident immediately to the Registered Nurse (RN) who would contact the Coordinator, or after business hours inform the Clinical-on-Call. The policy goes on to indicate that it was the Director of Long Term Care for the home, or their designate who would immediately report the allegation to the local office of the Ministry of Health and Long Term Care.

Interview with Director #100 and Coordinator #102 confirmed that the policy failed to identify the responsibility of any person with reasonable grounds to suspect that abuse or neglect may have occurred to report that alleged, suspected or witnessed abuse to the Director LTCHA.

PCP #123 identified in interview that they felt they had been let down by registered staff as their concerns were never reported to management. PCP #123 stated that she had been told there had been allegation of similar abuse by RPN #133 in other areas of the home.

PCP #125 identified that they had worked with RPN #133 during a specified period and had reported to Coordinator #105, allegations of sexual and verbal abuse of residents in addition to allegations of theft. A meeting was set up to discuss the allegations with Coordinator #105 and a person from Human Resources (HR), notes were taken. PCP #125 also indicated that there had been a phone conversation with Coordinator #105 with regard to allegations of abuse toward residents by RPN #133. PCP #125 indicated that Coordinator #105 told her that RPN #133 would not be a concern for much longer as they were being transferred.

Interview with Coordinator #105, identified that allegations related to theft had been made by PCP #125, but there was no recall of additional concerns related to allegations of abuse of residents of the home. Notes related to the meeting with PCP #125 were requested, however Coordinator #105 stated she had no records from the meeting and no notes were provided.

Review of the personnel record for RPN #133 identified that at a specified time, RPN #133 was reassigned within the home. The personnel record for RPN #133 contained no

investigation notes into allegations of abuse or neglect.

Interview with PCP #127 who worked with RPN #133 identified that in a specified time period, RPN #133 insisted on doing all care of the residents on the home area together and that PCP #127 had witnessed RPN #133 participate in non-consensual touching of residents and making inappropriate sexual comments about residents. PCP #127 indicated that they would tell RPN #133 that a resident had requested something for pain and the response from RPN #133 would be "I'll get to it when I get to it!" PCP #127 indicated that they reported concerns to Coordinator #105 at the time and had spoken to Coordinator #105 about how RPN #133 made them feel uncomfortable.

The most responsible person in the home at the time of the alleged abuse failed to immediately report the alleged, suspected or witnessed abuse and the information upon which it was based to the Director LTCHA.

The allegation of abuse by RPN #133 was not reported to the Director LTCHA when it was identified and reported by PCP's #123 and #128 to the Registered Nurses (#120 and #122) who were the most responsible persons in the home at the time of the incidents.

The allegation of abuse by RPN #133 was not immediately reported to the Director LTCHA and immediate action taken to protect the resident when resident #003 reported allegations of abuse to RPN #126, who then reported the allegation to RN #113, who was the most responsible person in the home. Resident #003 sustained additional verbal abuse from RPN #133 the day following the allegation.

The scope of this issue was a pattern. The severity of the issue was determined to be a level three with actual harm or risk for residents. Non-compliance related to failing to report abuse and neglect was previously issued under s. 20 on January 15, 2016, as a voluntary plan of corrective action (VPC). [s. 24. (1)]

Additional Required Actions:

DR # 006 – The above written notification is also being referred to the Director for further action by the Director.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Record review identified that resident #024 had an increase in pain. The record indicated that the resident was in pain. On a specified date resident #024 complained of pain and a telephone order for a change in analgesic was received.

Record review identified that the last recorded pain assessment was completed on a specified date prior to the resident's unrelieved pain; the resident was identified to have moderate to severe pain daily. No pain assessment was completed when resident #024 exhibited unrelieved pain.

Interview with Registered Nurse (RN) #120 confirmed that any registered staff member could complete a pain assessment. Where a resident had uncontrolled pain, it would be the expectation that the RN would be called, a pain assessment completed and the physician called. RN #120 indicated that she had not been notified of resident #024's unrelieved pain.

Record review identified that resident #024 had a change in condition and was transferred to hospital. The resident did not return to the home.

The licensee failed to ensure that resident #024 was reassessed when the resident's pain was not relieved by initial interventions.

The scope of this issue was isolated. The severity of the issue was determined to be a level three with actual harm or risk to residents. The home did have a history of non-compliance with this sub-section of the regulation. Non-compliance was issued September 4, 2013, as a VPC; May 13, 2014 as a CO; and September 26, 2014 as a linked CO. In addition non-compliance related to pain assessment was issued under s.8(1)b on September 4, 2013 as a CO; [s. 52. (2)]

Additional Required Actions:

DR # 007 – The above written notification is also being referred to the Director for further action by the Director.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident or that caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

The home received an allegation of abused and/or neglected by a staff member of the home.

The allegation identified the following;

A) Resident #024 was observed by Personal Care Provider #123 to be handled roughly by Registered Practical Nurse (RPN) #133, causing increased pain for the resident and RPN #133 was observed to withhold information about who was providing care to the resident on three occasions.
Resident #024 was complaining of unrelieved pain. PCP #123 notified RPN #133 of the resident's pain and RPN #133 dismissed the pain.

During interview PCP #123 stated that the alleged abuse was reported to Registered Nurse (RN) #120. The RN was the most responsible person in the home at the time of the incident and failed to report the incident to the Director LTCHA or the SDM.

B) RPN #133 made comments that were insulting, intimidating or humiliating to nine identified residents.

C) RPN #133 was observed making non-consensual comments of a sexual nature and/or participated in non-consensual touching of twenty identified residents.

D) RPN #133 withheld medication for six identified residents.

Interview with Personal Care Provider #123 and #128 identified that allegations of abuse were reported to RN #120 and #122 when they occurred.

Interview with Director #100 and Coordinator #102 identified that the Substitute Decision Makers or other persons specified by the residents named in the allegation had not been notified of the allegations.

Interview with the Substitute Decision Maker (SDM) for resident #006 confirmed that they had not been notified of an allegation of abuse involving resident #006, the details of the allegation or that an investigation had been undertaken with regard to the allegation. The SDM confirmed that a letter had been received from the home, after the investigation had been completed. The SDM indicated they had placed a call to Coordinator #102 and were told that they "did not need to worry", the person responsible was gone from the home.

The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were immediately notified upon becoming

aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident or that caused distress to the resident that could potentially be detrimental to the resident's health or well-being. [s. 97. (1) (a)]

2. The licensee has failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion of the investigation.

On a specified date, the home received an allegation of abuse and/or neglect of residents in the home.

The staff member was removed from the home and an investigation was initiated. On a specified date a letter was sent to the staff member indicating the results of the investigation. Letter's were sent to nine capable residents named in the allegation nine days later. Letters were sent to the SDM for four residents 23 days later. Record review and interview with Director #100 confirmed that no communication following the investigation was sent to the remaining residents.

The licensee failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion of the investigation.

The scope of this issue was widespread. The severity of the issue was determined to be a level one with minimal risk to residents. The home did not have a history of non-compliance with this sub-section of the regulation. [s. 97. (2)]

Additional Required Actions:

DR # 005 – The above written notification is also being referred to the Director for further action by the Director.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Review of investigation notes and interview with Director #100 and Coordinator #102 confirmed that the police were not notified of the allegations of neglect and abuse when they were made aware of the allegations.

The allegation included non-consensual touching and remarks of a sexual nature, the withholding of medications, the use of physical force that caused pain and comments that could be interpreted as threatening or intimidating, belittling or degrading and had the potential to diminish the residents dignity or self-worth.

During interview Director #100 stated that at the time that the incidents were reported it was not the belief of the management team that criminal activity had occurred. In reviewing the allegation and giving consideration to the length of time over which the allegations took place and the severity of the allegations, the home should have notified the police to determine whether the reported actions constituted a criminal offense.

Review of a report of Critical Incidents submitted to the Ministry of Health and Long Term Care identified forty-one reported alleged incidents of abuse (this may include resident to resident, family to resident and staff to resident abuse). Police were called for seven of these reported allegations of abuse. Documentation provided by the home and interview with Director #100 indicated that the most common reasons for not notifying police included; the investigation could not substantiate abuse occurred, the Substitute Decision Maker (SDM) or capable resident did not want police notified or the abuse involved two cognitively impaired residents.

The legislative requirement states that the appropriate police force will immediately be

notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offense. Allegations of abuse that the licensee suspects may constitute a criminal offense are to be immediately reported to the police. Subsequent investigation into the allegation may fail to substantiate the allegation, but does not negate the requirement to immediately report the allegation if it was suspected that the allegation constituted a criminal offense, The decision to report was not up to the SDM or capable resident if the licensee suspected that the alleged, suspected, or witnessed incident of abuse or neglect of a resident may have constituted a criminal offense. Incidents between two cognitively impaired residents may be reportable to the police, depending on the circumstances of the incident and whether the licensee suspected the incident constituted a criminal offense.

The licensee failed to ensure that the appropriate police force was immediately notified of alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offense.

The scope of this issue was isolated. The severity of the issue was determined to be a level two with minimal harm or potential for actual harm to residents. The home did not have a history of non-compliance with this sub-section of the regulation. [s. 98.]

Additional Required Actions:

DR # 009 – The above written notification is also being referred to the Director for further action by the Director.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the names of all residents involved in the incident.

The home received an allegation of abuse and neglect. An incident report was completed identifying only 71 percent of the residents named in the allegation.

Interview with the Director #100 confirmed that there was a discrepancy between the number of residents listed on the report to the Director and within the allegations. Director #100 identified that the home had become aware of the discrepancy but failed to

update the report to the Director with additional resident names, once identified.

The licensee failed to ensure that the report to the Director included the names of all residents involved in the specified allegation of abuse and neglect. [s. 104. (1) 2.]

2. The licensee has failed to ensure that the report to the Director included whether a family member, person of importance or SDM of any resident(s) involved in the incident was contacted and the name of such person or persons,

Review of the incident report submitted to the Director in relation to the specified allegation of abuse and neglect directed toward residents of the home failed to identify whether family members, persons of importance or the Substitute Decision Maker for the residents involved were contacted and the name of the persons.

Review of the amended report indicated that letters were to be distributed to residents and Substitute Decision Makers but had not yet been completed.

Both reports failed to identify the outcome or current status of the individuals who were involved in the incident.

Interview with Director #100 identified that a family member, person of importance or Substitute Decision Maker for residents identified in the allegation were not contacted at the time the allegation was received by the home and that not all residents had a family member, person of importance or Substitute Decision Maker notified when the investigation was completed.

The licensee failed to ensure that the report to the Director included whether a family member, person of importance or SDM of any residents involved in the incident contacted and the name of such persons and the outcome or current status of the individuals involved in the incident.

The scope of this issue was isolated. The severity of the issue was determined to be a level one with minimal or risk to residents. The home did not have a history of non-compliance with this sub-section of the regulation. [s. 104. (1) 3.]

Additional Required Actions:

DR # 008 – The above written notification is also being referred to the Director for further action by the Director.

WN #10: 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 residents in accordance with the directions for use specified by the prescriber.

Resident #009 was prescribed a specified medication to be provided daily. On a specified date the physician documented that due to concerns about skin breakdown and disruption of the resident's sleep, the administration time would be changed.

The Medication Administration record was updated with this change in the direction from the prescriber.

A documented allegation of abuse received by the home indicated that resident #009 was receiving the medication daily at a specified time.

Interview with Personal Care Provider (PCP) #123 indicated that Registered Practical Nurse #133 was observed by PCP #123 giving the medication daily, but not as directed by the prescriber.

Interview with PCP #128 confirmed that resident #009 received the medication daily at a specified time when RPN #133 was working.

The licensee failed to ensure that the prescribed medication was given in accordance with the directions for use specified by the prescriber.

The scope of this issue was isolated. The severity of the issue was determined to be a level two with minimal harm or potential for actual harm to residents. The home did not have a history of non-compliance with this sub-section of the regulation. [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 ensuring that drugs were administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 1st day of December, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBORA SAVILLE (192), SHARON PERRY (155)
Inspection No. / No de l'inspection :	2016_226192_0022
Log No. / Registre no:	015967-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 3, 2016
Licensee / Titulaire de permis :	ST. JOSEPH'S HEALTH CARE, LONDON 268 Grosvenor Street, P.O. Box 5777, LONDON, ON, N6A-4V2
LTC Home / Foyer de SLD :	Mount Hope Centre for Long Term Care 21 GROSVENOR STREET, P.O. BOX 5777, LONDON, ON, N6A-1Y6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Janet Groen

To ST. JOSEPH'S HEALTH CARE, LONDON, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Order / Ordre :

The licensee shall review and revise the policy titled Abuse and Neglect of Residents: Zero Tolerance to reflect the requirements under the Long Term Care Homes Act 2007 and Regulation 79/10; and

Shall ensure that all staff are educated on the revised policy.

Grounds / Motifs :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contained an explanation of the duty under section 24 to make mandatory reports. (192)

2. Section 24 states;
A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006.

The home's policy titled Abuse and Neglect of Residents: Zero Tolerance dated as revised December 2015, and confirmed with Director #100 to be the current policy stated;

"When any incident of alleged, witnessed or suspected abuse (of all types) or neglect of a resident occurs, it is mandatory that the person who becomes aware of the abuse report the incident immediately to the Registered Nurse (RN); the RN will then ..
Monday to Friday, 8:00 - 4:00, call the Coordinator
In the evening, at night, or on weekends, the building RN informs the Clinical-on-Call
Include all such incidents on the 24-hour summative report."

"The Director, Long Term Care or designate is required by law to immediately report any alleged, witnessed or suspected abuse or neglect of a resident that caused harm or the potential for harm, to the local office of the Ministry of Health and Long Term Care."

"If the person committing the abuse is the person who directs the work of the person who needs to report he alleged, witnessed, or suspected abuse, the report should be made to the person one leadership level above."

Interview with Director #100 and Coordinator #102 identified that Personal Care Providers would be expected to report alleged, witnessed or suspected abuse to Registered Practical Nurses, who would be expected to report to Registered Nurses, who would report to the Coordinator or Clinical-on-Call.

Interview with Personal Care Providers within the home identified that they would not feel confident that reports of alleged, witnessed or suspected abuse would be reported to management if first reported to Registered Practical Nurses

or Registered Nurses in the home. No Personal Care Provider or Registered Practical Nurse interviewed during this inspection identified their responsibility in reporting alleged, witnessed or suspected abuse to the Director as appointed by the Minister of Health.

The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contained an explanation of the duty under section 24 to make mandatory reports.

The scope of this issue was a pattern. The severity of the issue was determined to be a level three with actual harm or risk to residents. The home did have a history of non-compliance with this sub-section of the regulation. The Abuse Policy not meeting all requirements of the legislation was issued September 4, 2013 as a VPC and May 13, 2014 as a WN. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Issued on this 3rd day of October, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DEBORA SAVILLE

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