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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 22, 2018	2018_746692_0017	009995-18, 016640-18, 020809-18, 025947-18, 026359-18, 029288-18, 029785-18	Critical Incident System

Licensee/Titulaire de permis

1895357 Ontario Inc.
1202 Highway 94 R.R. #1 Corbeil ON P0H 1K0

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

Nipissing Manor Nursing Care Center
1202 Highway 94 Box 40 Corbeil ON P0H 1K0

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

SHANNON RUSSELL (692)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 5-9, 2018

The following intakes were inspected upon during this Critical Incident System inspection: one intake related to falls prevention, one intake related to alleged staff to resident abuse and five intakes related to alleged resident to resident abuse.

A Complaint inspection #2018_746692_0016 was conducted concurrently with this Critical Incident System inspection.

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

The Inspector also conducted a daily tour of the resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, observed resident to resident interactions, reviewed relevant health care records, internal investigation notes as well as reviewed the licensee's policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A Critical Incident Report (CIR), was submitted to the Director on a specific date; whereby, resident #003 reported to the staff that on a date approximately three months prior to the report to the Director, they witnessed resident #001 exhibiting an identified responsive behaviour towards resident #002, causing injury to resident #002.

A review of the homes policy titled "Zero Tolerance Policy on Abuse and Neglect", last reviewed January 2018, indicated that any person who had reasonable grounds to suspect that abuse has occurred or may have occurred must immediately report the suspicion to the Director.

A review of resident #001's progress notes, demonstrated that they had exhibited an identified responsive behavour towards resident #002 on a date approximately three months prior to the report to the Director, causing them to fall to the floor and sustain an injury.

In an interview with Registered Practical Nurse (RPN) #104, they indicated that resident

#003 reported to them that they witnessed resident #001 exhibit an identified responsive behaviour towards resident #002 causing them to fall and sustain an injury. RPN #104 confirmed that the incident occurred three months prior to being reported to the Director and was reported to the Registered Nurse (RN) at the time the incident occurred.

During an interview with RN #105, they indicated that the incident where resident #001 was exhibiting an identified responsive behaviour towards resident #002 causing resident #002 to sustain an injury was not reported to the Director until three months later. RN #105 confirmed the incident should have been reported to the Director immediately when the incident was reported to the home, however at that time the registered staff were not clear on the reporting guidelines.

In an interview with the Director of Care (DOC), they indicated that the incident in which resident #001 was engaged in an identified responsive behaviour towards resident #002 was not reported to the Director until three months after the incident occurred. The DOC confirmed it was the expectation that the incident was to be reported to the Director immediately and that this critical incident was reported late to the Director.

O. Reg 79/10, s. 98 of the LTCHA (2007), was also issued in relation to this finding. Refer to Written Notification (WN) #5 for details.

2. On September 05, 2018, the Director informed licensees via a memo regarding Amendments to the reporting requirements memo of July 5, 2018. The memo highlighted that the licensee must submit a report to the MOHLTC (Director) Monday to Friday, 8:30 a.m. to 4:30 p.m. by immediately initiating and submitting an on-line Critical Incident System (CIS) form. At all other times the licensee must call the after-hours reporting line and complete a CIS form first thing the following business day.

The Inspector reviewed a CIR that had been submitted to the Director for Abuse/Neglect on a date after the licensee received the September 05, 2018 memo. The CIR revealed that resident #007 was observed to be displaying an identified responsive behaviour towards resident #008. A further review of the CIR, indicated that the incident was not reported to the Director immediately.

In an interview with Personal Support Worker (PSW) #103, they indicated that a visitor to the home came to them stating that they had observed resident #007 exhibiting an identified responsive behaviour towards resident #008. PSW #103 reported the incident to the RN in charge.

During an interview with RN #116, they indicated that PSW #103 had reported to them what the visitor had reported to PSW #103. RN #116 confirmed the incident was to be reported to the Director immediately upon becoming aware of the incident and that it was not reported immediately.

In an interview with the DOC, they indicated that the incident in which resident #007 was displaying an identified responsive behaviour was expected to be reported immediately to the Director and that it was not, therefore it was reported late. The DOC stated the RN's were not clear on the reporting guidelines and that they should have reported the incident immediately. [s. 24. (1)]

3. On November 2, 2018, the Director informed Licensees of a Tip Sheet with Simplified Reporting Requirements and was based on the August 31, 2018, memo "Clarification of Mandatory and Critical Incident Reporting Requirements".

A CIR, was submitted to the Director for Abuse/Neglect after having received the memo from the Director on November 2, 2018. A review of the CIR demonstrated that resident #009 had exhibited an identified responsive behaviour towards resident #004. The licensee did not report as per the reporting requirements outlined by the Director in the July, September and November memos.

In an interview with RPN #109, they indicated that they had witnessed resident #009 display an identified responsive behaviour towards resident #004. RPN #109 intervened and reported immediately what they witnessed to RN #112.

During an interview with RN #112, they indicated that RPN #109 reported to them that they observed resident #009 display an identified responsive behaviour towards resident #004. RN #112 stated they did not report the incident immediately to the Director.

In an interview with the DOC, they indicated that the incident in which resident #009 exhibited an identified responsive behaviour towards resident #004 was expected to be reported immediately to the Director and it was not, therefore it was reported late. The DOC stated the RN's were not clear on the reporting guidelines and that they should have reported the incident immediately. [s. 24. (1)]

4. A CIR was submitted to the Director on a specified date, in response to resident #010 displaying an identified inappropriate behaviour of a sexual nature towards resident

#011.

A review of resident #010's health care record, indicated that they had a history of displaying inappropriate behaviour of a sexual nature towards other residents since their admission. The records indicated this inappropriate behaviour was fairly well managed, however, these inappropriate behaviours of a sexual nature had been escalating and were becoming more serious. A review of resident #010's Resident Assessment Instrument Minimum Data Set (RAI-MDS) demonstrated that they had a Cognitive Performance Scale (CPS) score indicating their cognition was intact.

A review of resident #010's electronic progress notes, revealed six documented incidents of resident #010 exhibiting inappropriate behaviour of a sexual nature towards other residents. The Inspector reviewed the MOH on-line reporting portal and determined that the six documented incidents were not reported to the Director.

In an interview with PSW #113, they identified that they were aware that resident #010 had a history of exhibiting inappropriate behaviour of a sexual nature towards other residents. PSW #113 stated they were to intervene by stopping the behaviour and report any incidents to the nurse immediately.

During an interview with RPN #104, they indicated that in each of the six documented incidents whereby resident #010 was displaying inappropriate behaviour of a sexual nature that the home did not report to the Director and each incident should have been reported immediately.

In an interview with RN #116, they confirmed that all six documented incidents, whether suspected or confirmed, were to be reported immediately to the Director and investigated. RN #116 confirmed the six documented incidents whereby, resident #010 was observed to be engaged in inappropriate behaviour of a sexual nature were not reported to the Director and they should have been reported immediately.

Together, Inspector #692 and the DOC reviewed the six documented notes whereby resident #010 was engaged in inappropriate behaviour of a sexual nature. The DOC confirmed that it was the expectation that all suspected or confirmed incidents of this nature were reported to the Director immediately and that each of the six documented incidents were not reported to the Director.

O. Reg 79/10, s. 19 (1) and s. 55, of the LTCHA (2007), was also issued in relation to

this finding. Refer to WN #2 and #4 for details. [s. 24. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 by anyone.

Sexual abuse is defined within the Ontario Regulations 79/10 of the Long-Term Care Homes Act (LTCHA) as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

A CIR was submitted to the Director on an identified date in response to resident #010 exhibiting inappropriate behaviour of a sexual nature towards resident #011.

A review of resident #010's health care record, indicated that they had a history of displaying inappropriate behaviour of a sexual nature towards other residents since their admission. The records indicated this inappropriate behaviour was fairly well managed, however, these inappropriate behaviours of a sexual nature had been escalating and were becoming more serious. A review of resident #010's Resident Assessment Instrument Minimum Data Set (RAI-MDS) demonstrated that they had a CPS score indicating their cognition was intact.

A review of resident #010's electronic progress notes, revealed six documented incidents of resident #010 exhibiting inappropriate behaviour of a sexual nature towards other

residents and the licensee did not implement interventions to mitigate the risk to other residents:

In an interview with PSW #113, they identified that they were aware that resident #010 had a history of exhibiting inappropriate behaviour of a sexual nature towards other residents. PSW #113 stated they were to intervene by ceasing the behaviour and report any incidents to the nurse immediately.

During an interview with RPN #104, they indicated that in each of the six documented incidents whereby resident #010 was displaying inappropriate behaviours of a sexual nature that the home should have taken further action by increased monitoring and implementing additional interventions. RPN #104 confirmed that the home did not protect residents as they should have been doing something to address the inappropriate behaviour.

In an interview with RN #116, they confirmed that the home did not put measures into place after the six documented incidents involving resident #010. RN #116 confirmed that the home did not protect the residents from being exposed to the inappropriate behaviours of a sexual nature by not taking immediate action after the documented incidents.

Together, Inspector #692 and the DOC reviewed the six documented notes whereby resident #010 was observed to be engaged in inappropriate behaviours of a sexual nature towards other residents. The DOC confirmed that there were interventions that should have been put in place and that the home should have taken further action. The DOC confirmed the home did not execute their due diligence in mitigating resident #010's inappropriate behaviour of a sexual nature, therefore putting other residents at risk. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the homes written policy to promote zero tolerance of abuse was complied with.

A CIR was reported to the Director on an identified date, indicating that RPN #109 witnessed PSW #106 engaged in an identified action towards resident #006, which caused an injury. A further review of the CIR did not indicate that PSW #106 was sent home at the time of the reported incident pending the outcome of the investigation.

A review of the homes policy titled "Zero Tolerance Policy on Abuse and Neglect", last reviewed January 2018, indicated that in response to suspected or actual abuse of a resident the licensee will immediately relieve the employee from their duties and send them home, pending an investigation.

During an interview with PSW #106, they indicated that they did exhibit an identified action towards resident #006 in an attempt to mitigate risk to resident #006. PSW #106 confirmed that the RN #108 spoke to them at the time of the incident, however they were not sent home and finished working their shift and met with the Administrator the following day.

In an interview with RN #108, they confirmed that RPN #109 reported to them that they had witnessed an incident where PSW #106 displayed an identified action towards resident #006. RN #108 indicated that they reported the incident to the Administrator and spoke to PSW #106 regarding the incident that was reported to them at the time the incident occurred. They confirmed they did not send PSW #106 home at the time of the incident and that PSW #106 continued to work the remainder of their shift.

In an interview with the Director of Care (DOC), they confirmed that PSW #106 was not sent home at the time of the reported staff to resident incident. The DOC confirmed that as per the homes policy PSW #106 should have been sent home immediately after the incident was reported, pending an investigation. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents, is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions had been developed and implemented to assist residents and staff who are at risk of harm or who were harmed as a result of a resident's behaviours and to minimize the risk of altercations and potentially harmful interactions between and among residents.

A CIR was submitted to the Director in response to resident #010 displaying an identified inappropriate behaviour of a sexual nature towards resident #011. Please refer to WN #1, finding four for additional information.

A further review of the CIR, revealed resident #010 was to be placed on an identified intervention after the incident occurred. Staff were to complete a specified document within specific time frames.

The Inspector reviewed the specified document for resident #010 and identified that documentation was missing on a number of occasions.

In an interview with PSW #113, they identified that resident #010 was to have an identified intervention in place and that the specified document was used to document the identified intervention. PSW #113 confirmed that it would be the expectation that the specified document was complete.

During an interview with RPN #104, they indicated that when a resident was to have the identified intervention in place, staff were to complete the specified document. This indicates that the identified intervention was completed. When the specified document was incomplete, this would indicate the identified intervention was not done by staff and whether the resident was exhibiting the identified inappropriate behaviour of a sexual nature. This would also create an obstacle in assessing the resident and developing a thorough treatment plan.

In an interview with RN #116, they stated that the identified intervention was implemented for resident #010 after they were observed engaged in an inappropriate behaviour of a sexual nature towards resident #011. They confirmed the expectation was for staff to complete all areas of the specified document. RN #116 confirmed there was multiple missing documentation and by not completing the documentation that would indicate the identified intervention was not completed by staff.

During an interview with the DOC, they confirmed that the expectation was for staff to be completing the identified intervention. Together, the Inspector and the DOC reviewed the specified document for resident #010 and identified there was multiple missing documentation. The DOC confirmed with the missing documentation that would indicate staff did not complete the identified intervention, which would pose a risk to other residents. [s. 55. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures and interventions have been developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours and to minimize the risk of altercations and potentially harmful interactions between and among residents., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

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

Two CIR's were submitted to the Director outlining alleged resident to resident abuse. Both CIR's were submitted for incidents that were witnessed to have occurred; whereby resident #001 exhibited an identified responsive behaviour towards resident #002, causing resident #002 to sustain an injury in each incident.

A further review of both CIR's and a review of the progress notes for resident's #001 and #002 did not demonstrate that the police were notified for both incidents.

In an interview with RPN #104, they confirmed that resident #001 engaged in an identified responsive behaviour towards resident #002 on both occasions, which resulted in resident #002 sustaining injuries. RPN #104 confirmed the police were not notified and they should have been.

In an interview with RN #105, they indicated that they are to report any incidents of the identified responsive behaviour of this nature involving residents to the police, especially when the resident had sustained an injury. RN #105 confirmed in both of these incidents the police were not contacted and a report was not completed.

During an interview with the Administrator and the DOC, they indicated staff are to report any incident that could be found under the criminal code to the police force and the police will conduct their own investigation. The Administrator confirmed it is not up to the licensee to determine if the incident meets the criteria under the criminal code that was why the direction was to report the incident to the police and the police will determine the actions they will take. The Administrator and DOC confirmed that the police were not notified regarding these two incidents of an identified responsive behaviour causing injury. [s. 98.]

Additional Required Actions:

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

Issued on this 23rd day of November, 2018

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

Ministère 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) :	SHANNON RUSSELL (692)
Inspection No. / No de l'inspection :	2018_746692_0017
Log No. / No de registre :	009995-18, 016640-18, 020809-18, 025947-18, 026359-18, 029288-18, 029785-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 22, 2018
Licensee / Titulaire de permis :	1895357 Ontario Inc. 1202 Highway 94, R.R. #1, Corbeil, ON, P0H-1K0
LTC Home / Foyer de SLD :	Nipissing Manor Nursing Care Center 1202 Highway 94, Box 40, Corbeil, ON, P0H-1K0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Wentworth Graham

To 1895357 Ontario Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 24 (1) of the Long Term Care Homes Act (LTCHA), 2007.
Specifically, the licensee shall:
1. Develop and implement a process to ensure that all staff are aware of what constitutes resident abuse and neglect and that they are aware of the appropriate process for reporting these allegations to the Director;
2. Ensure all staff are trained to identify and report all alleged, suspected and witnessed incidents of abuse immediately to the Director;
3. Maintain a record of re-training provided, including dates, times, attendees, trainers and material taught;
4. Develop and implement a monitoring system to ensure that abuse is reported as required by s. 24 (1) of the LTCHA, 2007.

Grounds / Motifs :

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

A Critical Incident Report (CIR), was submitted to the Director on a specific date;

whereby, resident #003 reported to the staff that on a date approximately three months prior to the report to the Director, they witnessed resident #001 exhibiting an identified responsive behaviour towards resident #002, causing injury to resident #002.

A review of the homes policy titled "Zero Tolerance Policy on Abuse and Neglect", last reviewed January 2018, indicated that any person who had reasonable grounds to suspect that abuse has occurred or may have occurred must immediately report the suspicion to the Director.

A review of resident #001's progress notes, demonstrated that they had exhibited an identified responsive behavour towards resident #002 on a date approximately three months prior to the report to the Director, causing them to fall to the floor and sustain an injury.

In an interview with Registered Practical Nurse (RPN) #104, they indicated that resident #003 reported to them that they witnessed resident #001 exhibit an identified responsive behaviour towards resident #002 causing them to fall and sustain an injury. RPN #104 confirmed that the incident occurred three months prior to being reported to the Director and was reported to the Registered Nurse (RN) at the time the incident occurred.

During an interview with RN #105, they indicated that the incident where resident #001 was exhibiting an identified responsive behaviour towards resident #002 causing resident #002 to sustain an injury was not reported to the Director until three months later. RN #105 confirmed the incident should have been reported to the Director immediately when the incident was reported to the home, however at that time the registered staff were not clear on the reporting guidelines.

In an interview with the Director of Care (DOC), they indicated that the incident in which resident #001 was engaged in an identified responsive behaviour towards resident #002 was not reported to the Director until three months after the incident occurred. The DOC confirmed it was the expectation that the incident was to be reported to the Director immediately and that this critical incident was reported late to the Director.

O. Reg 79/10, s. 98 of the LTCHA (2007), was also issued in relation to this finding. Refer to Written Notification (WN) #5 for details. (692)

2. 2. On September 05, 2018, the Director informed licensees via a memo regarding Amendments to the reporting requirements memo of July 5, 2018. The memo highlighted that the licensee must submit a report to the MOHLTC (Director) Monday to Friday, 8:30 a.m. to 4:30 p.m. by immediately initiating and submitting an on-line Critical Incident System (CIS) form. At all other times the licensee must call the after-hours reporting line and complete a CIS form first thing the following business day.

The Inspector reviewed a CIR that had been submitted to the Director for Abuse/Neglect on a date after the licensee received the September 05, 2018 memo. The CIR revealed that resident #007 was observed to be displaying an identified responsive behaviour towards resident #008. A further review of the CIR, indicated that the incident was not reported to the Director immediately.

In an interview with Personal Support Worker (PSW) #103, they indicated that a visitor to the home came to them stating that they had observed resident #007 exhibiting an identified responsive behaviour towards resident #008. PSW #103 reported the incident to the RN in charge.

During an interview with RN #116, they indicated that PSW #103 had reported to them what the visitor had reported to PSW #103. RN #116 confirmed the incident was to be reported to the Director immediately upon becoming aware of the incident and that it was not reported immediately.

In an interview with the DOC, they indicated that the incident in which resident #007 was displaying an identified responsive behaviour was expected to be reported immediately to the Director and that it was not, therefore it was reported late. The DOC stated the RN's were not clear on the reporting guidelines and that they should have reported the incident immediately. [s. 24. (1)]regular business hours. [s. 24. (1)] (692)

3. 3. On November 2, 2018, the Director informed Licensees of a Tip Sheet with Simplified Reporting Requirements and was based on the August 31, 2018, memo "Clarification of Mandatory and Critical Incident Reporting Requirements".

A CIR, was submitted to the Director for Abuse/Neglect after having received the memo from the Director on November 2, 2018. A review of the CIR demonstrated that resident #009 had exhibited an identified responsive behaviour towards resident #004. The licensee did not report as per the reporting requirements outlined by the Director in the July, September and November memos.

In an interview with RPN #109, they indicated that they had witnessed resident #009 display an identified responsive behaviour towards resident #004. RPN #109 intervened and reported immediately what they witnessed to RN #112.

During an interview with RN #112, they indicated that RPN #109 reported to them that they observed resident #009 display an identified responsive behaviour towards resident #004. RN #112 stated they did not report the incident immediately to the Director.

In an interview with the DOC, they indicated that the incident in which resident #009 exhibited an identified responsive behaviour towards resident #004 was expected to be reported immediately to the Director and it was not, therefore it was reported late. The DOC stated the RN's were not clear on the reporting guidelines and that they should have reported the incident immediately. [s. 24. (1)] (692)

4. 4. A CIR was submitted to the Director on a specified date, in response to resident #010 displaying an identified inappropriate behaviour of a sexual nature towards resident #011.

A review of resident #010's health care record, indicated that they had a history of displaying inappropriate behaviour of a sexual nature towards other residents since their admission. The records indicated this inappropriate behaviour was fairly well managed, however, these inappropriate behaviours of a sexual nature had been escalating and were becoming more serious. A review of resident #010's Resident Assessment Instrument Minimum Data Set (RAI-MDS) demonstrated that they had a Cognitive Performance Scale (CPS) score indicating their cognition was intact.

A review of resident #010's electronic progress notes, revealed six documented incidents of resident #010 exhibiting inappropriate behaviour of a sexual nature towards other residents. The Inspector reviewed the MOH on-line reporting portal and determined that the six documented incidents were not reported to the Director.

In an interview with PSW #113, they identified that they were aware that resident #010 had a history of exhibiting inappropriate behaviour of a sexual nature towards other residents. PSW #113 stated they were to intervene by stopping the behaviour and report any incidents to the nurse immediately.

During an interview with RPN #104, they indicated that in each of the six documented incidents whereby resident #010 was displaying inappropriate behaviour of a sexual nature that the home did not report to the Director and each incident should have been reported immediately.

In an interview with RN #116, they confirmed that all six documented incidents, whether suspected or confirmed, were to be reported immediately to the Director and investigated. RN #116 confirmed the six documented incidents whereby, resident #010 was observed to be engaged in inappropriate behaviour of a sexual nature were not reported to the Director and they should have been reported immediately.

Together, Inspector #692 and the DOC reviewed the six documented notes whereby resident #010 was engaged in inappropriate behaviour of a sexual nature. The DOC confirmed that it was the expectation that all suspected or confirmed incidents of this nature were reported to the Director immediately and that each of the six documented incidents were not reported to the Director.

O. Reg 79/10, s. 19 (1) and s. 55, of the LTCHA (2007), was also issued in relation to this finding. Refer to WN #2 and #4 for details. [s. 24. (1)] (692)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 05, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 22nd day of November, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Shannon Russell

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