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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 3, 2014	2014_220111_0011	O-000388-14	Resident Quality Inspection

Licensee/Titulaire de permis

MEDLAW CORPORATION LIMITED
42 Elgin Street, Thornhill, ON, L3T-1W4

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

PINECREST NURSING HOME (2731)
3418 County Road 36, R.R. #2, BOBCAYGEON, ON, K0M-1A0

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

LYNDA BROWN (111), GWEN COLES (555), KELLY BURNS (554), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): May 12-16, 20-22, 2014

Four Critical incident inspections were completed concurrently (log #000970, 000994, 001013, 001089) during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Registered Nurses (RN), Registered Practical Nurses(RPN), Personal Support Workers (PSW), Housekeeping Aides (HA), Dietary Aides (DA), Activity Aides (AA), Physiotherapy Assistant (PTA), Residents, Families, Resident Council President, RAI Coordinator & Receptionist.

During the course of the inspection, the inspector(s) reviewed health records of current and deceased residents, toured the home, observed dining service, observed medication administration, reviewed the homes policies (Prevention of abuse, restraints, infection prevention and control, preventative maintenance, continence care and bowel management, Responsive behaviours, bathing, housekeeping), review the following committee meeting minutes: food, resident council, outbreak, Professional Advisory (PAC), Behavioral Support Ontario (BSO), Continuous Quality Improvement (CQI), staff training records, resident and staff personnel files.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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. 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 :

Under O.Reg. 79/10, sexual abuse is defined 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".

Furthermore, non-compliance was previously identified under LTCHA, 2007, s.20(1) &

O.Reg.79/10, s.97 & 98 during an inspection completed on September 17, 2013 under inspection #2013_049143_0047 in relation to the reporting of incidents of sexual abuse.

During this critical incident inspection into 4 critical incidents of resident to resident sexual abuse, actual harm and/or risk of harm was demonstrated as vulnerable and/or cognitively impaired residents were recipients of the sexual abuse. A pattern was demonstrated as there were 2 separate resident's involved in the sexual abuse, the incidents reoccurred over a three month period, affected approximately 10 vulnerable and/or cognitively impaired residents, and some of which had reoccurring incidents by one or both Resident#1 & Resident #3. Only 2 of the incidents from Resident #1 and only 2 of the incidents from Resident #3 were reported to the police and the Director. Many of the incidents were not reported to any of the SDM's.

Related to Resident #1 (log #000994 & 001013):

Review of the health record for Resident #1 indicated there were 13 documented incidents of either verbal or physical sexual abuse that occurred towards Re9sident #2,#953, #960,#970, #977,#988, (and unidentified residents) by Resident #1. Resident #970 & #988 were the recipient of more than one incident of sexual abuse by Resident #1.

Related to Resident #3 (log #000970 & 001089):

Review of the health record for Resident #3 indicated the there were 12 documented incidents of either verbal or physical sexual abuse that occurred towards Resident #988, #974, #981, #901, and unidentified residents from Resident #3. Resident #981 & #974 were the recipient of more than one incident of sexual abuse by Resident #3. Resident #988 was the recipient of more than one incident of sexual abuse by Resident #3 and Resident #1.

During this inspection, observation of Resident #981, #974, #988, #970, #977, #960 indicated the residents were confined to a mobility aide and cognitively impaired.

3. The licensee failed to protect approximately 10 residents from sexual abuse by 2 different residents as evidenced by the following:
- The Director was not immediately notified when there was alleged, suspected or witnessed incidents of sexual abuse of Resident #2, #953, #960, #970, #977,#988,

(and unidentified residents) by Resident #1 that resulted in harm or risk of harm to the residents. The Director was not immediately notified when there was alleged, suspected or witnessed incidents of abuse of Resident#974,#981,#988,#900 & #999, by Resident #3 that resulted in harm or risk of harm to the residents(as identified in under WN#11).
- There was no evidence that every alleged, suspected or witnessed incidents of sexual abuse involving Resident #1 & Resident #3 were immediately investigated(as identified under WN#9).
- The licensee's policy "Prevention of Abuse and Neglect" was not complied with (as identified under WN#8).
- The licensee failed to immediately notify the SDM of Resident #1, # 3 (and the identified female residents above), of every alleged, suspected or witnessed incidents of sexual abuse(as identified under WN#19).
- The licensee failed to ensure that the appropriate police force was immediately notified of all the alleged, suspected and witnessed incidents of resident to resident sexual abuse that the licensee suspects may constitute a criminal offense(as identified under WN#20).
-There was no evidence that Resident #1 & Resident #3 were reassessed when they were demonstrating ongoing responsive behaviours, that the behavioural triggers for the residents were identified where possible, and strategies were developed and implemented to respond to these behaviours, where possible(as identified under WN#13).

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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

The licensee failed to ensure that all doors leading to non-residential areas of the home were kept closed and locked.

The door entering the service hall (which leads to a non-residential area), was observed propped open on May 12th at 11:32 & 13:49, May 14th at 14:50, and May 15, 2014 at 10:10 hrs and was unsupervised. The hall leads to a door to the outside of the home.

On May 12, 2014, the housekeeping door in the service hallway was also observed propped open during the above time periods and this room contains hazardous chemicals for cleaning and disinfection. The door leading to the outside was also not locked but alarmed during the above time periods.

Interview of the Administrator indicated that the door leading to the non-residential area was to be kept closed and locked at all times as the area was not intended for residents to access.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas of the home are kept locked and closed, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

The licensee failed to ensure when a resident was restrained by a physical device, that the restraining of the resident was included in the resident's plan of care.

During this inspection, Resident #941 was observed in bed with a physical restraint in place. The resident was unable to remove the physical restraint when asked by the Inspector.

On two specified dates and times, Resident #941 was observed in a mobility aide with two trunk restraints in place. The resident did not appear to be leaning or sliding in the wheelchair.The resident was unable to remove the trunk restraints when asked by the Inspector.

Interview with Staff #219, #221, and #206 indicated the physical restraint is used for Resident #941 when in bed "to promote sleep". The staff also indicated the two trunk restraints are used when the resident is in the mobility aide "for comfort and positioning". The staff confirmed the resident cannot remove the physical restraints.

Review of Resident #941 care plan did not identify the use of physical restraining devices.

2. The licensee failed to ensure that alternatives to restraining the resident were considered, and tried where appropriate, but have not been effective in addressing the risk.

Review of clinical records for Resident #941 indicated the resident was assessed on a specified date for a "Personal Assistance Services Device (PASD)" and required the two trunk restraints "to support positioning of torso". The physical restraint was "required at night to promote sleep as resident feels safer with side rails". The resident was not assessed for use of any alternatives to physical restraints or any other interventions tried.

3. The licensee failed to ensure that the restraining of a resident by a physical device included an order by the physician or registered nurse int he extended class.

Review of the health care record for Resident #941 indicated all the physical restraint orders were discontinued.

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 restraining of residents by physical device includes a plan of care, alternatives considered and tried and were not effective, and an order by a physician or registered nurse in the extended class, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

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

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

s. 229. (12) The licensee shall ensure that any pet living in the home or visiting as part of a pet visitation program has up-to-date immunizations. O. Reg. 79/10, s. 229 (12).

Findings/Faits saillants :

The licensee failed to ensure that the Infection Prevention and Control program is evaluated and updated at least annually, in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The home has had 3 outbreaks in the last 8 months.

Interview with Staff #208 (responsible for Infection Prevention and Control) indicated that Infection Prevention and Control is discussed at CQI (Committee for Quality Improvement) and PAC (Professional Advisory Committee) meetings, however staff do not complete a program evaluation annually.

Review of CQI meeting minutes (from December 20, 2013 to May 6, 2014) did not indicate any evidence of an Infection Prevention and Control program evaluation or updates. Review of the PAC meeting minutes (from January 16, 2013 to January 15, 2014) did not indicated any evidence of Infection Prevention and Control Program evaluation or updates. [s. 229. (2) (d)]

2. The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program.

During this inspection, the home was declared in a respiratory outbreak, causative organism identified as Influenza B.

-Observation of Room 4A, 6B, 7A, 7D, 10B, 11, 12B, 14A & 20 staff did not provide hand towels resulting in residents not being able to wash and dry their hands.
-On May 20, 2014 Staff #218 was observed completing insulin administration, blood sugar testing, and then administering oral medications to 3 different residents in the dining room without performing hand hygiene before or after contact with each resident. [s. 229. (4)]

3. On May 12, 2014 (during the lunch meal service):
- Staff #201 was observed scraping resident meal plates and then proceeded to serve dessert without hand hygiene being performed.
- Staff #213 was observed performing Range of Motion (ROM) for resident #940 wearing gloves and then performed ROM on another Resident #960,using the same gloves.
-On May 16, 2014 two PSWs were observed leaving resident rooms, following tray service, wearing gloves and walking into the dining room to obtain further meal trays and did not remove gloves.
-Interview of the DOC indicated that staff were not to be wearing gloves while assisting with meal service.
-Observation of Room 12 had a urinal sitting on the floor with dried urine and this room has two residents that would not use a urinal. [s. 229. (4)]

4. On May 12, during the lunch meal observation the following was observed:
-Staff #202 was plating bread onto residents' plates using bare hands.
-Staff #201 was picking through Resident #948’s meal plate (removing the carrots)and then gave the plate to the resident; Interview of Staff#201 indicated that the resident did not like carrots but that her "hands were clean".
-Staff #205 was scraping food from several residents' plates with gloved hands and then proceeded to serving desserts using the same gloved hands;
-Interview of the DOC indicted that staff were not to be handling food with their hands (were to use kitchen utensils) and that nursing staff were not to be using gloves when serving food. [s. 229. (4)]

5. The licensee failed to ensure access to point of care hand hygiene agents.

On May 12, 2014, Resident rooms (4A, 6B, 7A, 7D, 10B, 11, 12B, 14A, 25, 26)were observed without readily accessible hand hygiene agents at the point of care. Room 20 (4 bed room) only had one point of care hand hygiene available outside of the room. On May 13, 2014 the above resident’s rooms were equipped with a bottle of Isagel (alcohol based, no rinse hand cleansing gel). [s. 229. (9)]

6. The licensee failed to ensure that each resident admitted to the home is screened for tuberculosis(TB) within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

Review of licensee policy entitled "Infection Control Policies and Procedures: Tuberculosis Screening/Exposure" (dated November 2012) indicates that "All residents will have a two-step mantoux test upon admission (within 14 days)" and "the second "booster" dose given 7-21 days after the first, if the first test is negative."

Review of the following Resident health records indicated:
-Resident #3 had the TB 2-Step Mantoux Skin Test (Step 1) completed within 14 days of admission (tested negative) but to date, the Step 2 has not been completed.
-Resident #4 had the TB 2-Step Mantoux Skin Test (Step 1) completed greater than 14 days after admission.
-Residents #5 and #6 had no documented evidence of a TB screen completed.

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 the infection prevention and control program is evaluated and updated annually, that staff participate in the implementation of the program, to ensure access to point of care hand hygiene agents, and to ensure that residents admitted to the home are screened for tuberculosis according to best practices,, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee failed to ensure that every resident has the right, to have his or her personal health information, within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

During this inspection, (during the lunch meal), Staff #200 and #204 were heard discussing the health condition of Resident #956; during the same conversation, both staff were also heard discussing the vitals of other residents. The conversation occurred while staff #204 was assisting Resident #955 and #974 with their meals. Activity Staff #216 was present in the room at time of the conversations and would not be privy to resident health information being discussed.

During the same meal service, Staff #201 was heard shouting across the dining room, asking Staff #216 and #217 what Resident's #952, #591 and #968 had consumed during lunch; the majority of residents were in the dining room at the time.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 12. Furnishings

Specifically failed to comply with the following:

s. 12. (2)The licensee shall ensure that,
(a) resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care; O. Reg. 79/10, s. 12 (2).
(b) resident beds are capable of being elevated at the head and have a headboard and a footboard; O. Reg. 79/10, s. 12 (2).
(c) roll-away beds, day beds, double deck beds, or cots are not used as sleeping accommodation for a resident, except in an emergency; O. Reg. 79/10, s. 12 (2).
(d) a bedside table is provided for every resident; O. Reg. 79/10, s. 12 (2).
(e) a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so; and O. Reg. 79/10, s. 12 (2).
(f) a clothes closet is provided for every resident in the resident's bedroom. O. Reg. 79/10, s. 12 (2).

Findings/Faits saillants :

The licensee failed to ensure that each resident had a comfortable easy chair provided in the resident's bedroom.

Observation of rooms #2, 4, 10, 14 (which have 2 residents in each room) only have one chair available.
Observation of rooms # 16, 18, 20 & 22 (which has 4 residents in each room) only had 3 chairs available.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

The following were observed:
- Dark black/brown staining around the toilet base/flooring in rooms #28, 27, 26, 23, 21, 20, 77, 4, 8, 7, 10, 12, 9 and tub room; many of the same rooms had caulking around the toilet base lacking and unable to be cleaned effectively.
- The flooring in the tub/shower room was observed visibly soiled with dark coating of dust/ debris in both the corners of the room and shower stalls.
- Ceiling Tiles in the tub/shower room were observed soiled or having brownish staining over the tub.
- The carpeted area outside of the activity room was observed May 12 to May 16, 2014 to have a large whitish stained area. [s. 15. (2) (a)]

2. The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and a good state of repair which is a potential risk to

the health, safety and well-being of residents.

The following areas were identified:
- The window frames in many resident rooms, lounges and dining rooms were observed to have paint chipped off along perimeter of the of the frame, exposing the wood of the frame in several areas in Rooms # 4, 7, 8, 9, 10, 20, 21, 23, 26, 28, 77, south lounge, and many windows in the main dining room.
- Dark brown/black staining (approximately 15cm x 5cm) was observed on the lower edge of the window frame in room #28; the area was damp to the touch.
- Window panes were observed to be 'fogged' in the south lounge and room #14.
- Walls in room #2, 3, 7, 10, 14, 16, 20 and 23 were observed to have wall damage, paint chipping, black scuff marks, and/or evidence of wall repair without being completed (lacking paint).
- Wooden doors (resident room and or washroom) in room #7, 9, 20, 21 and 26 were observed chipped, scuffed or requiring sanding.
- Laminate on the foot boards on beds in room #8 and 12 were observed to be lifting and or chipped.
- The laminate countertop in the washroom surrounding the sinks in room #7, 15, 21, and 23 were observed to be lifting and or chipped in areas.
- The laminate countertop covering on the nursing station desk was observed chipped and or lifting along the top and lower edges; sharp edges were exposed.
- The dresser in room #26 was observed to be chipped with sharp edges exposed.
- Tub/Shower room walls and or shower stalls observed to have paint chipping in several areas.
- Two bath chairs in the tub/shower room were damaged; the seat of the Dolphin chair was observed to be chipped along the edges of the seat and the other chair was observed to have the left corner of the seat was missing, exposing the foam underlay, the edges of the vinyl exposed were jagged and sharp.
- Geri-chair was observed sitting in the hallway on the south hall, both arms of the chair were severely cracked, torn and observed to have the foam underlay and wood on the length of the arms exposed.
-the carpeted area within the home was noted to have several areas which were wrinkled, and an area where the carpet seam was lifting (areas which potentially pose a falls or tripping hazard).

Non intact surfaces cannot be effectively cleaned and sanitized or disinfected as needed presenting a potential infection prevention and control risk; jagged or non-intact surfaces pose an increased potential risk of skin tears to residents.

Maintenance Repair Request binder (reviewed from November 30, 2013 through to May 14, 2014) did not have any of the above maintenance concerns identified.

Interview of the Administrator indicated no awareness of the areas requiring maintenance and or repair (other than the two bath chairs). The Administrator was not aware of any plans for the above areas to be repaired, but indicated discussions would be had with the Maintenance Worker upon to work the following week.

WN #8: 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 :

The licensee failed to ensure the home's policy to promote zero tolerance of abuse and neglect of residents, was complied with.

This was issued as a Compliance Order under LTCHA,2007, s.19(WN#1).

Review of the homes policy "Prevention of Abuse and Neglect" indicated:
Under section Two-Actions to be taken by staff:
-document a brief factual note (not allegations or opinions) writing the details of the alleged or witnessed abuse or neglect as soon as possible.
-report any witnessed, suspected, or alleged abuse to a supervisor/manager, DOC or Administrator, immediately.

Under Part A-Investigation and Reporting of Abuse and Neglect:
-There are two types of procedures (internal reporting and MOHLTC reporting procedures) for reporting all alleged, suspected or witnessed incidents of abuse. The "Resident Abuse Allegation Report" (part A & B) is for the internal reporting and the Critical Incident Reporting System is the for the MOHLTC reporting.

Related to Resident #3 (log #000970 & 001089):
Note: refer to WN#1.

- The progress notes indicated opinions (not factual notes) were documented on 6 specified dates when incidents of alleged, suspected or witnessed resident to resident sexual abuse occurred as they did not provide specific dates, times or which residents were the recipients of the alleged, suspected or witnessed incidents of sexual abuse by Resident #3.
-There was no documented evidence of staff reporting incidents of alleged, suspected, or witnessed incidents of resident sexual abuse by Resident #3 on 8 specified dates to the DOC/Administrator.
-There was no documented evidence the staff completed the homes internal "Resident Abuse Allegation Report" for any of the documented or reported incidents of resident to resident alleged, suspected or witnessed sexual abuse by Resident #3.
-Interview of RN#204 who completed the progress notes on 3 specified dates was unable to recall when the incidents occurred, which residents were the recipients of the sexual abuse by Resident #3, and had never seen the homes "Resident Abuse Allegation Report" before.

Related to Resident #1 (log #000994 & 001013):
Note: refer to WN#1.

-There was no indication that a factual note was documented when incidents of alleged, suspected , or witnessed resident sexual abuse occurred by Resident #1 on 2 specified dates as the there was no indication when the incidents occurred and which residents were the recipients of the abuse.
-There was no documented evidence of staff reporting to the DOC/Administrator incidents of alleged, suspected, or witnessed resident sexual that occurred on 6 specified dates.
-There was no documented evidence the staff completed the homes internal "Resident Abuse Allegation Report" for any of the documented incidents of alleged, suspected, or witnessed resident to resident sexual abuse by Resident #1.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to immediately investigate and ensure appropriate action was taken in response to every alleged, suspected or witnessed incidents of abuse of a resident that the licensee knows of or was reported to the licensee.

This was issued as a Compliance Order under LTCHA,2007, s.19(WN#1).

Related to Resident #3 (Log #000970 & 001089):
Note: refer to WN#1.

There was no documented evidence of an investigation or appropriate action taken into the documented incidents of alleged, suspected or witnessed resident to resident sexual abuse by Resident #3 that occurred on 8 specified dates.

Interview of RN#204 indicated that on one specified date, nursing staff had reported their concerns with Resident #3 behaviours but "they did not provide specific dates or times" so "just charted what was told and left a note on the shift report communication book". RN #204 was also unable to recall who was involved in the incidents.

Interview of the DOC indicated that only 2 of the incidents that occurred were investigated.

2. Related to Resident #1 (Log #000994 & 001013):
Note: refer to WN#1.

There was no documented evidence of an investigation or appropriate action was taken into documented incidents of alleged, suspected or witnessed incidents of resident to resident sexual abuse by Resident #1 that occurred on 6 specified dates.

Interview of the DOC indicated that only 2 of the incidents that occurred were investigated.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

The licensee failed to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home, in accordance with manufacturers' instructions.

During the initial tour of the home on May 12, 2014, it was observed that the two bath chair lifts in the tub rooms did not have a seat belt on or near the lift. Staff #201, was able to locate a black seat belt (buried under yellow gowns and towels) hanging on a towel bar to the right of the toilet.

Interview of Staff #205 and #212 indicated that seat belts are used on the bath chair/lifts for only some of the residents who may 'wiggle about' when sitting on the bath chair/lift or those residents who 'float' when in the bathtub.

Interview of the DOC indicated the home does not require a seat belt to be used during bathing of resident's when using the bath chairs.

Review of the manufacturer's guidelines indicated the following:
- Dolphin Bath Chair – page 14 of the owner's operation manual indicates 'the dolphin bath chair comes equipped with a safety belt to be used for agitated or dependent residents'.
- GK-Hektor Bath Chair – page 6 of the owner's operation manual indicates 'bathing procedure - #5-9 directs user to open the safety belt, close the safety belt around the patient's body and to carry out the bathing procedure'.

Failing to use the bath chairs/lifts in accordance with manufacturers' instructions places the residents at risk for injury.

WN #11: 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 :

The licensee failed to ensure that when a person had reasonable grounds to suspect abuse of resident by anyone that resulted in harm or a risk of harm to the resident, immediately report the suspicion to the Director.

This was issued as a Compliance Order under LTCHA,2007, s.19(WN#1).

Related to Resident #1 (Log # 000994 & 001013):
Note: refer to WN#1.

The staff had reasonable grounds to suspect sexual abuse of resident by another resident, resulting in harm or risk of harm had occurred on 6 specified dates and failed to immediately report the information to the Director.

Related to Resident #3 (Log #000970 & 001089):
Note: refer to WN#1.

The staff had reasonable grounds to suspect sexual abuse of resident by another resident that resulted in harm or risk of harm had occurred on 5 specified dates and failed to immediately report the information to the Director.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

The licensee failed to ensure that resident's personal care items were labelled.

The following were observed:
-6 resident washrooms had either denture cups, used razors, bar soap, toothbrushes, deoderants, make-up, polident, comb, brushes and mouthwash sitting on the sink vanities unlabelled and they are shared washrooms. One shared resident bathroom had a used urinal on the floor that would not be used by those residents.
-Tub / Shower room had 3 used brushes, a comb and 2 deodorants sitting on a shelf; all items were unlabelled.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

The licensee failed to ensure that for each resident demonstrating responsive behaviours, the behavioural triggers for the resident were identified where possible, and strategies were developed and implemented to respond to these behaviours, where possible.

This was issued as a Compliance Order under LTCHA, 2007, s.19 (WN#1).

Interview of the Administrator indicated the home has a Behavioural Suppport Ontario (BSO) team in the home consisting of nursing staff, management and activation staff that meet monthly to discuss resident responsive behaviours and provides interventions/recommendations to manage residents' responsive behaviours. The Administrator indicated both Resident #1 & #3 were discussed at the meetings.

Review of the BSO meeting minutes during a three month period indicated:
-on a specified month, Resident #1 was identified as demonstrating specific responsive behaviours. There were interventions identified to manage the responsive behaviours which resulted in some improvement and further recommendations were suggested for distraction. There was also a meeting scheduled with police to determine which behaviours were reportable. The minutes also indicated that although the resident was discharged from the specialized services, they were to be contacted again if the responsive behaviours did not improve. Resident #3 was not identified.
-two months later, Resident #1 was again identified with the same responsive behaviours. The interventions identified included contacting the police and Ministry, the physician reassessed medications (with some improvement)and the resident was referred again to the specialized services. There was also one new recommendation indicated to manage the responsive behaviour. Resident #3 responsive behaviour was not identified but interventions to manage the responsive behaviour were identified. One of the interventions identified included a referral to specialized services. The recommendations included were from the specialized services and indicated the recommendation would not have any effect. The minutes also indicated a meeting was held with police who recommended contacting the BSO team when having problems but "BSO was not available in their LHIN", and the "police clarified what was to be reported". The meeting minutes also discussed consent and need to protect cognitively impaired residents.

2. Related to Resident #3 (log #000970 & 001089):
Note: refer to WN#1.

Review of the progress notes for Resident #3 for a 3 month period indicated the resident had demonstrated ongoing responsive behaviours towards several residents and staff. The resident also targeted vulnerable (cognitively impaired) and specific residents (Resident #981 & #989) were targeted more than once.

Review of the plan of care for Resident #3 indicated the responsive behaviour occurred but:
-there was no indication that specific residents were triggers for the resident,
-there was no indications that the resident also demonstrated the behaviours towards staff during care. -the strategies identified in the plan were not consistently utilized
-there was no indication how staff would "protect other residents if unable to protect themselves" especially when the resident would re-approach the resident again after redirection.
-there was no indication of the use specialized services and use of assessment tools that were used were actually identified in the plan.
-there was no indication that other strategies would protect vulnerable residents or recommendations by specialized services would be implemented.
-there was also no indication that other strategies were considered when the current strategies used were determined to be ineffective in preventing or reducing the responsive behaviours.

Related to Resident #1 (log #000994 & 001013):
Note: refer to WN#1.

Review of the progress notes of Resident #1 for a 5 month period indicated the resident had demonstrated ongoing responsive behaviours towards several cognitively impaired residents over a three month period, the triggers were clearly identified, the responsive behaviour was random, the resident was also cognitively impaired and easily redirected. The recommendations provided by the specialized resource were not identified as strategies or consistently implemented. Interventions identified by the BSO team or nursing staff were not all identified as strategies

Review of the crisis care plan for Resident #1 indicated the responsive behaviour was identified but:
-the triggers and strategies recommending by the specialized resource were not identified or consistently implemented to manage the responsive behaviour.
-interventions identified by the BSO team or nursing staff were not all identified as

strategies.
-there was no indication that specific interventions that were used were consistently used when the behaviour occurred.
- there was no indication how staff were going to protect other residents that were unable to protect themselves.
-there was no indication that other strategies were considered when the current strategies were determined to be ineffective in preventing or reducing the responsive behaviours and the resident was not referred back to specialized services as recommended for a period of time despite the responsive behaviour continuing.

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

The licensee failed to advise families and persons of importance to residents on an-going basis of their right to establish a Family Council.

The home does not currently have a Family Council.

Interview with the Administrator indicated that family information nights were held in 2011 and 2012 which included information about establishing a Family Council. The Administrator confirmed that no family information nights were convened during 2013.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

The licensee failed to ensure that the daily menu is communicated to all residents.

On May 12, 2014 during the lunch meal, Staff #201 was observed asking residents their meal preference for dinner meal as the following choices: "chicken salad sandwich or macaroni and cheese" and did not communicate the entire meal.

Interview of Staff #201 indicated that this was the homes practice of meal communication, that staff asked the resident the prior meal for their next meal choice.

Review of the posted menu for the May 12, 2014 dinner indicated:
Choice #1-Chicken Salad Sandwich, Sugar Snap Peas, Bean Salad and Stewed Rhubarb
Choice #2-Macaroni and Cheese, Brussell Sprouts, Whole Wheat Bread and a Butter Tart

Review of the Food Committee Meeting Minutes on October 23, 2013 Resident #902 communicated "trouble ordering meals as does not know what some of the choices are or what they contain" and "that staff are unable to explain the choices offered".

Interview of the Administrator indicated they were unaware that only a portion of the menu was being communicated.

2. The licensee failed to ensure that the dining room tables are at an appropriate height to meet the needs of all residents.

During this inspection during the lunch meal the following was observed:
-Resident #978, was having difficulty reaching their meal plate. Interview of Staff #205 indicated that the resident's current chair was broken and the resident was using a replacement chair.
- Resident #962 did not have the required assistive aide on their chair and was observed having difficulty reaching the meal plate.

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

The licensee failed to ensure that a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home at least once in every year.

Interview of the Administrator indicated that a resident satisfaction survey was not completed in 2013.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

The licensee failed to ensure that the procedures for cleaning of the resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces were implemented.

Interview conducted with Resident #961 indicated that the floors in the bedrooms "appear dirty".

Observations of 7 residents' rooms on May 16, 2014 identified soiled and/or discolored floors along baseboards, near radiators, and black marks were noted under beds and tables.

Review of the homes policy "Housekeeping Room Assignments" (reviewed April 18, 2013) indicated under #4. Bedrooms: floor and baseboards - vacuum, damp mop, and buff".

Interview with Staff #215 reported that bedroom floors are cleaned daily which includes sweeping and mopping. The staff member indicated that specified rooms are required to receive a full cleaning each day which is outlined on "Housekeeping Room Assignments". Staff #215 reported that buffing was not completed and was not aware how often the buffing of floors is completed.

Interview with the Administrator indicated certain rooms are completed everyday which require full cleaning and includes buffing of bedroom floors as per the procedure entitled "Housekeeping Room Assignments". The Administrator was not aware the housekeeping staff were not completing the buffing of the bedroom floors as per the home's policy.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

The licensee failed to ensure that all hazardous substances in the home are kept inaccessible to residents at all times.

On May 12, 2014 observation of the tub room indicated the door was unlocked and unsupervised. The tub room contained the following hazardous cleaning agents:
- 2 bottles of blue Non-Acid Crème Cleanser.
- McCuaig Tub Disinfectant Cleaner.

Review of the Material Safety Data Sheets (MSDS) for the chemicals indicated the following:
- blue Non-Acid Crème Cleanser: is an industrial cleaning agent; WHMIS hazard class as 'very toxic material'. Handling requirements: avoid contact with skin, eyes and clothing. Do not taste or swallow. Keep out of reach of children.
- McCuaig Tub Disinfectant: is a disinfectant cleaner for hard surfaces; is classified as a drug (DIN 02016907) and acute exposure potential is identified as resulting in vomiting, convulsions and mucosal damage.

Interview of Staff #204 and the DOC indicated that the tub room was to be kept locked at all times when not in use and interview of Staff #203 indicated that the blue Non-Acid Crème Cleanser was not to be left or stored in the tub rooms.

WN #19: 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).

Findings/Faits saillants :

The licensee failed to ensure that the resident's substitute decision-maker(SDM), if any, and any other person specified by the resident were immediately notified upon the licensee becoming aware of an alleged, suspected, or witnessed incident of abuse or neglect of a resident, that resulted in pain or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being.

This was issued as a Compliance Order under LTCHA,2007, s.19(WN#1).

Related to Resident #1 (Log #000994 & 001013):

There was no documented evidence the SDM of Resident #1 was notified of the alleged, suspected, or witnessed incidents of sexual abuse (or the recipients of the abuse)that were documented on 6 specified dates.

Related to Resident #3 (Log #000970 & 001089):
Note: refer to WN#1.

There was no documented evidence the SDM of Resident #3 was notified of the alleged, suspected, or witnessed incidents of sexual abuse (or the recipients of the abuse) that were documented on 5 specified dates and on one of the dates, the SDM was not notified until the day after.

WN #20: 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 :

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

This was issued as a Compliance Order under LTCHA,2007, s.19(WN#1).

Related to Resident #1 (Log #000994 & 001013):

There was no documented evidence the police were notified of alleged, suspected or witnessed incidents of resident sexual abuse that occurred on 5 specified dates.

Related to Resident #3 (Log #000970 & 001089):

There was no documented evidence the police were notified of alleged, suspected or witnessed incidents of resident sexual abuse that occurred on 8 specified dates.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

The licensee failed to ensure that when a resident is restrained by a physical device, the resident is monitored at least every hour by a member of the registered nursing staff.

Resident #941 was observed on a specified date in bed with a physical restraint in place. On 2 other specified dates and times, Resident #941 was observed in a mobility aide with 2 trunk restraints in place and the resident was unable to remove any of the physical restraining devices.

Review of health record and observation for Resident #941 had no indication of monitoring of any of the physical restraints that were in use.

Interview with DOC indicated that Resident #941 physical restraining devices were not recorded as monitored as they were considered a Personal Assistive Safety Device (PASD).

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining

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Findings/Faits saillants :

The licensee failed to ensure that the staff were provided re-training on an annual basis on Infection Prevention and Control practices.

Under O Reg. 70/10 section 219 (4) the licensee shall ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76(2) and subsection 76(4) of the Act includes, (a) hand hygiene; (b) modes of infection transmission; (c) cleaning and disinfection practices; and (d) use of personal protective equipment.

Under O. Reg. 79/10 Retraining s.219 (1) the intervals for the purposes of subsection 76(4) of the Act are annual intervals.

Review of "Staff Training Records" for 2013 had no documented evidence of Infection Prevention and Control training completed for staff.

Interview with Staff #208 (responsible for Infection Prevention and Control) reported that staff "do not receive annual re-training in Infection Control, it is only received on hire".

Issued on this 4th day of June, 2014

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111), GWEN COLES (555), KELLY BURNS (554), SAMI JAROUR (570)
Inspection No. / No de l'inspection :	2014_220111_0011
Log No. / Registre no:	O-000388-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 3, 2014
Licensee / Titulaire de permis :	MEDLAW CORPORATION LIMITED 42 Elgin Street, Thornhill, ON, L3T-1W4
LTC Home / Foyer de SLD :	PINECREST NURSING HOME (2731) 3418 County Road 36, R.R. #2, BOBCAYGEON, ON, K0M-1A0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MARY CARR

To MEDLAW CORPORATION LIMITED, 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) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to include the following:
(a) A process to ensure that residents who demonstrate responsive behaviours, including behaviours of a sexual nature where consent has not been provided, have a written plan of care that includes at a minimum:
- identification of behavioural triggers
- documented strategies to respond to the resident's responsive behaviours
- documentation of the resident's responses to interventions
- actions to be taken to minimize the risk of altercations and potentially harmful interactions between and among residents
(b) A Responsive Behaviour Program to include a structured process for the reassessment of the effectiveness of planned intervention; with a focus of sexual inappropriate behaviours
(c) The development of a monitoring process to ensure that:
- every incident of alleged, suspected or witnessed incident of abuse is immediately investigated.
- the resident's SDM is immediately notified of every incident of alleged, suspected or witnessed incident of abuse
- the Director is immediately notified if there are reasonable grounds to suspect abuse of a resident that resulted in harm or risk of harm to a resident.
-the appropriate police force have been immediately notified of all alleged, suspected, or witnessed incidents of sexual abuse that the licensee suspects may constitute a criminal offense
- a written report is submitted to the Director with respect to the alleged, suspected or witnessed incident of abuse or a resident by anyone which shall include:
- a description of the incident and the individuals involved

- action taken in response to the incident
- analysis and follow up action
- the name and title of the person making the report
- that the Director is informed of the results of every investigation undertaken in response to an alleged, suspected or witnessed incident of abuse.

(d) Ensure that staff education is provided of the homes Prevention of Abuse policy, which includes identification of incidents/actions that constitute sexual abuse as defined in O.Reg.79/10 s.2.(1) and legislated reporting requirements of all incidents of alleged, suspected or witnessed incidents of sexual abuse of a resident.

The plan shall identify the time line for completing the tasks and who will be responsible for completing those tasks.

The plan is to be submitted to Lynda Brown by June 13, 2014 via email to Lynda.Brown2@ontario.ca.

Grounds / Motifs :

1. Under O.Reg. 79/10, sexual abuse is defined 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".

Furthermore, non-compliance was previously identified under LTCHA, 2007, s.20(1) & O.Reg.79/10, s.97 & 98 during an inspection completed on September 17, 2013 under inspection #2013_049143_0047 in relation to the reporting of incidents of sexual abuse.

During this critical incident inspection into 4 critical incidents of resident to resident sexual abuse, actual harm and/or risk of harm was demonstrated as vulnerable and/or cognitively impaired residents were recipients of the sexual abuse. A pattern was demonstrated as there were 2 separate resident's involved in the sexual abuse, the incidents reoccurred over a three month period, affected approximately 10 vulnerable and/or cognitively impaired residents, and some of which had reoccurring incidents by one or both Resident#1 & Resident #3. Only 2 of the incidents from Resident #1 and only 2 of the incidents from Resident #3 were reported to the police and the Director. Many of the incidents were not reported to any of the SDM's.

Related to Resident #1 (log #000994 & 001013):

Review of the health record for Resident #1 indicated there were 13 documented incidents of either verbal or physical sexual abuse that occurred towards Resident #2, #953, #960, #970, #977, #988, (and unidentified residents) by Resident #1. Resident #970 & #988 were the recipient of more than one incident of sexual abuse by Resident #1. (111)

2. Related to Resident #3 (log #000970 & 001089):

Review of the health record for Resident #3 indicated the there were 12 documented incidents of either verbal or physical sexual abuse that occurred towards Resident #988, #974, #981, #901, and unidentified residents from Resident #3. Resident #981 & #974 were the recipient of more than one incident of sexual abuse by Resident #3. Resident #988 was the recipient of more than one incident of sexual abuse by Resident #3 and Resident #1.

During this inspection, observation of Resident #981, #974, #988, #970, #977, #960 indicated the residents were confined to a mobility aide and cognitively impaired. (111)

3. The licensee failed to protect approximately 10 residents from sexual abuse by 2 different residents as evidenced by the following:
- The Director was not immediately notified when there was alleged, suspected or witnessed incidents of sexual abuse of Resident #2, #953, #960, #970, #977,#988,(and unidentified female residents) by Resident #1 that resulted in harm or risk of harm to the residents. The Director was not immediately notified when there was alleged, suspected or witnessed incidents of abuse of Resident#974,#981,#988,#900 & #999, by Resident #3 that resulted in harm or risk of harm to the residents(as identified in under WN#11).
- There was no evidence that every alleged, suspected or witnessed incidents of sexual abuse involving Resident #1 & Resident #3 were immediately investigated(as identified under WN#9).
- The licensee's policy "Prevention of Abuse and Neglect" was not complied with (as identified under WN#8).
- The licensee failed to immediately notify the SDM of Resident #1, # 3 (and the identified residents above), of every alleged, suspected or witnessed incidents of sexual abuse(as identified under WN#19).
- The licensee failed to ensure that the appropriate police force was immediately notified of all the alleged, suspected and witnessed incidents of resident to resident sexual abuse that the licensee suspects may constitute a criminal

offense(as identified under WN#20).
-There was no evidence that Resident #1 & Resident #3 were reassessed when they were demonstrating ongoing responsive behaviours, that the behavioural triggers for the residents were identified where possible, and strategies were developed and implemented to respond to these behaviours, where possible(as identified under WN#13). (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 04, 2014

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
Performance Improvement and Compliance 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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
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
Direction de l'amélioration de la performance et de la conformité
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 June, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

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