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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 30, 2016	2016_284545_0018	019308-15	Follow up

Licensee/Titulaire de permis

BRUYERE CONTINUING CARE INC.
43 BRUYERE STREET OTTAWA ON K1N 5C8

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

RESIDENCE SAINT- LOUIS
879 CHEMIN PARC HIAWATHA OTTAWA ON K1C 2Z6

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

ANGELE ALBERT-RITCHIE (545)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): June 28-30, and July 4-8, 2016

As part of this Follow-Up inspection (Log #: 019308-15) originating from Critical Incident (Log #: O-001613-15) related to Duty to Protect, four Critical Incidents related to resident to resident alleged abuse and improper care/treatment were also inspected, such as:
-Log #: 018237-16 related to improper care/treatment
-Log #: 024933-15 related to alleged physical abuse
-Logs #: 012389-16 & 016860-16 related to alleged sexual abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, Clinical Manager, Education Lead, Environmental Services Supervisor (ESS), Registered Nurses (RN), a RAI Assessor, Registered Practical Nurses (RPN), Personal Support Workers (PSW), external agency providers and Manager from AlternaCare, one Housekeeping Aide, one Dietary Aide, Scheduling Resource staff , a Unit Clerk, a Trust Account Clerk, and residents and family members.

The inspector also conducted a tour of the resident care areas, reviewed residents’ health care records, the home's Zero Tolerance of Abuse (Abuse, Residents, policy number: CLIN CARE 32 LTC, revised December 2015), staff work routines and schedules, observed residents' rooms, observed residents' common areas including dining rooms, reviewed the home's Abuse training materials including attendance, and observed the delivery of resident care and services, including resident-staff interactions.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

6 WN(s)
0 VPC(s)
1 CO(s)
1 DR(s)
0 WAO(s)

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

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

On June 27, 2015, the licensee was issued a Compliance Order under section 19(1), to ensure protection of residents from abuse by anyone and ensure that residents were not neglected by the licensee or staff by preparing, submitting and implementing a plan to include requirements as stated below (A to F):

(A) Specific actions that will be taken by the licensee to ensure that every alleged, suspected or witnessed incidents of abuse of a resident by anyone is immediately reported to the Director and is immediately investigated.

(B) Revisions to the licensee's Zero Tolerance of Abuse and Neglect of residents' policy to include the reporting obligations in the LTCH Act, 2007.

(C) Retraining of all staff on their obligations under the revised Zero Tolerance of Abuse and Neglect policy with particular attention to the requirement of every person to immediately report every alleged, suspected or witnessed incident of abuse of a resident both to the Director and to the appropriate individual identified within the home. This retraining needs to be evaluated to ensure staff understand their obligations.

(D) Annual retraining as required under the LTCH Act.

(E) Develop a monitoring process to ensure staff training is completed as required and that staff report every alleged, suspected or witnessed incidents of abuse of a resident as required as required.

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

The compliance date for the Compliance Order of June 27, 2015 was November 2, 2015. An extension was requested by the home on October 14, 2015 and granted until December 1, 2015.

Upon entrance to the home on June 28, 2016, Inspector #545 requested to review documentation to demonstrate completion of the home's Plan which was submitted to the Director on July 23, 2015.

On July 4, 2016 the inspector concluded this, based on information gathered in July 2016, that requirements (A), (C) and (E) had not been completed as set-out in the Plan:

REQUIREMENT (A)
"Specific actions that will be taken by the licensee to ensure that every alleged, suspected or witnessed incidents of abuse of a resident by anyone is immediately reported to the Director and is immediately investigated".

On a specified date in June 2016: the home submitted a Critical Incident (CI) indicating that resident #031 was found in resident #033's bedroom trying to pull his/her blankets off while constricting his/her neck, or to climb into bed with the resident who expressed being scared. One-on-one supervision had been increased on two days prior to this incident to include the night shift to ensure other residents' safety, as resident #031 was wandering at night. The staff assigned to provide one-on-one supervision had left to answer another resident's call bell, therefore did not providing one-on-one supervision to resident #031.

In an interview with resident #033, he/she indicated to the inspector that he/she remembered the incident of a specified date in June 2016 very well as he/she feared that resident #031 would have choked him/her with his/her large hands. The resident indicated that he/she woke up at around 0100 hours when someone was pulling on his/her blankets, the person's hands were near his/her neck and he/she made every effort to hold the blankets up. Resident #033 indicated that he/she was scared and was shaking and screamed very loud and that's when a staff member came in and called the person by his/her name and took the resident out of the bedroom, telling him/her he/she should not be in other residents' room. Resident #033 indicated that he/she thought the resident wanted to climb in bed with him/her. Resident #033 further indicated that in the morning, he/she immediately called a family member to report the incident, added that he/she didn't know if the staff had already called the family member but wanted to make sure they knew about the incident that terrified him/her. Resident #033 indicated that

he/she didn't feel safe, that he/she was cognitively aware and feared those that wandered in his/her room, like resident #031.

PSW #209 indicated to Inspector #545 that she was assigned to provide one-on-one supervision for resident #031 on a specified date in June 2016. She indicated that around 0100 hours she answered another resident's call bell, and left the resident alone in the room, thinking that the resident was asleep. After returning from caring for another resident, PSW #209 indicated that she found resident #031 in resident #033's bedroom, by resident #033's head. PSW #209 further indicated that resident #033 was frightened, jumped and screamed. The PSW indicated to the Inspector that she took resident #031 back to his/her room and did not report the incident to the registered nursing staff, added that she reported it to regular PSW #214 later and that's when he indicated that he was aware of the incident as resident #033 had told him while he provided morning care. PSW #209 indicated that she did not remember when she last received training on the Zero Tolerance of Abuse policy.

RN #215 indicated that she was in-charge of the unit on a specified date in June 2016. The RN indicated that PSW #209 was assigned to provide one-on-one supervision to resident #031 to prevent him/her from wandering into residents' rooms as per the resident's plan of care and for the safety of the residents on the unit due to a history of sexual behaviours. RN #215 indicated to Inspector #545 that on a specified date in June 2016 at a specified time, it was PSW #214 that informed her that PSW #209 had found resident #031 in resident #033's bedroom, and that resident #033 was very upset. The RN indicated that she did not investigate the incident immediately, either by speaking to PSW #209 or by assessing resident #033's condition. She added that she checked on resident #033 four hours later and found resident #033 asleep and left. The RN indicated that other than documenting a note in resident #031's chart to indicate that the resident had wandered in another resident's room, she did not immediately investigate the incident reported to her by PSW #214. According to a progress note dated on a specified date in June 2016, after receiving a telephone call from resident #033's family member who feared for the safety of the resident, the Administrator conducted an investigation, contacted the police and reported the incident to the Director under the LTCHA, 2007. (Log #: 018237-16)

REQUIREMENT (C)
"Retraining of all staff on their obligations under the revised Zero Tolerance of Abuse and Neglect policy with particular attention to the requirement of every person to immediately report every alleged, suspected or witnessed incident of abuse of a resident both to the

Director and to the appropriate individual identified within the home. This retraining needs to be evaluated to ensure staff understand their obligations”.

The Administrator provided Inspector #545 with the current Zero Tolerance of Abuse and Neglect policy, titled: Abuse, Residents, Policy Number: CLIN CARE 32 LTC, revised December 2015. The revised policy included the requirement of every person to immediately report every alleged, suspected or witnessed incident of abuse of a resident both to the Director and to the appropriate individual identified within the home. The Administrator indicated that the policy was revised in September 2015 then sent to the home’s translation department then finalized December 2015.

The Education Lead and Administrator provided the Inspector with attendance reports for two different education sessions related to abuse which they indicated was based on the revised policy:

1) Abuse Blitz took place between October 19 and 23, 2015 whereby the management team visited the different units on different shifts and reviewed ten questions related to abuse with staff. According to the attendance report, approximately 57% of all staff did not receive this training.

2) Face-to-face in-services on Prevention of Abuse were provided to the registered nursing staff and supervisors/managers by the Education Lead between October 21 and November 2, 2015. According to the sign-in sheets approximately 30% of the registered nursing staff and approximately 67% of the supervisors/managers did not receive this training.

It was noted that resident #031 was assigned one-on-one supervision hired from an external agency (AlternaCare). Starting April 16, 2016 to this present date, the agency changed assignment from sitters to Personal Care Workers. Both the Manager of the external agency and the Education Lead indicated that Abuse training had not been provided to any of the AlternaCare Agency Staff (16 new staff since April 16, 2016) who were assigned to provide one-on-one supervision to resident #031.

The Administrator was unable to find documentation to demonstrate that this retraining was evaluated to ensure staff understood their obligations to immediately report every alleged, suspected or witnessed incident of abuse of a resident.

REQUIREMENT (E)

“Develop a monitoring process to ensure staff training is completed as required and that staff report every alleged, suspected or witnessed incidents of abuse of a resident as required”.

The Administrator indicated that the home had not yet implemented a monitoring process to ensure staff training was completed as required. She further indicated that the annual Abuse training scheduled for June 2016, as per the home's Plan, had been postponed to the fall of 2016 and that face-to-face training would be replacing the usual online training.

Furthermore, there were new documented incidents of abuse related to resident #031.

In following up on this inspection, Inspector #545 conducted three critical incidents related to alleged sexual abuse involving resident #031:
-Log #: 012389-16 related to alleged sexual abuse of resident #034 by resident #031 on a specified date in 2016
-Log #: 016860-16 related to alleged sexual abuse of resident #032 by resident #031 on a specified date in June 2016
-Log #: 018237-16 related to improper care/treatment of resident #033 by resident #031 on a specified date in June 2016

Note that resident #031 was referred to as resident #002 in Compliance Order issued July 27, 2015 (Log # 2015_289550_0003).

O. Reg 79/10 s. 2(1)b defines sexual as any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or 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; (“mauvais traitement d’ordre sexuel”).

Resident #031 was admitted to the home on a specified date in November 2014 with a known history of sexual behaviour towards residents. Resident #031 was diagnosed with a specified dementia and was receiving anti-psychotic and antidepressant medications to manage behaviours.

The one-on-one schedule was reviewed by the Inspector from a period of three months in 2016, which indicated that a staff member was assigned to provide one-on-one supervision to resident #031, such as:
-day & evening shifts from a specified date in April to a specified date in May
-day shift only for two days in May
-part of evening shift a specific date in June
-day shift for ten days in June
-day, evening & night shifts for seventeen days in June 13
Agency staff were assigned to provide one-on-one supervision day/evening on weekends, and then day/evening/night shifts seven days per week starting a specified date in June 2016.

In a gray binder in the report room, two sets of written directions were found; one for registered nursing staff and one for the personal support workers. Both were dated a specified date in December 2015 and according to the Administrator, these were the most current directions (titled: Important changes in directions for resident #031) she provided staff on how to manage resident #031’s behaviours. The current written directions provided various instructions, including:

For the Registered Nursing Staff:
-One-on-one supervision will be continued 24 hours per day to ensure safety to our residents, at times service will be provided by AlternaCare (external agency), note that they are considered sitters and will not be providing care to the resident
-One-on-one staff must monitor closely
-One-on-one staff may assist with other tasks on the unit when resident #031 is in his/her bedroom; put alarm on; noting that the alarm doesn’t function 100% of the time
-Ask staff to read/sign these directions

For the Personal Support Workers:
-Speak with registered nursing staff to understand reason for one-on-one supervision and for type of behaviours to watch for
-Read, sign and date that you have read these directions
-Must monitor resident #031 VERY closely, especially near a specified group of residents
-May assist with other tasks on the unit when resident #031 is in his/her bedroom; put alarm on; noting that the alarm doesn’t function 100% of the time
-When on break, notify your colleagues to ensure supervision
-Assist with feeding other residents in dining room between 1700-1730 hours, then go for supper

-Notify registered nursing staff immediately if you observe signs of behaviour
-Provide a verbal report to the registered nursing staff and to the PSW that will be replacing you on the 1:1 monitoring, at the end of your shift

The sign sheets for above directions were reviewed, and no signatures were found after a specified date in February 2016.

On June 29, 2015 the inspector observed resident #031 eating lunch independently in the dining room in presence of assigned one-one-one external provider (AlternaCare Agency) and ambulating towards the bathroom in his/her bedroom. The resident’s current care plan indicated that resident #031 was receiving one-on-one supervision on days and evenings. Note that the resident was provided one-on-one supervision on days, evenings and nights since a specified date in June 2016.

On June 29, 2016 at 1432 hours, Inspector #545 observed a small battery operated device (Posey Wireless Pager) installed on the outside frame of resident #031’s bedroom door, facing the hallway. The device was not activated, and no lights appeared on the device. Environmental Services Supervisor #224 indicated that he didn’t know who had installed the device. Later he provided the Inspector with an invoice for a Posey Wireless Infrared Alarm, purchased on a specified date in March 2015 to detect resident #031's whereabouts.

In discussion with AlternaCare agency PSWs #204, #205, #229, #231 and #232, four out of the five agency staff were unaware that resident #031 required one-on-one supervision due to inappropriate sexual behaviour towards residents. All five indicated they did not have access to the resident’s plan of care, were not aware of the home’s Zero Tolerance of Abuse and Neglect policy and had not been provided training. The AlternaCare agency manager indicated she believed that one-on-one supervision was provided to resident #031 to protect other residents from the resident's aggressive behaviour.

Three (3) Critical Incidents related to abuse involving resident #031 were submitted by the licensee to the Director under the LTCHA, 2007.

INCIDENT #1 BETWEEN RESIDENT #031 AND RESIDENT #034
On a specified date in April 2016: a Critical Incident was submitted indicating that resident #031 was observed by Housekeeping Aide #206 in the dining room at a specific time, exhibiting inappropriate sexual touching towards resident #034’s. Staff assigned to

provide one-on-one was providing care to other residents at the time of the incident.

PSW #228 indicated she was assigned to provide one-on-one to resident #031 on a specific date in April 2016, added that her primary responsibility was to monitor resident #031 from inappropriately touching residents. She further indicated that after bringing resident #031 to the dining room for lunch, she left the dining room to get other residents up for lunch. She indicated that she was not monitoring resident #031 when the resident got up from the dining room table and approached resident #034 who was at a nearby table and exhibited inappropriate sexual touching. PSW #228's signature did not appear on the written care plan sheet to indicate she had read/understood her responsibilities, as per the Administrator's directions.
(Log# 012389-16)

INCIDENT #2 BETWEEN RESIDENT #031 AND RESIDENT #032
On a specified date inJune 2016: a Critical Incident was submitted indicating that resident #031 was found in resident #032's at the foot of the resident's bed at a specified time, while the resident was lying in bed with no clothing except for an incontinence brief. In a progress note dated a specified date in May 2016, it was documented by the Administrator, that the one-on-one supervision had been discontinued due to the resident's condition. Note that there was no description to explain what the resident's condition was. The Administrator indicated that she based her decision on the RAI-MDS assessment which was completed 18 days previous to the incident in May 2016, which indicated the resident was a two-person transfer upon return from hospital. The Administrator added that she wanted to be fiscally responsible with the High Intensity Needs dollars. RN #202 indicated she was surprised when she was informed upon arriving on the unit for the evening shift, that the one-on-one supervision had been discontinued the day before, as she had concerns that resident #031's inappropriate sexual behaviours towards vulnerable residents would reoccur. RN #202 further indicated that a staff member had brought resident #031 to the dining room for supper then left to get other residents; upon returning, the resident was gone. The RN indicated a search was immediately started and just as they were to initiate a Code Yellow for a missing resident, the resident was found standing without mobility aids in resident #032's bedroom, by the bed. She indicated that resident #032 was unable to say if sexual abuse had taken place due to cognitive impairment. Note that the care plan did not reflect the resident's level of mobility or the discontinuation of one-on-one supervision that took place on the day of the incident. (Log # 016860-16).

INCIDENT #3 BETWEEN RESIDENT #031 AND RESIDENT #033
On a specified date in June, 2016: a Critical Incident (CI) as previously indicated above under item (A), PSW #209 indicated she was assigned to provide one-on-one supervision for resident #031 on a specified date in June 2016. She indicated that around 0100 hours she answered another resident's call bell, and left the resident alone in his/her bedroom, thinking that the resident was asleep. The PSW indicated that when she returned to the resident's bedroom, she observed the resident entering resident #033's bedroom. She indicated registered nursing staff had instructed her on previous shifts to provide assistance to other staff member when resident #031 was in his/her room and sleeping, and felt she needed to help on the unit. (Log # 018237-16)

RPN #213 indicated to the Inspector that she was aware resident #031 was provided one-on-one supervision on all three shifts for the safety of the residents on the unit due to sexually inappropriate behaviours. She indicated that the sitters hired by the agency were responsible in providing one-on-one supervision and monitoring of the resident; for example to take him/her to activities. She indicated that all care provision should be done by the home's staff; added she was not aware that the agency staff were providing direct care to the resident.

Furthermore, based on the information noted above, the licensee failed to comply with three (3) other sections of the legislation which was found to be in direct relation to this compliance order, such as:

1. The licensee failed to comply with LTCHA s. 6(1)c:
Whereby every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. (Refer to WN #002)

2. The licensee failed to comply with LTCHA s. 20(2) h:
Whereby at a minimum, the policy to promote Zero Tolerance of Abuse and Neglect of residents, shall deal with any additional matters as may be provided for in the regulations, such as:
-O. Reg 79/10 s. 2 whereby "verbal abuse" is clearly defined
-O. Reg 79/10 s. 97(1) a whereby very 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, are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse of a 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. (Refer to WN #003)

3. The licensee failed to comply with O. Reg 79/10 s. 97. (1)a:
Whereby 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, are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse of a 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 (Refer to WN #004)

The scope and severity of the evidence supporting this compliance order, as well as the compliance history related to the identified compliance issues, were reviewed. The ongoing non-compliance of this Compliance Order poses a risk to the safety of the residents living in the home, especially given the fact that 3 of the incidents noted in this report involved a resident identified in the CO served on June 27, 2015.

Note that this non-compliance is being referred to the Director under the LTCHA, 2007 for further action.

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that plan of care set out clear directions to staff and others who provided direct care to resident #031.

Resident #031 was admitted to the home on a specified date in November 2014 with a known history of sexual behaviour towards residents. Resident #031 was diagnosed with a specified dementia and was receiving anti-psychotic and antidepressant medications to manage behaviours. Resident #031's current written plan of care provided by the home, including the specific instruction sheets dated a specified date in December 2015, provided conflictual information directing assigned one-on-one staff to provide close monitoring of resident #031, but also to provide assistance with other tasks on the unit, and to use the alarm remembering that it did not work 100% of the time. (Refer to WN #001). [s. 6. (1) c]

2. The licensee has failed to ensure that the care set out in the plan of care; such as Advanced Directives was provided to resident #036 as specified in the plan.

Resident #036 was admitted to the home on a specified date in July 2012 with several medical conditions, including. According to the assessment completed on a specified date in November 2015, the resident was cognitively intact and had no changes in health, end stage disease or signs and symptoms to indicate a risk in serious decline.

A review of the resident's health record was completed by Inspector #545 and the following documents indicated that the resident had selected not to be resuscitated:

- The Ministry of Health Do Not Resuscitate Confirmation form: signed on a specified date in February 2015 indicated that the "Physician's current opinion is that CPR will almost certainly not benefit the patient and is not part of the plan of treatment, and the physician has discussed this with the capable patient, or the SDM when the patient is capable";

- Electronic chart on the main page: Code Status: "Advanced Directive - CPR will not be attempted, transfer to acute care for diagnosis or treatment may be included if medically indicated"; and

- Annual Care Conference dated a specified date in April 2015, indicated that the resident was in attendance with the physician and the RN and that the Advanced Directives were discussed, and that the resident remained a Level 3 Transfer to Acute Care Hospital without CPR.

In progress notes dated a specified date in December 2015, the following were documented:
- at a specified time, resident #036 rang the bell, complaining of stomach pain, stating not feeling well and thinking it was due to a sandwich he/she ate at suppertime, the resident was alert and orientated with stable vital signs: no dyspnea, respiration and oxygen saturation were stable. RPN #219 administered an anti-acid medication with hot water and continued to monitor;

- 15 minutes later, resident #036 rang again indicating that pain was still present, pointing to the top of his/her abdomen, refusing to go to the hospital when offered. The resident was observed calm, accepted a narcotic medication to ease the pain, and then requested a specified benzodiazepine;

- 15 minutes later, the resident is asleep and the breathing is regular, will continue to monitor;

- approximately 2 hours later, the resident is awake, complains of stomach cramps pointing to the top of his/her stomach, adding that it was irradiating to his/her back. Vital signs were stable, continues to refuse to go to the hospital stating he/she did not believe it was his/her heart;

- 40 minutes later, the physician is notified of the resident's condition and he advises to

send the resident to the hospital. The ambulance is called;

- 5 minutes later, the nurse returns to the room and finds the resident without vital signs, resident is moved to the floor and CPR is initiated;

- 20 minutes later, the ambulance attendants arrive and continued CPR with defibrillator, when it was noted that the resident was DNR (do not resuscitate), and CPR was stopped; and

- 15 minutes later, the physician is notified and informed staff that there was no need to contact the coroner.

In an interview with RPN #219, she indicated that it was the registered staff's responsibility to verify the resident's Advanced Directives in the health record before initiating CPR and that in this case she had not done this until after the ambulance attendants had arrived and taken over from the nursing staff. [s. 6. (7)]

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

Findings/Faits saillants :

1. The licensee has failed to ensure that at a minimum, the policy to promote zero tolerance of abuse and neglect of residents, shall deal with any additional matters as may be provided for in the regulations, as per section 20 of the Act, subsections:
(b) shall clearly set out what constitutes abuse and neglect; and
(h) shall deal with any additional matters as may be provided for in the regulations.

The Administrator indicated that the home's Zero Tolerance of Abuse and Neglect, titled: Abuse, Residents, policy number: CLIN CARE 32 LTC, revised December 2015 was the current policy in use.

According to O. Reg 79/10 s. 2 "verbal abuse” is defined as
(a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident, or
(b) any form of verbal communication of a threatening or intimidating nature made by a

resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences. ("mauvais traitement d'ordre verbal").

Note that the definition for "verbal abuse" was missing from the home's Abuse, Residents policy.

According to O. Reg 79/10 s. 97 1(a) 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, 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.

Note that the home's Abuse, Residents policy indicates under section 5.1 Disclosure, that the Clinical Manager immediately discloses any alleged, suspected, or witnessed abuse to the resident, if s/he is not already aware. If the resident is capable and wants us to advise anyone else, the clinical manager does so, as soon as is reasonably possible. According to s. 97(a) of the regulations, the home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, 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.

The Administrator indicated that she was not aware that the resident's substitute decision-maker or any other person specified by the resident should be notified, if a resident was capable of making own decisions (Refer to WN #004). [s. 20. (2)]

WN #4: 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 :

1. The licensee has failed to ensure that resident #036’s SDM or any other person specified by the resident was immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident’s health or well-being.

On a specified date in September 2015 the home submitted a Critical Incident (CI) indicating that resident #035 had physically abused resident #036 on the same day. In reviewing the CI, no person specified by the resident was immediately notified.

In a progress note dated a specified date in September 2015 it was documented that resident #036 was punched with fist by another resident at lunch time. The resident complained of pain on two specified body parts. It was documented that resident #036 was very emotional, stating that he/she was not used to being battered. There was no information to indicate that a person specified by the resident was notified of the physical abuse to resident #036.

In a review of the resident’s health record, it was documented that the resident had identified two family members as contacts and person to notify.

RN #234 and RPN #235 who were named in the critical incident report as being involved in managing the incident on a specified date in September 2015, indicated that it was the responsibility of the registered staff to contact the substitute decision-maker, however neither could recall the incident, and could not say if a family member had been contacted.

The Administrator indicated that she met with resident #036 post incident and indicated that the resident’s family member had not been contacted, added that she believed that only the family of cognitively impaired residents would be notified of abuse that resulted in injury or pain. (Log #024933-15) [s. 97. (1) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to inform the Director immediately, in as much detail as is possible in the circumstances, of resident #036's unexpected or sudden death.

Resident #036 died unexpectedly on a specified date in December 2015. (Refer to WN #002)

According to a progress note dated a specified date in December, 2015 by the physician, it was documented that the resident died suddenly, was found with no pulse, no respiration. The Death Certificate indicated that resident #036's immediate cause of death was a heart attack, within hours between onset and death.

The Ottawa Paramedic Service Report of Death indicated that resident #036's death was unexpected.

During an interview with the Administrator, she indicated that she was surprised when was informed of the resident's death, as it was not expected. She further indicated that the home had not informed the Director of resident #036's unexpected/sudden death, as required by the legislation. [s. 107. (1) 2.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policies and protocols were implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

According to the home's Safe Medication Practices policy # 19, revised in August 2015, it was documented under the following sections:

- 4.0 Administering Medication, item 4.7: "The patient takes medication in the presence of the regulated health professional, unless he/she is enrolled in the Self-Medication Program, or there is a Physician's Order on the chart allowing the patient to keep a medication(s) at their beside for self-administration”; and

- 5.0 Documentation of Medication Administration, item 5.1: "The regulated health professional documents all medication s/he has administered on the MAR or Flow Sheet immediately after administration, documenting the effects of all PRN medications”.

On June 6, 2016 at 0905 hours, Inspector #545 observed resident #037 leaving the dining room with a coffee and a small box of dry cereal on the seat of his/her walker. At 0908, the Inspector observed PSW #220 showing RPN #203 one medication cup filled with pills and another filled with a yellow liquid left on a table in the dining room, while resident #038 with moderate to severe cognitive impairment was sitting alone at the table having breakfast. The RPN took both pre-poured medication cups and placed them in the medication cart and continued the medication pass, indicating to the Inspector that the medications belong to resident #037 and that she would administer to the resident once she was done with the medication pass.

At 0912 hours, during an interview with resident #037, he/she indicated to the Inspector that he/she had not eaten breakfast this morning as he/she was not hungry, added that he/she had gone to the dining room to get a coffee and a box of Bran Flakes for later. The resident indicated that he/she had not received any medication this morning, and had not seen any at his/her table.

In a review of resident #037's Medication Administration Record, it was documented that RPN #203 had administered nine different medications, including one narcotic medication at 0900:

The RPN indicated to the Inspector that she had left all medications with resident #037, at the dining room table, assuming he/she would take the medications with his/her breakfast. She further indicated that she had not observed the resident take the medications.

Later, during an interview with the Clinical Manager, she indicated that when she met with RPN #203 around 0950 on June 6, 2016, resident #037's morning pre-poured medications were in the Medication Cart, had been signed as administered and that she was planning to administer once she had completed the Medication Pass on the unit. [s. 114. (3) (a)]

Issued on this 4th day of October, 2016

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

Original report signed by the inspector.

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

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

Long-Term Care 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) :	ANGELE ALBERT-RITCHIE (545)
Inspection No. / No de l'inspection :	2016_284545_0018
Log No. / Registre no:	019308-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Sep 30, 2016
Licensee / Titulaire de permis :	BRUYERE CONTINUING CARE INC. 43 BRUYERE STREET, OTTAWA, ON, K1N-5C8
LTC Home / Foyer de SLD :	RESIDENCE SAINT- LOUIS 879 CHEMIN PARC HIAWATHA, OTTAWA, ON, K1C-2Z6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Chantale Cameron

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To BRUYERE CONTINUING CARE 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)

Linked to Existing Order / Lien vers ordre existant: 2015_289550_0003, CO #001;

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 ensure that residents of the home are protected from abuse by anyone; to that effect the licensee shall:

1. Take immediate action to effectively protect residents from resident #031;

2. Revise the plan of care of resident #031 to ensure effective interventions are implemented to manage responsive behaviors of a sexual nature;

3. Ensure clear directions are provided to all staff providing direct care to residents with responsive behaviors, including resident #031, at the beginning of every shift to ensure residents with responsive behaviors are monitored and actions are taken if those behaviors pose a risk to residents, in accordance with O. Reg. 79/10, section 55;

4. Ensure that every alleged, suspected or witnessed incidents of abuse of a resident by anyone is immediately reported to the Director and immediately investigated, in accordance with s. 23 and s. 24 of the LTCHA, 2007;

5. Revise the Zero Tolerance of Abuse and Neglect of Residents' policy, including all of the abuse definitions, to reflect the requirements set in section 20 of the LTCHA, 2007 and section 96 of the O. Reg 79/10; and

6. Provide annual training on Zero Tolerance of Abuse and Neglect policy. Ensure that all staff, including all supervisors and managers, as well as Sitters and Personal Care Workers who provide care to residents and work in the home pursuant to a contract/agreement between the licensee and third party, receive this training with particular attention to those who did not receive the training in 2015.

Document above initiatives and submit a detailed written progress report to inspector Joanne Henrie via email at OttawaSAO.MOH@ontario.ca on the 15th day of October, November, and December 2016.

Grounds / Motifs :

1. On June 27, 2015, the licensee was issued a Compliance Order under section 19(1), to ensure protection of residents from abuse by anyone and ensure that residents were not neglected by the licensee or staff by preparing, submitting and implementing a plan to include requirements as stated below (A to F):

(A) Specific actions that will be taken by the licensee to ensure that every alleged, suspected or witnessed incidents of abuse of a resident by anyone is immediately reported to the Director and is immediately investigated.

(B) Revisions to the licensee's Zero Tolerance of Abuse and Neglect of residents' policy to include the reporting obligations in the LTCH Act, 2007.

(C) Retraining of all staff on their obligations under the revised Zero Tolerance of Abuse and Neglect policy with particular attention to the requirement of every person to immediately report every alleged, suspected or witnessed incident of abuse of a resident both to the Director and to the appropriate individual identified within the home. This retraining needs to be evaluated to ensure staff understand their obligations.

(D) Annual retraining as required under the LTCH Act.

(E) Develop a monitoring process to ensure staff training is completed as required and that staff report every alleged, suspected or witnessed incidents of abuse of a resident as required as required.

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

The compliance date for the Compliance Order of June 27, 2015 was November 2, 2015. An extension was requested by the home on October 14, 2015 and granted until December 1, 2015.

Upon entrance to the home on June 28, 2016, Inspector #545 requested to review documentation to demonstrate completion of the home's Plan which was submitted to the Director on July 23, 2015.

On July 4, 2016 the inspector concluded this, based on information gathered in July 2016, that requirements (A), (C) and (E) had not been completed as set-out in the Plan:

REQUIREMENT (A)
"Specific actions that will be taken by the licensee to ensure that every alleged, suspected or witnessed incidents of abuse of a resident by anyone is immediately reported to the Director and is immediately investigated".

On a specified date in June 2016: the home submitted a Critical Incident (CI) indicating that resident #031 was found in resident #033's bedroom trying to pull his/her blankets off while constricting his/her neck, or to climb into bed with the resident who expressed being scared. One-on-one supervision had been increased on two days prior to this incident to include the night shift to ensure other residents' safety, as resident #031 was wandering at night. The staff assigned to provide one-on-one supervision had left to answer another resident's call bell, therefore did not providing one-on-one supervision to resident #031.

In an interview with resident #033, he/she indicated to the inspector that he/she remembered the incident of a specified date in June 2016 very well as he/she feared that resident #031 would have choked him/her with his/her large hands. The resident indicated that he/she woke up at around 0100 hours when someone was pulling on his/her blankets, the person's hands were near his/her neck and he/she made every effort to hold the blankets up. Resident #033 indicated that he/she was scared and was shaking and screamed very loud and that's when a staff member came in and called the person by his/her name and took the resident out of the bedroom, telling him/her he/she should not be in other residents' room. Resident #033 indicated that he/she thought the resident wanted to climb in bed with him/her. Resident #033 further indicated that in the morning, he/she immediately called a family member to report the incident, added that he/she didn't know if the staff had already called the family member but wanted to make sure they knew about the incident that terrified him/her. Resident #033 indicated that he/she didn't feel safe, that he/she was cognitively aware and feared those that wandered in his/her room, like resident #031.

PSW #209 indicated to Inspector #545 that she was assigned to provide one-on-one supervision for resident #031 on a specified date in June 2016. She indicated that around 0100 hours she answered another resident's call bell, and left the resident alone in the room, thinking that the resident was asleep. After returning from caring for another resident, PSW #209 indicated that she found resident #031 in resident #033's bedroom, by resident #033's head. PSW #209 further indicated that resident #033 was frightened, jumped and screamed. The PSW indicated to the Inspector that she took resident #031 back to his/her room and did not report the incident to the registered nursing staff, added that she reported it to regular PSW #214 later and that's when he indicated that he was aware of the incident as resident #033 had told him while he provided morning

care. PSW #209 indicated that she did not remember when she last received training on the Zero Tolerance of Abuse policy.

RN #215 indicated that she was in-charge of the unit on a specified date in June 2016. The RN indicated that PSW #209 was assigned to provide one-on-one supervision to resident #031 to prevent him/her from wandering into residents' rooms as per the resident's plan of care and for the safety of the residents on the unit due to a history of sexual behaviours. RN #215 indicated to Inspector #545 that on a specified date in June 2016 at a specified time, it was PSW #214 that informed her that PSW #209 had found resident #031 in resident #033's bedroom, and that resident #033 was very upset. The RN indicated that she did not investigate the incident immediately, either by speaking to PSW #209 or by assessing resident #033's condition. She added that she checked on resident #033 four hours later and found resident #033 asleep and left. The RN indicated that other than documenting a note in resident #031's chart to indicate that the resident had wandered in another resident's room, she did not immediately investigate the incident reported to her by PSW #214. According to a progress note dated on a specified date in June 2016, after receiving a telephone call from resident #033's family member who feared for the safety of the resident, the Administrator conducted an investigation, contacted the police and reported the incident to the Director under the LTCHA, 2007. (Log #: 018237-16)

REQUIREMENT (C)
"Retraining of all staff on their obligations under the revised Zero Tolerance of Abuse and Neglect policy with particular attention to the requirement of every person to immediately report every alleged, suspected or witnessed incident of abuse of a resident both to the Director and to the appropriate individual identified within the home. This retraining needs to be evaluated to ensure staff understand their obligations".

The Administrator provided Inspector #545 with the current Zero Tolerance of Abuse and Neglect policy, titled: Abuse, Residents, Policy Number: CLIN CARE 32 LTC, revised December 2015. The revised policy included the requirement of every person to immediately report every alleged, suspected or witnessed incident of abuse of a resident both to the Director and to the appropriate individual identified within the home. The Administrator indicated that the policy was revised in September 2015 then sent to the home's translation department then finalized December 2015.

The Education Lead and Administrator provided the Inspector with attendance reports for two different education sessions related to abuse which they indicated was based on the revised policy:

1) Abuse Blitz took place between October 19 and 23, 2015 whereby the management team visited the different units on different shifts and reviewed ten questions related to abuse with staff. According to the attendance report, approximately 57% of all staff did not receive this training.

2) Face-to-face in-services on Prevention of Abuse were provided to the registered nursing staff and supervisors/managers by the Education Lead between October 21 and November 2, 2015. According to the sign-in sheets approximately 30% of the registered nursing staff and approximately 67% of the supervisors/managers did not receive this training.

It was noted that resident #031 was assigned one-on-one supervision hired from an external agency (AlternaCare). Starting April 16, 2016 to this present date, the agency changed assignment from sitters to Personal Care Workers. Both the Manager of the external agency and the Education Lead indicated that Abuse training had not been provided to any of the AlternaCare Agency Staff (16 new staff since April 16, 2016) who were assigned to provide one-on-one supervision to resident #031.

The Administrator was unable to find documentation to demonstrate that this retraining was evaluated to ensure staff understood their obligations to immediately report every alleged, suspected or witnessed incident of abuse of a resident.

REQUIREMENT (E)
“Develop a monitoring process to ensure staff training is completed as required and that staff report every alleged, suspected or witnessed incidents of abuse of a resident as required”.

The Administrator indicated that the home had not yet implemented a monitoring process to ensure staff training was completed as required. She further indicated that the annual Abuse training scheduled for June 2016, as per the home's Plan, had been postponed to the fall of 2016 and that face-to-face training would be replacing the usual online training.

Furthermore, there were new documented incidents of abuse related to resident #031.

In following up on this inspection, Inspector #545 conducted three critical incidents related to alleged sexual abuse involving resident #031:
-Log #: 012389-16 related to alleged sexual abuse of resident #034 by resident #031 on a specified date in 2016
-Log #: 016860-16 related to alleged sexual abuse of resident #032 by resident #031 on a specified date in June 2016
-Log #: 018237-16 related to improper care/treatment of resident #033 by resident #031 on a specified date in June 2016

Note that resident #031 was referred to as resident #002 in Compliance Order issued July 27, 2015 (Log # 2015_289550_0003).

O. Reg 79/10 s. 2(1)b defines sexual as any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or 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; ("mauvais traitement d'ordre sexuel").

Resident #031 was admitted to the home on a specified date in November 2014 with a known history of sexual behaviour towards residents. Resident #031 was diagnosed with a specified dementia and was receiving anti-psychotic and antidepressant medications to manage behaviours.

The one-on-one schedule was reviewed by the Inspector from a period of three months in 2016, which indicated that a staff member was assigned to provide one-on-one supervision to resident #031, such as:
-day & evening shifts from a specified date in April to a specified date in May
-day shift only for two days in May
-part of evening shift a specific date in June
-day shift for ten days in June
-day, evening & night shifts for seventeen days in June 13
Agency staff were assigned to provide one-on-one supervision day/evening on

weekends, and then day/evening/night shifts seven days per week starting a specified date in June 2016.

In a gray binder in the report room, two sets of written directions were found; one for registered nursing staff and one for the personal support workers. Both were dated a specified date in December 2015 and according to the Administrator, these were the most current directions (titled: Important changes in directions for resident #031) she provided staff on how to manage resident #031's behaviours. The current written directions provided various instructions, including:

For the Registered Nursing Staff:
-One-on-one supervision will be continued 24 hours per day to ensure safety to our residents, at times service will be provided by AlternaCare (external agency), note that they are considered sitters and will not be providing care to the resident
-One-on-one staff must monitor closely
-One-on-one staff may assist with other tasks on the unit when resident #031 is in his/her bedroom; put alarm on; noting that the alarm doesn't function 100% of the time
-Ask staff to read/sign these directions

For the Personal Support Workers:
-Speak with registered nursing staff to understand reason for one-on-one supervision and for type of behaviours to watch for
-Read, sign and date that you have read these directions
-Must monitor resident #031 VERY closely, especially near a specified group of residents
-May assist with other tasks on the unit when resident #031 is in his/her bedroom; put alarm on; noting that the alarm doesn't function 100% of the time
-When on break, notify your colleagues to ensure supervision
-Assist with feeding other residents in dining room between 1700-1730 hours, then go for supper
-Notify registered nursing staff immediately if you observe signs of behaviour
-Provide a verbal report to the registered nursing staff and to the PSW that will be replacing you on the 1:1 monitoring, at the end of your shift

The sign sheets for above directions were reviewed, and no signatures were found after a specified date in February 2016.

On June 29, 2015 the inspector observed resident #031 eating lunch independently in the dining room in presence of assigned one-one-one external provider (AlternaCare Agency) and ambulating towards the bathroom in his/her bedroom. The resident's current care plan indicated that resident #031 was receiving one-on-one supervision on days and evenings. Note that the resident was provided one-on-one supervision on days, evenings and nights since a specified date in June 2016.

On June 29, 2016 at 1432 hours, Inspector #545 observed a small battery operated device (Posey Wireless Pager) installed on the outside frame of resident #031's bedroom door, facing the hallway. The device was not activated, and no lights appeared on the device. Environmental Services Supervisor #224 indicated that he didn't know who had installed the device. Later he provided the Inspector with an invoice for a Posey Wireless Infrared Alarm, purchased on a specified date in March 2015 to detect resident #031's whereabouts.

In discussion with AlternaCare agency PSWs #204, #205, #229, #231 and #232, four out of the five agency staff were unaware that resident #031 required one-on-one supervision due to inappropriate sexual behaviour towards residents. All five indicated they did not have access to the resident's plan of care, were not aware of the home's Zero Tolerance of Abuse and Neglect policy and had not been provided training. The AlternaCare agency manager indicated she believed that one-on-one supervision was provided to resident #031 to protect other residents from the resident's aggressive behaviour.

Three (3) Critical Incidents related to abuse involving resident #031 were submitted by the licensee to the Director under the LTCHA, 2007.

INCIDENT #1 BETWEEN RESIDENT #031 AND RESIDENT #034
On a specified date in April 2016: a Critical Incident was submitted indicating that resident #031 was observed by Housekeeping Aide #206 in the dining room at a specific time, exhibiting inappropriate sexual touching towards resident #034's. Staff assigned to provide one-on-one was providing care to other residents at the time of the incident.

PSW #228 indicated she was assigned to provide one-on-one to resident #031 on a specific date in April 2016, added that her primary responsibility was to monitor resident #031 from inappropriately touching residents. She further indicated that after bringing resident #031 to the dining room for lunch, she left

the dining room to get other residents up for lunch. She indicated that she was not monitoring resident #031 when the resident got up from the dining room table and approached resident #034 who was at a nearby table and exhibited inappropriate sexual touching. PSW #228's signature did not appear on the written care plan sheet to indicate she had read/understood her responsibilities, as per the Administrator's directions.
(Log# 012389-16)

INCIDENT #2 BETWEEN RESIDENT #031 AND RESIDENT #032
On a specified date inJune 2016: a Critical Incident was submitted indicating that resident #031 was found in resident #032's at the foot of the resident's bed at a specified time, while the resident was lying in bed with no clothing except for an incontinence brief. In a progress note dated a specified date in May 2016, it was documented by the Administrator, that the one-on-one supervision had been discontinued due to the resident's condition. Note that there was no description to explain what the resident's condition was. The Administrator indicated that she based her decision on the RAI-MDS assessment which was completed 18 days previous to the incident in May 2016, which indicated the resident was a two-person transfer upon return from hospital. The Administrator added that she wanted to be fiscally responsible with the High Intensity Needs dollars. RN #202 indicated she was surprised when she was informed upon arriving on the unit for the evening shift, that the one-on-one supervision had been discontinued the day before, as she had concerns that resident #031's inappropriate sexual behaviours towards vulnerable residents would reoccur. RN #202 further indicated that a staff member had brought resident #031 to the dining room for supper then left to get other residents; upon returning, the resident was gone. The RN indicated a search was immediately started and just as they were to initiate a Code Yellow for a missing resident, the resident was found standing without mobility aids in resident #032's bedroom, by the bed. She indicated that resident #032 was unable to say if sexual abuse had taken place due to cognitive impairment. Note that the care plan did not reflect the resident's level of mobility or the discontinuation of one-on-one supervision that took place on the day of the incident. (Log # 016860-16).

INCIDENT #3 BETWEEN RESIDENT #031 AND RESIDENT #033
On a specified date in June, 2016: a Critical Incident (CI) as previously indicated above under item (A), PSW #209 indicated she was assigned to

provide one-on-one supervision for resident #031 on a specified date in June 2016. She indicated that around 0100 hours she answered another resident's call bell, and left the resident alone in his/her bedroom, thinking that the resident was asleep. The PSW indicated that when she returned to the resident's bedroom, she observed the resident entering resident #033's bedroom. She indicated registered nursing staff had instructed her on previous shifts to provide assistance to other staff member when resident #031 was in his/her room and sleeping, and felt she needed to help on the unit. (Log # 018237-16)

RPN #213 indicated to the Inspector that she was aware resident #031 was provided one-on-one supervision on all three shifts for the safety of the residents on the unit due to sexually inappropriate behaviours. She indicated that the sitters hired by the agency were responsible in providing one-on-one supervision and monitoring of the resident; for example to take him/her to activities. She indicated that all care provision should be done by the home's staff; added she was not aware that the agency staff were providing direct care to the resident.

Furthermore, based on the information noted above, the licensee failed to comply with three (3) other sections of the legislation which was found to be in direct relation to this compliance order, such as:

1. The licensee failed to comply with LTCHA s. 6(1)c:
Whereby every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. (Refer to WN #002)

2. The licensee failed to comply with LTCHA s. 20(2) h:
Whereby at a minimum, the policy to promote Zero Tolerance of Abuse and Neglect of residents, shall deal with any additional matters as may be provided for in the regulations, such as:
-O. Reg 79/10 s. 2 whereby "verbal abuse" is clearly defined
-O. Reg 79/10 s. 97(1) a whereby very 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, are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse of a 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. (Refer to WN #003)

3. The licensee failed to comply with O. Reg 79/10 s. 97. (1)a:
Whereby 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, are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse of a 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 (Refer to WN #004)

The scope and severity of the evidence supporting this compliance order, as well as the compliance history related to the identified compliance issues, were reviewed. The ongoing non-compliance of this Compliance Order poses a risk to the safety of the residents living in the home, especially given the fact that 3 of the incidents noted in this report involved a resident identified in the CO served on June 27, 2015.

Note that this non-compliance is being referred to the Director under the LTCHA, 2007 for further action. (545)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 30th day of September, 2016

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Angele Albert-Ritchie

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