Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 10, 2018;	2018_742527_0014 (A2)	015252-18	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No. 8) GP Inc. as general partner of CVH (No. 8) LP
766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Shelburne Long Term Care Home
200 Robert Street SHELBURNE ON L9V 3S1

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

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Amended by KATHLEEN MILLAR (527) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The word "found" related to resident #001 and #013 sexual abuse incident was removed throughout the Licensee Inspection & Order Reports.

15 minute checks related to resident #013 and the sexual abuse incident of resident #020 was re-worded as discussed with the DOC and Administrator.

The word "kicked" related to the abuse incident involving resident #017 and PSW #118 was removed.

Resident #025 was corrected and an amendment to wording.

Issued on this 10 day of October 2018 (A2)

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

Original report signed by the inspector.

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

Shelburne Long Term Care Home
200 Robert Street SHELBURNE ON L9V 3S1

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

Amended by KATHLEEN MILLAR (527) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): June 27, 28, 29, July 3, 4, 5, 6, 9, 10 and 11, 2018

The following Critical Incidents and Complaints were inspected concurrently with the Resident Quality Inspection (RQI):

Critical Incident System (CIS):

Log #025756-17, related to alleged resident to resident abuse;

Log #004200-18, related to alleged staff to resident abuse;

Log #000037-18, related to alleged resident to resident abuse;

Log #012236-18, related to alleged resident to resident abuse;

Log #013425-18, related to alleged resident to resident abuse; and

Log #007993-18, related to alleged staff to resident abuse.

Complaints:

Log #012236-18, related to alleged resident to resident abuse;

Log #006027-18, complaint related to short staffing, bathing, and laundry;

Log #015858-18, complaint related to resident fearing staff; and

Log #016042-18, complaint related to the temperature in the home.

The Follow-Up Order was also inspected concurrently with the RQI:

Log# 004698-18, Compliance Order (CO) #001, related to inspection #2018_544527_0003, for s. 8 (1) (b), follow up to the CO related to falls.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), the Quality and Education Coordinator, the Resident Assessment Instrument (RAI) Coordinator, the Resident Services Coordinator, the Behavioural Support Ontario (BSO) Personal Support Worker (BSO PSW), the Activation Director, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), security staff, housekeeping aides, laundry aides, dietary aides, the Residents' Council President, residents and family members.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services, reviewed relevant documents, including but not limited to, clinical records, policies and procedures, internal investigation notes, training records and meeting minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

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

15 WN(s)
8 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 8. (1)	CO #001	2018_544527_0003	527

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 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 :

(A2)
1. The licensee failed to ensure that all residents were protected from abuse by anyone and free from neglect by the licensee or staff.

A) The critical incident report submitted to the Director on two specific dates in 2018, indicated that there was an incident of alleged sexual abuse that occurred by resident #013 towards residents #001 and #020.

The clinical record and the investigation notes were reviewed for residents #013 and #001, which indicated that on specific date and time, resident #013 was in resident #001's room, inappropriately touching the resident. Resident #001 also informed the staff that resident #013 was in their room one other time within the last month.

When resident #001 was interviewed they explained the two incidents involving resident #013, and said that the first time they never said anything to the staff, until it happened again. The resident said that they felt safe and protected in the home and had no physical injury, although it was emotionally upsetting and especially when it happened a second time.

On a specific date in 2018, resident #020 was asleep in their bed when resident #013 entered their room and was not found by staff until some time later. Staff found resident #013 in bed with resident #020.

The clinical record and investigative notes were reviewed, which indicated that resident #013 was on safety checks every 15 minutes and the resident had been up and wandering throughout the night. At a specific date and time, resident #013 had been re-directed to the lounge. The staff were unable to locate the resident and then conducted a second search, which included going into resident rooms. It

was at this time that the staff found resident #013 in bed with resident #020. The clinical record for resident #020 revealed that they required further treatment as a result of the incident.

Resident #020's family were interviewed and said the resident was still upset emotionally from this incident. They felt that if the staff were conducting their safety checks, that this sexual abuse would have been prevented.

The resident was interviewed and when asked about the incident with resident #013, resident #020's facial expression changed to sadness, they dropped their head and said it hurt. Resident continued to be upset, although it was a month since the incident occurred.

The Director of Care (DOC) was interviewed and acknowledged both incidents of sexual abuse by resident #013 towards resident #001 and #020. The DOC indicated that as a result of the second incident with resident #020, the home implemented one to one monitoring related to resident #013's high risk sexual behaviours. The DOC acknowledged that at the time of the incident, the staff were involved in an incident with another resident. The DOC acknowledged that the night staff were aware that resident #013 had been wandering throughout the night, staff had just re-directed the resident to the lounge and staff were aware that the resident had previously exhibited inappropriate sexual behaviours. The DOC also acknowledged that with the second incident, the staff had conducted an initial search, which they were not able to locate resident #013 and the staff probably did not want to disturb other residents by going into their rooms. The staff were required to conduct a more thorough search of resident rooms and it was then they located resident #013.

This area of non-compliance was identified during Critical Incident System (CIS) Inspections, log #008168-18 and log #012236-18, conducted concurrently during the RQI.

B) The critical incident report submitted to the Director on a specific date in 2017, which indicated that resident #014 was involved in an incident of sexual abuse towards resident #016.

Resident #014 had a history of sexually inappropriate responsive behaviours, which resulted in four incidents towards three residents in 2017 and one incident in 2018.

A clinical record review was completed, which identified that resident #014 entered a common area where resident #016 was sitting, staff entered the room a few minutes later and noticed resident #014 was inappropriately touching resident #016.

Prior to this incident, safety checks were supposed to be implemented for monitoring resident #014's whereabouts and to redirect the resident from inappropriately touching other residents. Resident #014 was also not to be in common areas of the home unsupervised by staff. Safety checks including monitoring the resident's whereabouts every fifteen minutes by PSW staff were not completed on a specific date in 2017 and were inconsistently documented throughout the same month in 2017. The DOC acknowledged there were no 15 minute safety checks being completed on a specific date and time in 2017 and documentation was incomplete on the day of the incident. After reviewing the clinical record, the DOC was unable to locate any paper documentation of safety checks. The safety checks were discontinued on a specific date in 2017. On following day after the safety checks were discontinued in 2017, the resident was in a common area unsupervised and was witnessed reaching inappropriately touching resident #015.

In an interview with PSW #121, they indicated they had never seen inappropriate behaviours and staff were to monitor and keep resident #014 away from certain residents.

The DOC acknowledged that there was no evidence of safety checks being conducted and that it was expected to be completed.

The licensee failed to ensure that resident #001, #015, #016, and #020 were protected from abuse by resident #013 and #014.

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care Specifically failed to comply with the following:

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others who provide direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

A) Resident #013 exhibited sexually inappropriate behaviours towards resident #001 and #020 in two specific months in 2018, subsequently the resident was placed on one to one monitoring.

The clinical record was reviewed and specifically the responsive behaviour plan of care, which confirmed the incidents of responsive behaviours and the actions taken by the home.

The one to one staff were interviewed and only the Personal Support Workers (PSWs), Registered Practical Nurses (RPNs) and Registered Nurses (RNs) had access to the plan of care. The agency staff, dietary and housekeeping staff who provided one to one care were reliant on the charge nurse to keep them aware of the contents of the plan of care, as they did not have convenient an/or immediate access to the plan of care. Dietary Aide #115 acknowledged that the non-clinical staff that performed one to one for this resident had no access to the resident's responsive behaviour plan of care.

RN #113 was interviewed and also acknowledged that it was their role to keep the one to one staff up to date on the responsive behaviour interventions and acknowledged that the non-clinical staff performing the one to one role, did not have convenient and immediate access to the plan of care.

B) Resident #019 exhibited sexually inappropriate behaviours towards other residents who were cognitively impaired during a six month period in 2018. Early in 2018, the resident was placed on one to one monitoring.

The clinical record was reviewed and specifically the responsive behaviour plan of care, which confirmed the incidents of responsive behaviours and the actions taken by the home.

The licensee failed ensure that the staff and others who provided direct care to resident #013 and #019, were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

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

A) Resident #017 was allegedly abused by PSW #118 during a bath. The resident informed a staff member on a specific date in 2018, that PSW #118 was physically abusive to them during a bath, then told them not to tell anyone. An investigation was completed by the home, which identified there was no evidence of the alleged abuse. As part of the preventative measures, the home decided that PSW #118 would not bath resident #017 and implemented that in the future two PSWs would be present during baths with the resident.

PSW #135 was interviewed and stated that resident #017 required one person assistance during their baths. RPN #128, was interviewed and also stated that the resident required one person assistance during bathing.

Upon review of resident #017's written plan of care, the current interventions for bathing included that one staff member was to assist with bathing.

The DOC acknowledged that the resident should have two person assistance for bathing and that the written plan of care should have been updated to reflect this. (694)

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #004200-18, conducted concurrently during the RQI.

B) Resident #007 had altered skin integrity. The clinical record was reviewed and identified the resident's altered skin integrity and the Treatment Administration Record (TAR) identified the treatment for the altered skin integrity. There were no skin and wound goals or interventions noted on resident #007's written plan of care. Resident #007 did not have their written plan of care revised with the altered skin integrity or change in care needs.

During an interview with PSW #121, they were unaware of resident #007's altered skin integrity. They indicated that any changes, related to skin and wound care, would be in the communication book and did not recall any changes for resident #007.

In an interview with RPN #134, they acknowledged that resident #007 had altered skin integrity. RPN #134 indicated that residents with actual or potential altered skin integrity should have weekly skin assessments and their written plan of care updated to reflect the goals and interventions. RPN #134 acknowledged that resident #007 did not have goals or interventions related to altered skin integrity in their written plan of care.

C) Resident #014 had a history of responsive behaviours, which resulted in sexual abuse of residents.

In an interview with PSW #121, they said that staff had not seen inappropriate behaviours by resident #014, but was aware through the communication binder

that resident #014 was to be monitored closely; resident #014 was to be kept away from certain residents; and removed and redirected away from common areas of the home.

Resident #014 was involved in four incidents of sexually inappropriate behaviour towards residents at specific dates and times in 2017 and 2018.

The clinical record was reviewed and one of the interventions for resident #014, was that they were not to go into common areas, unless supervised one to one by staff. The one to one monitoring for resident #014 was not identified on the resident’s responsive behaviour plan of care until after the fourth incident of resident #014 sexually abusing a resident. Resident #014's written plan of care was not revised when the care needs changed.

The DOC was interviewed and acknowledged that the written plan of care for resident #014 did not include the intervention, which directed staff to not allow the resident into common areas of the home unsupervised after the fourth incident in 2018.

The licensee failed to ensure that resident #007, #014 and #017, had a written plan of care for each resident that was reassessed and the plan of care reviewed and revised any time the resident’s care needs changed or care set out in the plan was no longer necessary.

This area of non-compliance was identified during Critical Incident System Inspections (CIS), log #025304-17; log #013425-18; log #000037-18; and log #025756-17, conducted concurrently during the RQI.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care was provided to the resident as specified in the plan; that the staff and others who provide direct care to a resident were kept aware of the contents of the resident's plan of care and have convenient and immediate access to it; and to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (a) a goal in the plan was met; (b) the resident's care needs change or care set out in the plan was no longer necessary; or (c) care set out in the plan had not been effective, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The critical incident report submitted to the Director on a specific date in 2017, indicated that resident #014 was involved in an incident of sexual abuse that occurred towards resident #016.

A clinical record review was completed and in the progress notes, the BSO #107 was reviewing the documentation and identified the incident. Subsequently, they notified management that the incident occurred on a specific date and time and a CIS report was subsequently submitted to the Director.

Notification to the Director by Critical Incident systems report, investigation and SDM notifications did not occur until three days after the incident occurred in 2017.

Interviews with RPN #123 and PSW #122, were completed separate and independently with each staff member. They acknowledged annual training for all staff was provided about abuse and immediate reporting of all incidents at the time of any incident. The charge nurse and management must be notified; there must be documentation of the incident; and they were expected to notify family members.

The licensee's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting", RC-02-02-02 and last updated April 2017, directed any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the administrator/designate/reporting manager.

The licensee failed to ensure that their policy to promote zero tolerance of abuse and neglect was complied with.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #000037-18, conducted concurrently during the RQI.

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 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

(A2)
1. The licensee failed to report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

A) LTCH Inspector #527 conducted the critical incident inspection related to staff to resident abuse towards resident #006 and #021 on a specific date in 2018.

The home reported to the Director that resident #006 and #021, were involved in an incident whereby PSW #134 was allegedly being rough with both residents. Resident #022 over heard resident #006 and #021's response to the care that PSW #134 was providing behind the privacy curtain for both residents.

The CIS was submitted to the Director on a specific date in 2018, which was when resident #022 reported the incident to the home; however the home did not report the results of the investigation and the actions taken to the Director.

The DOC was interviewed and acknowledged that they did not report the results of their investigation of this incident to the Director.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #007993-18, conducted concurrently during the RQI.

B) Resident #013 was in resident #001's bed and inappropriately touching them.

The CIS was submitted to the Director on a specific date in 2018; however the home did not report the results of their investigation and the actions taken to the Director.

The DOC was interviewed and acknowledged that they had not reported the outcome of their investigation to the Director.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #008168-18, conducted concurrently during the RQI.

The licensee failed to report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b), were reported to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

The licensee's policy titled "Responsive Behaviours", number RC-17-01-04, and last revised February 2017, directed staff to use the DOS tool to document observed behaviour over time, for example five to seven days and allow for a thorough evaluation of any patterns of behaviour identified and what interventions were needed to minimize or eliminate the behaviour. In addition, the mapping tool for medication monitoring of residents with responsive behaviours would be implemented for two weeks, which required registered staff to document on each shift.

The clinical record was reviewed for resident #013 and #019, which identified the following:

(i) Resident #013's DOS was inconsistently documented for a number of days during specific months in 2018. The resident exhibited new sexual responsive behaviours towards resident #001 and there was no DOS documentation. The resident's sexual responsive behaviours worsened and the resident sexually abused resident #020. DOS was implemented and continued for four weeks after this incident. There was inconsistent documentation and there was no analysis of the resident's behaviours and/or identified interventions to minimize or eliminate the responsive behaviours.

On a specific date in 2018, the resident had a change in dose of medication as ordered by the physician. The registered staff implemented the mapping tool for medication monitoring in residents with responsive behaviours for a specified period, during a specific month in 2018. During this time there was inconsistent documentation and on several shifts there was no documentation.

Resident #013 was being monitored for sexually inappropriate behaviours during a specific month in 2018 and was being monitored at least every shift. The documentation was inconsistently documented during this time period. During another specific month in 2018, many of the safety checks every 15 minutes were not documented.

(ii) Resident #019's, had one to one implemented on a specific date early 2018. The BSO PSW had implemented DOS charting on a specific date in 2018. The home was only able to locate the DOS charting for a specific date in 2018, but did not include the other months the staff were expected to complete the DOS charting.

The DOC and BSO PSW were interviewed and acknowledged that the documentation related to DOS and POC, were incomplete and the staff were expected to complete the documentation.

The licensee failed to ensure that any actions taken with respect to resident #013 and #019, under a program, including assessments, reassessments, interventions and the resident’s responses to interventions were documented.

This area of non-compliance was identified during a Critical Incident System (CIS)

Inspection, log #012236-18 and log #008168-18, conducted concurrently during the RQI

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are 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. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) 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. 53 (3).

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 :

1. The licensee failed to ensure that (c) a written record was kept relating to each evaluation under clause (b) that included 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.

LTCH Inspector #527 requested to review the licensee's 2017 annual program evaluation related to the Responsive Behaviour Program and the home was unable to locate the written record.

The DOC was interviewed and acknowledged that they were unable to locate the written record of the licensee's annual program evaluation for Responsive Behaviours.

The licensee failed to ensure that a written record of the Responsive Behaviour Program was kept that, included 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.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #012236-18 and log #008168-18, conducted concurrently during the RQI.

2. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident were identified, where possible.

A) Resident #013 exhibited sexually inappropriate behaviours on date in 2018, towards resident #001 and on another specific date in 2018, towards resident #020.

The clinical record was reviewed and DOS was initiated; however there was no analysis documented and there was no other documentation on the resident's clinical record which identified the possible behavioural triggers for the resident's sexually inappropriate behaviour. There were no triggers identified on the responsive behaviour plan of care.

Interviews were conducted with PSW #125, RPN #101, RN #113 and Dietary Aide #115, and they were unsure what the triggers were for the resident's sexually inappropriate behaviour. The staff were not aware of any responsive behaviour debrief or analysis of the assessments that may have identified the triggers. None of the staff were aware of what the assessments were that could assist to identify the triggers to the resident's responsive behaviours.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #012236-18 and log #008168-18, conducted concurrently during the RQI.

B) Resident #019 exhibited sexually inappropriate behaviours towards cognitively impaired residents.

The clinical record was reviewed and there was DOS initiated on a specific date in

2018; however there was no other DOS initiated for new or worsened behaviours. There was also no analysis documented and there was no other documentation on the resident's clinical record, which identified the behavioural triggers for the resident's sexually inappropriate behaviour. There were no triggers identified on the responsive behaviour plan of care.

Interviews were conducted with PSW #125, RPN #101, RN #113, contracted staff #112 and #133, and they were unsure what the triggers were for the resident's sexually inappropriate behaviour. The staff were not aware of any responsive behaviour debrief or analysis of the assessments that may have identified the triggers. None of the staff were aware of what the assessments were that could assist to identify the triggers for the resident's responsive behaviours.

The licensee failed to ensure that, for resident #013 and #019, who were demonstrating responsive behaviours, that the behavioural triggers for the resident were identified, where possible.

3. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, (c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions were documented.

The licensee's policy titled "Responsive Behaviours", number RC-17-01-04, and last revised on February 2017, was reviewed and directed staff to document each episode of behaviour and the resident's responses to the interventions when experiencing responsive behaviours.

A) Resident #013 had a history of sexually inappropriate responsive behaviours, which resulted in two incidents towards two residents in 2018.

The clinical record was reviewed, which revealed that the DOS was initiated prior to the first incident of sexually inappropriate behaviours in 2018. The DOS charting was reviewed, which identified inconsistent charting of the resident's behaviours and responses to the interventions. The one to one shift report documentation of the resident's sexually inappropriate behaviours were reviewed. This documentation, which was a tool used to document the one to one's shift report, was also used to track every instance of the resident's sexual behaviours, if there were any near misses, what interventions were implemented and if they were effective and if the charge nurse was notified of the behaviours exhibited by the

resident. The one to one shift report identified inconsistencies in the documentation and each instance of the resident's responsive behaviours were not documented, which would have included, what interventions were implemented and what was the resident's response to the interventions.

The DOC and BSO were interviewed and acknowledged that the staff were inconsistently documenting on DOS and one to one shift report, which was required to monitor/track the resident's sexual behaviours, triggers, and responses to the interventions implemented. The DOC acknowledged that this was an ongoing issue with staff documentation.

This area of non-compliance was identified during Critical Incident System (CIS) Inspections log #008168-18 and log #012236-18, conducted concurrently during the RQI.

B) Resident #014 had a history of sexually inappropriate responsive behaviours, which resulted in four incidents towards three residents.

The clinical record was reviewed, which indicated that the DOS was initiated inconsistently after the second incident of sexually inappropriate behaviours in 2017. The completed DOS charting was reviewed and showed inconsistent charting of the resident's behaviours and responses to the interventions.

Every fifteen minute safety check documentation of the resident's sexually inappropriate behaviours were reviewed. The fifteen minute safety checks were discontinued the day after an incident. The fifteen minute safety checks identified inconsistencies in the documentation and each instance of the resident's responsive behaviours were not documented, which would have included, what interventions were implemented and what was the resident's response to those interventions.

The licensee's policy titled "Responsive Behaviours", number RC-17-01-04, last revised on February 2017, directed staff to document each episode of behaviour and the resident's responses to the interventions when experiencing responsive behaviours.

The DOC was interviewed and acknowledged that the staff were inconsistently documenting on DOS and fifteen minute safety checks, which was an ongoing issue with staff not completing documentation. The purpose was required to

monitor and track the resident's sexual behaviours, triggers, and responses to the interventions implemented. The DOC confirmed that the fifteen minute safety checks were discontinued post incident and were not completed on paper documentation as records could not be located. There was no increased monitoring. (694)

This area of non-compliance was identified during Critical Incident System (CIS) Inspections log #025304-17 and log #013425-18, log #000037-18 and log #025756 -17.

C) Resident #019 had a history of sexually inappropriate responsive behaviours in 2018, towards cognitively impaired residents.

The clinical record was reviewed, which revealed that the Dementia Observation System (DOS) was completed on a specific date in 2018; however there was no documentation of the resident's behaviour and responses during a specific time. There was no other DOS documentation completed to assess the resident's responsive behaviours. The staff implemented a responsive behaviour assessment tool titled "Antecedent, Behaviour and Outcome (ABO) Data Collection Chart" on a specific date in 2018. There was no other documentation on this tool and it wasn't used at any other time when the resident was exhibiting sexually inappropriate behaviours. There was also no analysis of the information on the ABO Charting assessment tool and if the resident's responses to the intervention was effective or not.

The one to one shift report documentation of the resident's sexually inappropriate behaviours were reviewed. The one to one shift report identified inconsistencies in the documentation and each instance of the resident's responsive behaviours were not documented, which would have included, what interventions were implemented and what was the resident's response to the interventions.

The DOC and BSO were interviewed and acknowledged that the staff were inconsistently documenting on DOS, the ABO Charting tool and one to one shift report, which was required to monitor/track the resident's sexual behaviours, triggers, and responses to the interventions implemented. The DOC acknowledged that this was an ongoing issue with staff documentation.

The licensee failed to ensure that, for resident #013, #014 and 019, who were demonstrating responsive behaviours, that actions were taken to respond to the

needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

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 under the Responsive Behaviours Program, (c) a written record was kept relating to each evaluation under clause (b) that included 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., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

Resident #013 exhibited sexually inappropriate behaviours towards two residents on specific dates in 2018.

The clinical record was reviewed, which identified that one of the steps to minimize the risk of potentially harmful interactions between residents was to implement checks for resident #013 every 15 minutes.

Resident #013 had been up wandering on a specific date and time and was re-directed to the lounge. According to the investigative notes and the Critical Incident System (CIS) report, the staff went to find the resident to provide care and they could not find the resident in the lounge or their room. The staff did not find the resident until later. They found the resident #013 in resident #020's bed and had sexually abused the resident.

The DOC was interviewed and acknowledged the sexual abuse of resident #020 as a result of resident #013's sexually inappropriate behaviours and it was at this time, the home implemented one to one monitoring for resident #013.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #013 towards resident #020, by identifying and implementing interventions.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #012236-18 and log #008168-18, conducted concurrently during the RQI.

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 ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions., to be implemented voluntarily.

WN #8: 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. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's substitute decision maker was notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

The critical incident was inspected in relation to resident #017 informing staff on a specific date in 2018, that the resident was allegedly abused by PSW #118, during a bath.

Resident #017 stated that PSW #118 physically abused them during a bath, then told the resident not to tell anyone.

The home's investigation notes and the progress notes were reviewed. There was no evidence that the resident's SDM was informed of the results of the investigation. The CIS report indicated that the resident's SDM was contacted when the abuse was reported. There was no documentation as to whether the SDM was contacted immediately after the investigation was completed.

The DOC stated the investigation was completed by the previous Administrator; however the DOC could not find evidence that the SDM for resident #017 was contacted immediately after the investigation was completed.

The licensee failed to ensure that the SDM for resident #017 was notified of the results of the investigation immediately after the alleged abuse investigation was 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 that the resident and the resident's substitute decision maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation., to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

According to a Medication Incident Report from a specific month in 2018, it was discovered that resident #017 did not receive their medication on a specific date and time in 2018. Resident #017 was assessed and monitored after the incident was identified and no harm was noted.

As per the Electronic Medication Administration Record (eMAR) from the date of the incident, the medication was due at a specific time every day. The medication was signed off by RPN #101 as being administered; however as per the interview with RPN #101, the RPN did not administer the medication that was due at that time.

The licensee's policy titled "Medication Management," number RC-16-01-07, and last revised February 2018, directed staff to administer medication as per the instructions on the eMAR.

The DOC was interviewed and acknowledged that resident #017 failed to receive the medication at the scheduled time it was due.

The licensee failed to ensure that the medication was administered to resident #017 in accordance with the directions for use specified by the prescriber.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance To ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

A) Resident #013 had a history of inappropriate sexual behaviours and the licensee had reported two incidents of sexual abuse to the Director on two specific dates in 2018.

The licensee's policy titled "Zero Tolerance of Resident Abuse and Neglect Program", defined Sexual Abuse as: Any consensual or 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.

The licensee's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting", directed any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at that time. The policy reviewed and directed "staff and board members must immediately report every alleged, suspected, or witnessed incidents of abuse of a resident by anyone".

The clinical record review revealed that there were three incidents of sexually inappropriate behaviours/sexual abuse by resident #013 towards residents #023, #024 and #025, that were not reported immediately to the Director as alleged abuse with the potential for harm.

RN #113 and RPN #130 were interviewed and acknowledged that these incidents met their home's definition of sexual abuse and were unsure if management was notified immediately of the incidents; however they were not aware why management or whomever was responsible, did not report the alleged sexual abuse to the Director.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #012236-18 and log #008168-18, conducted concurrently during the RQI.

B) Resident #014 had a history of inappropriate sexual behaviours and the licensee had reported four previous incidents of sexual abuse to the Director on three specific dates in 2017 and one specific date in 2018.

The clinical record review revealed that there were four incidents of sexually inappropriate behaviours/sexual abuse by resident #014 towards residents #015, #016 and #021. The incident involving resident #016 on a specific date in 2017, was not reported immediately to the Director as alleged abuse with the potential for harm.

The DOC was interviewed and acknowledged the incident that occurred on a specific date in 2017, met their home's definition of sexual abuse and that the Director was not notified immediately, when management of the home became aware.

The licensee failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

This area of non-compliance was identified during Critical Incident System (CIS) Inspections log #025304-17; log #013425-18; log #000037-18 and log #025756-17.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) 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. 31 (4).

Findings/Faits saillants :

1. The licensee failed to ensure there was a written staffing plan for the nursing and personal support services programs.

An anonymous complaint was received by the Ministry of Health and Long Term Care (MOHLTC) on a specific date in 2018, stating that the PSWs were often working short staffed and were rushed to provide care to residents.

Upon review of the shift replacement call log and acknowledged by PSW #135, #131, and #129, the PSWs were working one person short on specific dates and times in 2018. PSW #135 explained that residents were not receiving their baths at their scheduled times and the home had to re-schedule on the following shifts to ensure that residents received their bath.

The Resident Services Coordinator #109 was interviewed and indicated the complement of PSWs on each shift on any given day.

PSW #135 provided LTCH Inspector #695 with the list of residents who did not receive a bath over a specific weekend in 2018, and there were 12 residents in total. The PSW explained that they have started offering these residents a bath; however they continue to be short staffed and also need to give a bath to the residents already assigned to them for the specific date of the interview.

PSW #129 provided the list of residents for a specific date who did not receive their bath on their scheduled date and it was nine residents in total.

The DOC was interviewed and acknowledged that coverage for PSWs had been an ongoing issue in the home. The DOC was unable to provide a written staffing plan for the home and acknowledged that there should be one.

The licensee failed to complete a written staffing plan, which included a staffing mix that was consistent with residents' assessed care and safety needs, specifically one that had a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work.

2. The licensee failed to maintain a written record of the annual evaluation of the staffing plan that included the date of the evaluation, names of persons who participated in the evaluation, a summary of changes made and the date that those changes were implemented.

An anonymous complaint was received by the MOHLTC on a specific date in 2018, stating that the PSWs were often working short staffed and were rushed to provide

care for residents.

The DOC provided LTCH Inspector #695 with the annual program evaluation from 2017 for the staffing plan. The annual program evaluation did not include the date on which it was held and the names of the members who attended. One strategy from the evaluation was to communicate with community colleges; however no dates were provided as to when the changes were implemented.

The DOC acknowledged that the Annual Program Evaluation was not very clear and did not know what date it took place or who attended.

The licensee failed to maintain a written record of the annual program evaluation of the staffing plan that included the date of the evaluation, names of persons who participated in the evaluation, a summary of changes made and the date that those changes were implemented.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a continence assessment was completed, using a clinically appropriate assessment instrument, for resident #012, that included the identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

Resident #012 was inspected for continence care related to a Minimum Data Set (MDS) trigger of decline in continence 90 days after admission and, decline from one MDS to the next bladder continence. Resident #012 was admitted on a specific date in 2017.

According to the residents MDS from admission, the resident was occasionally incontinent of bladder. According to the most recent MDS six months after admission, the resident was frequently incontinent of bladder.

In an interview with PSW #117, the PSW explained that the resident is frequently incontinent of bladder at a specific time of day and sometimes incontinent during other times of day.

In an interview with RPN #123, they indicated that all residents that have incontinent episodes were to receive a continence assessment upon admission and when there was a change in condition. RPN #123 stated that resident #012 had incontinence episodes and acknowledged that there was no continence assessment for the resident completed.

The licensee's policy titled “Continence Management Program,” directed staff to complete a continence assessment upon admission for all residents, with any deterioration in continence level, at required jurisdiction frequency, and with any change in condition that may affect bladder or bowel continence.

The DOC was interviewed and acknowledged that resident #012 had urinary continence since admission and there was no continence assessment completed for the resident.

The licensee failed to ensure that a continence assessment was completed for resident #012 using a clinically appropriate assessment tool, which included the identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

WN #13: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training
Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents, as a condition of continuing to have contact with residents, received training relating to behaviour management.

Resident #013 and #019 had a history of sexual responsive behaviours. Both residents had sexually abused female residents' in the home over the past three to six months.

Resident #013 was on safety checks every 15 minutes and subsequently placed on one to one monitoring related to the sexual abuse of female resident #020.

Resident #019 had sexually inappropriate behaviours consistently and sexually abused several female residents, which included, but not limited to, resident #023.

Resident #019 was placed on one to one monitoring since and continued for approximately six months and throughout the RQI inspection.

PSW #125 was interviewed and told LTCH Inspector #527 that they could not remember when they had training last related to behaviour management. Staff member #132 was interviewed and they shared that they had not received training on behaviour management and would like to receive training because they were asked to provide one to one coverage for residents with responsive behaviours.

Contracted staff #112 was interviewed and acknowledged that they had not received any training on behaviour management from the home and had provided one to one for a resident with responsive behaviours for three weeks.

The DOC and BSO PSW were interviewed and acknowledged that not all staff that provided one to one received training in behaviour management, especially the non-clinical staff in 2017. They were unable to provide any documentation to reflect that orientation and/or training related to responsive behaviours was provided to contracted staff who were assigned to provide one to one care for residents with responsive behaviours.

The licensee failed to ensure that all staff who provided direct care to residents, as a condition of continuing to have contact with residents, received training relating to behaviour management.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #012236-18 and log #008168-18, conducted concurrently during the RQI.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were implemented to have a process to report and locate residents' lost clothing and personal items.

During stage one of the RQI, resident #012 expressed concern regarding missing clothing for over 2 weeks. On specific date in 2018, resident #012 stated that they reported the missing clothing to staff, but had not heard back.

Resident #003 stated that the resident regularly checks their closet because often times there had been clothes that did not belong to them placed there by staff.

PSW #117 stated that if a resident had informed them that there was clothing missing, they would go directly to laundry to notify them. The PSW stated that resident #012 had told the PSW about the missing clothing many times and the nurses were aware. The PSW does not recall what follow up was completed or which nurses were aware. The PSW also stated that clothing was often found in the wrong residents' closet.

RPN #123 and RN #100 did not recall being informed that resident #012's clothing was missing. Both the RPN and RN in separate interviews indicated that the residents clothing was frequently found in the wrong resident's closet.

Upon observation in resident #017's closet, clothing was found with resident #007's

name labelled on it. PSW #118 acknowledged that this clothing item was in the wrong residents' closet.

RN #100 stated that a form was supposed to be filled out regarding missing items, but that half the time it was not completed. RPN #123 was not aware of a form that needed to be completed.

In separate interviews with Laundry/Housekeeping Aide #119 and #132, they both stated they did not recall hearing about the resident's missing clothing. Laundry/Housekeeping Aide #132 stated that there was no clear process as to what to do when they believed they found an item that was missing.

The Administrator was interviewed and acknowledged that the home does not have a clear process for reporting and locating missing clothing.

The licensee failed to ensure that procedures were implemented to ensure a process was in place to report and locate residents' lost clothing and personal items.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all direct care staff receive the required training: annually, or if the licensee has assessed the individual training needs of a staff member, that the training was received based on these assessed needs.

The licensee's annual Responsive Behaviour Program training was reviewed for 2017. Not all direct care providers completed their annual training. The licensee's training records indicated that 91 per cent of the direct care providers received Responsive Behaviour training in 2017.

The Quality Lead and Education Coordinator and the BSO PSW were interviewed and acknowledged that not all direct care providers were trained in 2017 related to the Responsive Behaviour Program.

The DOC was interviewed and also acknowledged that not all direct care providers received their annual training for Responsive Behaviours in 2017.

The licensee failed to ensure that all direct care staff received the required training annually for Responsive Behaviours.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #012236-18 and log #008168-18, conducted concurrently during the RQI.

Issued on this 10 day of October 2018 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
500 Weber Street North,
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Télécopieur: (519) 885-9454

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by KATHLEEN MILLAR (527) - (A2)

Inspection No. / No de l'inspection : 2018_742527_0014 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 015252-18 (A2)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Oct 10, 2018;(A2)

Licensee / Titulaire de permis : CVH (No. 8) GP Inc. as general partner of CVH (No. 8) LP
766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8

LTC Home / Foyer de SLD : Shelburne Long Term Care Home
200 Robert Street, SHELBURNE, ON, L9V-3S1

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Heidi Vanderhorst

To CVH (No. 8) GP Inc. as general partner of CVH (No. 8) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCHA.

a) The licensee shall ensure that residents #001, #015, #016, #020, and all other residents, are protected from sexual abuse from residents #013 and #014.

b) To ensure that when 15 minute safety checks and one to one monitoring are in place, that guidelines are developed and implemented for resident #013 and #014.

c) When 15 minute safety checks and one to one monitoring are in place for resident #013 and #014, that there is a system developed and implemented to ensure the monitoring of the residents is completed and that there is documentation to support this monitoring.

Grounds / Motifs :

(A2)
1. The licensee failed to ensure that all residents were protected from abuse by anyone and free from neglect by the licensee or staff.

A) The critical incident report submitted to the Director indicated that there was an incident of alleged sexual abuse that occurred by resident #013 towards residents

#001 and #020.

The clinical record and the investigation notes were reviewed for residents #013 and #001, which indicated that resident #013 was lying on top of resident #001 in their bed and attempting to kiss the female resident. Resident #001 also informed the staff that resident #013 was in their room one other time within the last month. Resident #001 was able to make enough physical motion and sound that resident #013 got off the female resident.

When resident #001 was interviewed they explained the two incidents involving resident #013, and said that the first time they never said anything to the staff, until it happened again. The resident said that they felt safe and protected in the home and had no physical injury, although it was emotionally upsetting and especially when it happened a second time.

On a specific date in 2018, resident #020 was asleep in their bed when resident #013 entered their room and was not found by staff until some time later. Staff found resident #013 in bed with resident #020.

The clinical record and investigative notes were reviewed, which indicated that resident #013 was on safety checks every 15 minutes and the resident had been up and wandering throughout the night. At a specific date and time, resident #013 had been redirected to the lounge. The staff were unable to locate the resident and then conducted a second search, which included going into resident rooms. It was at this time that the staff found resident #013 in bed with resident #020. The clinical record for resident #020 revealed that they required further treatment as a result of the incident.

The Director of Care (DOC) was interviewed and acknowledged both incidents of sexual abuse by resident #013 towards resident #001 and #020. The DOC indicated that as a result of the second incident with resident #020, the home implemented one to one monitoring related to resident #013's high risk sexual behaviours. The DOC acknowledged that at the time of the first incident, the staff were involved in an incident with another resident. The DOC acknowledged that the night staff were aware that resident #013 had been wandering throughout the night, staff had just re-directed the resident to the lounge and staff were aware that the resident had previously exhibited inappropriate sexual behaviours. The DOC also acknowledged that with the second incident, the staff had conducted an initial search, which they

were not able to locate resident #013 and the night staff probably did not want to disturb other residents by going into their rooms. The night staff were required to conduct a more thorough search of resident rooms and it was then they located resident #013 in bed with resident #020.

This area of non-compliance was identified during Critical Incident System (CIS) Inspections, log #008168-18, CIS #2762-000008-18, and log #012236-18, CIS #2762-000009-18, conducted concurrently during the RQI.

B) The critical incident report submitted to the Director on a specific date in 2017, which indicated that resident #014 was involved in an incident of sexual abuse towards resident #016.

Resident #014 had a history of sexually inappropriate responsive behaviours, which resulted in four incidents towards three residents in 2017 and one incident in 2018.

A clinical record review was completed, which identified that resident #014 entered a common area where resident #016 was sitting, staff entered the room a few minutes later and noticed resident #014 was inappropriately touching resident #016.

Prior to this incident, safety checks were supposed to be implemented for monitoring resident #014's whereabouts and to redirect the resident from inappropriately touching other residents. Resident #014 was also not to be in common areas of the home unsupervised by staff. Safety checks including monitoring the resident's whereabouts every fifteen minutes by PSW staff were not completed on a specific date in 2017 and were inconsistently documented throughout the same month in 2017. The DOC acknowledged there were no 15 minute safety checks being completed on a specific date and time in 2017 and documentation was incomplete on the day of the incident. After reviewing the clinical record, the DOC was unable to locate any paper documentation of
safety checks. The safety checks were discontinued on a specific date in 2017. On the following day after the safety checks were discontinued in 2017, the resident was in a common area unsupervised and was witnessed reaching inappropriately touching resident #015.

In an interview with PSW #121, they indicated they had never seen inappropriate behaviours and staff were to monitor and keep resident #014 away from certain residents.

The DOC acknowledged that there was no evidence of safety checks being conducted and that it was expected to be completed.

The licensee failed to ensure that resident #001, #015, #016, and #020 were protected from abuse by resident #013 and #014.

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents. The scope of the issue was a level 2 as it related to three of four residents reviewed. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA that included:

- Voluntary Plan of Correction issued November 15, 2016, (2016_511586_001). (527)

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

Sep 28, 2018(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 10 day of October 2018 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by KATHLEEN MILLAR - (A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Service Area Office / Bureau régional de services : Central West