Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 31, 2020	2020_664602_0013	002529-20, 004931-20, 007605-20, 011754-20, 012748-20, 016530-20	Critical Incident System

Licensee/Titulaire de permis

Sherwood Park Manor
1814 County Road #2 East BROCKVILLE ON K6V 5T1

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

Sherwood Park Manor
1814 County Road #2 East BROCKVILLE ON K6V 5T1

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

WENDY BROWN (602), AMBER LAM (541)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 10 - 13, 2020

Log#007605-20/CIS #2640-000002-20, Log#004931-20/CIS #2640-000007-20 & Log#016530-20/CIS #2640-000008-20 - regarding alleged resident to resident sexual abuse,
Log#002529-20/CIS #2640-000005-20, Log#011754-20/CIS #2640-000013-20 & Log#012748-20/CIS #2640-000014-20 - regarding a fall with injury requiring hospitalization.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the acting DOC, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Resident and Family Services Manager and residents.

The inspector(s) reviewed resident health care records: including plans of care, medication administration records and progress notes as well as resident incident reports, physician tour sheets, inquiry documentation and relevant policies and procedures. Resident care and services observations were also completed.

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

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 comply with their zero tolerance of abuse and neglect policy related to alleged resident to resident sexual abuse incidents that occurred on three specified dates.

The home' s policy titled Zero Tolerance of Abuse and Neglect last reviewed September 2019, includes the following definition for sexual abuse
(a) subject to subsection (3), 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
(b) 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;

The licensee's Zero Tolerance of Abuse and Neglect policy outlines investigation and reporting requirements as follows:

p. 3 of 19: Step 3. - Reports by staff and board members under this policy, and third party reports of abuse or neglect, will be immediately investigated in accordance with the investigation procedures in Part B, Section Two: Reporting and Notifications.
The licensee did not comply with this step of their policy for each of the three incidents as there was no evidence to show investigations were completed.

p. 4 of 19: Step 4. - Appropriate action will be taken in response to any alleged, witnessed or un-witnessed incident of resident abuse or neglect as outlined in the Procedures
On August 13, 2020, acting DOC #107 confirmed that there was no external consult referral for resident #002, neither were changes were made to resident #001, #002 & #003's care plans specific to responsive behaviours; appropriate action was not completed as outlined in this step of the licensee's policy.

p. 4 of 19: Step 8. Police will be notified (if warranted).
DOC #101 and Acting DOC #107 were unable to provide evidence that the police were contacted as part of their response to each of the 3 incidents

p. 4 of 19: Obligation Step 1. immediate reports to the Director.
The licensee did not comply with this step in their policy for the incidents occurring on two separate specified dates, in that the Director was notified a specified period of time after the incident(s) occurred.

p. 13 of 19: Appendix A: Report to the Director – In making a report to the Director under subsection 23 (2) of the Act, the license shall include the following material in writing with respect to the alleged … incident of abuse of a resident will include:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including, i. names of all residents involved in the incident.
3. Actions taken in response to the incident, including, i. what care was given or action taken as a result of the incident, and by whom, … iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and v. the outcome or current status of the individual or individuals who were involved in the incident.
4. Analysis and follow-up action, including, … i. the immediate actions that have been taken to prevent recurrence, and ii. the long-term actions planned to correct the situation and prevent recurrence.
A review of each CI report found that names of all residents involved in the incident (CI#1), care given (CI#3), name POA/SDM (CI#1), outcome or current status of the individual or individuals who were involved in the incident (CI#1, #2 & #3), and/or the long-term actions planned to correct the situation and prevent recurrence (CI#1 & #2) were not included in one or more of the reports

The licensee failed to comply with multiple steps in their policy to promote zero tolerance of abuse and neglect. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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 #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to immediately investigate CI #1, CI #2 and CI #3.

On a specified date and time, resident #003 was found in resident #001's room; resident #001 was inappropriately touching resident #003. In the subsequent telephone call to DOC#101 to notify them of the incident, RN #102 was advised that the DOC would follow up on the incident on a specified number of days later. DOC #101 confirmed in an interview that an investigation into CI #1 was not completed.

Resident #001 was found inappropriately touching resident #002 in their room on a specified date (CI #2), and again, in a similar incident a specified period later (CI #3). DOC #101 confirmed in an interview that an investigation was not completed following CI #2. The acting DOC #107 confirmed that they were unable to locate an investigation file or documentation specific to completion of an investigation into CI #3.

The licensee failed to investigate each of the three incidents. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures every alleged, suspected or witnessed incident of abuse or neglect that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to immediately report the C! #1 and CI #3 to the Director.

On a specified date, resident #001 was found inappropriately touching resident #003. The incident was reported to the Director by DOC #101 a specified period of time later. In a subsequent incident, resident #001 was observed inappropriately touching resident #002. The incident was reported a specified period of time after the incident. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures a person who has reasonable grounds to suspect that abuse or neglect of a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to notify the police following three separate incidents of alleged resident to resident sexual abuse.

On a specified date, resident #003 was located in resident #001's room; resident #001 was inappropriately touching resident #003 who was heard saying "stop" and "I don't like that". Resident #003 was removed from the room. Resident #001 was counselled regarding inappropriate behaviour.

RN#102 contacted DOC#101 following the incident to report that resident #003 had been allegedly sexually assaulted by resident #001 and thought the police should be notified of the incident. According to a summary email authored by RN#103, RN #102 indicated DOC#101 advised that this was not necessary and that they would follow up on the incident.

On a subsequent date, resident #002 was found in resident #001's room; resident # 001 was observed to be inappropriately touching resident #002. The residents were separated and assessed; no injury was reported. There is no indication on CI #2's report that the police were notified of the incident.

According to CI#3's report, resident #002 was observed entering resident #001's room; when staff followed, resident #001 was found to be inappropriately touching resident #002. During the inquiry conducted into CI #3, DOC #101 advised inspector #103 that the police were not notified. [s. 98.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

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

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

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the report(s) to the Director included names of all residents involved in the incident, care given as a result of the incident, name of Power of Attorney/Substitute Decision Maker (POA/SDM), outcome or current status of the individual or individuals who were involved in the incident, and the long-term actions planned to correct the situation and prevent recurrence.

Review of CI#1, #2 & #3 noted the following information was not included in the report(s) to the Director:
CI#1:
• resident #001's name,
• name of resident #001's POA/SDM,
• outcome of the individuals involved in the occurrence and the
• the long-term actions planned to prevent recurrence
CI#2:
• outcome of the individuals involved in the occurrence and the
• long-term actions to prevent recurrence
CI#3:
• care that was given to either resident and the
• outcome of the individuals involved in the occurrence. [s. 104. (1) 4.]

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 that ensures the report to the Director shall include the following material in writing with respect to the abuse or neglect of a resident: i. names of all residents involved in the incident, ii. actions taken in response to the incident, including what care was given or action taken as a result of the incident, and by whom, iii. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, iv. the outcome or current status of the individual or individuals who were involved in the incident and v. the long-term actions planned to correct the situation and prevent recurrence, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The following findings are further evidence to support CO #001 issued on March 10, 2020 and amended on May 25 and June 25, 2020 during inspection 2020_664602_0005. The incidents below occurred before the amended compliance due date of October 31, 2020.
The licensee failed to protect resident #002 and #003 from alleged sexual abuse by resident #001.

Critical Incident #2640-000002-20 (CI #1): On a specified date and time PSW #112 noted resident #003 was not in their room. According to the home's “Resident Incident Report Form" resident #003 was located in resident #001's room; resident #001 was observed inappropriately touching resident #003. Resident #003 was heard saying "stop" and "I don't like that". Resident #003 was removed from the room. Resident #001 was counselled regarding inappropriate behaviour.

RN#102 contacted DOC#101 to report the incident. The DOC directed RN#102 to assess resident #003 take specified precuations. CI #1's report indicated resident #001 and #003 were separated and settled following discovery of resident #003 in resident #001's room; there was no assessment documentation found in either residents' health care record.

In a summary email regarding the incident, RN#103 indicated that RN #102 reported resident #003 had been sexually assaulted by resident #001 and that in a subsequent contact with DOC #101 they stated they thought the police should be contacted. DOC#101 was reported to have advised RN#102 that this was not necessary as they would follow up on the incident. There was no indication that resident POAs, police, Ministry of Long-term Care (MLTC) or physician(s) were contacted by that shift's staff; nor was there indication that staff followed the licensee's zero tolerance of abuse and

neglect policy.

Critical Incident #2640-000007-20 (CI #2): On a specified date and time resident #002 was found in resident #001's room; resident # 001 was observed to be inappropriately touching resident #002. The residents were separated and assessed; no injury was reported. The POAs, physician and the MLTC were alerted to the incident. There is no indication in CI #2's report that the police were notified of the incident. Follow up was to include an external consult and extra staff allocated for observation for resident #002.

During interviews on August 10, 2020, DOC #101 was unable to provide evidence that investigations into CI #1 & #2 were completed. A review of CI #2's report and related progress notes indicated extra staff and the completion of a external agency referral were to be provided for observation of resident #002. Despite monitoring, resident #001 was involved in a similar incident with resident #002 a short period of time later. Acting DOC #107 confirmed that the external consult was not completed.

Critical Incident #2640-000008-20 (CI #3): On a specified date and time resident #002 was observed entering resident #001’s room; when staff followed, resident #001 was found inappropriately touching resident #002. The residents were separated. During the follow up inquiry conducted by inspector #103, DOC #101 advised inspector #103 that the MLTC and the police were not notified at the time of the incident.

The licensee failed to protect resident #002 and #003 from alleged sexual abuse by resident #001 in that they failed to: follow their abuse policy, investigate each incident, report the incidents to the police, and immediately report the CI #1 and CI #3 to the Director. [s. 19. (1)]

Issued on this 2nd day of September, 2020

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

Original report signed by the inspector.