Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
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159 rue Cedar Bureau 403
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 30, 2015	2015_336620_0002	025895-15	Critical Incident System

Licensee/Titulaire de permis

ANSON GENERAL HOSPITAL
58 Anson Dr. IROQUOIS FALLS ON P0K 1E0

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

SOUTH CENTENNIAL MANOR
240 FYFE STREET IROQUOIS FALLS ON P0K 1E0

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

ALAIN PLANTE (620)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 29, 30, 2015; October 01, 02, 2015; October 08, 2015 (Follow-up phone call).

This inspection was being conducted as a result of a Critical Incident Report to the Ministry of Health and Long Term Care received on September 16, 2015.

During the course of the inspection, the inspector(s) spoke with Residents, Resident's Substitute Decision Maker(SDM), Resident's Family/Friends, Ontario Provincial Police Officers (OPP), Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), and Personal Support Workers (PSW).

The inspector observed resident staff interaction, reviewed policies and procedures, reviewed health records, reviewed training records, and reviewed personnel records.

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

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from sexual abuse by a staff member #107.

Under O.Reg. 79/10 sexual abuse is defined as any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member.

Inspector #620 entered the home to inspect an incident of suspected abuse submitted by the home to the Director.

A review of the Critical Incident (CI) Report revealed that resident #001 reported an incident of alleged sexual abuse to staff. The staff was informed that a resident was sexually abused by staff member #107. The ADOC was notified of the alleged abuse and a CIS submission was made to the Director.

Inspector #620 reviewed the notes from the home's investigation documents which included a written statement by the alleged staff member. The written statement detailed that the staff member provided care to the specified resident. The written statement also revealed that an action of sexual abuse had occurred.

The home's training records revealed that staff member #107 received training in Responsive Behaviour Program, Duty to Report Policy, and Zero Tolerance of Abuse and Neglect Policy.

Inspector #620 interviewed the resident #001. The resident stated that they were sexually abused by a staff member.

An interview with a staff member revealed that they were aware of staff member #107's actions for many years, but did not feel as though the particular actions constituted sexual abuse.

Inspector #620 interviewed staff member #107. They stated that they did provide care for the resident #001. The staff member confirmed that they had conducted inappropriate behavior of a sexual nature toward this resident. The staff member also identified other residents for which they conducted an action of inappropriate behaviour of a sexual nature. The staff member revealed that they had experienced fear that the action would lead to them being accused of inappropriate behaviour.

Inspector #620 interviewed the DOC. The DOC confirmed that the staff member 107's actions constituted sexual abuse, and should not have occurred. The DOC further noted

that the staff member #107 had been advised that the inappropriate behaviour would not be tolerated. The DOC confirmed that staff member #107 would not work in the home until the completion of the home's investigation.

Inspector #620 reviewed the home's Abuse Police entitled, "Zero Tolerance of Abuse and Neglect Policy: LTC-630, dated December 05, 2012." The policy stated that the home would provide training on the relationship between power imbalances, and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care.

Inspector # 620 interviewed staff members #102, and 103. Both staff members indicated that they did not receive training related to power imbalance. During an interview with staff member #107 they indicated that they were unaware of what a power imbalance was and that they could not recall having had training with regards to this.

The DOC was asked to provide training records related to training on the relationship between power imbalances as outlined in the home's, "Zero Tolerance of Abuse and Neglect Policy: LTC-630." The DOC provided a video series entitled "One is Too Many". A review of the video series by Inspector #620 revealed that the video series did not address power imbalance. The DOC confirmed that the video series did not address power imbalance and that training specific to power imbalance had not occurred, and should have.

The scope of this issue was determined to be pattern due to the number of residents involved. There was no ongoing non-compliance. The severity is determined to be actual harm/risk, as the home does acknowledge that an abuse did occur. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy that promotes zero tolerance of abuse and neglect was complied with.

Inspector #620 reviewed the home's Abuse Policy entitled, "Zero Tolerance of Abuse and Neglect Policy: LTC-630, dated December 05, 2012." The policy stated that the home would provide training on the relationship between power imbalances, and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care.

The DOC was asked to provide documentation related to training on the relationship between power imbalances as outlined in the home's, "Zero Tolerance of Abuse and Neglect Policy: LTC-630." The DOC provided a video series entitled "One is Too Many". A review of the video series by Inspector #620 revealed that the video series did not address power imbalance. The DOC confirmed that the video series did not address power imbalance and that training specific to power imbalance had not occurred, and should have.

Inspector # 620 interviewed two RNs. Both RNs indicated that they did not receive training related to power imbalance. During an interview with staff #107 they indicated that they were unaware of what a power imbalance was and that they could not recall having had training with regards to this.

The scope of this issue was determined to be a pattern. There was no ongoing non-compliance. The severity is determined to be actual harm/risk, as the home does acknowledge that an abuse did occur. [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 specifically, to ensure that training is provided on the relationship between power imbalances between staff and residents, and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents were fully respected and promoted; specifically, that a resident was unaware of the name and title of a specific staff member who was providing direct care to the resident.

Resident #001 was interviewed by Inspector #620 following an allegation of sexual abuse by a staff member. The resident was unable to identify the correct name of the specified staff member.

During an interview with Inspector #620, the staff #107 acknowledged presenting them self as a Doctor with a fabricated name to residents on many occasions. The staff member denied asking a certain resident to call them by the fabricated Doctor's name.

A record review by Inspector #620 revealed that in a performance appraisal of the staff #107, under the heading of Accountability/Professional Conduct and Work Ethics, the staff member was noted to address them self by a fabricated Doctor's name.

Inspector #620 interviewed the OPP Officer investigating the incident. They revealed that the staff #107 acknowledged referring to them self by a fabricated Doctor's name to resident #001. The Officer stated that the staff member said that they did this in order to get residents to comply with them more easily when they were providing care.

Inspector #620 interviewed the DOC. The DOC confirmed that upon first meeting the staff #107, they presented them self to the DOC by a fabricated Doctor's name. The DOC stated that the staff member was warned to end this practice. The DOC confirmed that the staff member had been reprimanded for representing them self by a fabricated Doctor's name in the past. [s. 3. (1) 7.]

Issued on this 2nd day of December, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ALAIN PLANTE (620)
Inspection No. / No de l'inspection :	2015_336620_0002
Log No. / Registre no:	025895-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 30, 2015
Licensee / Titulaire de permis :	ANSON GENERAL HOSPITAL 58 Anson Dr., IROQUOIS FALLS, ON, P0K-1E0
LTC Home / Foyer de SLD :	SOUTH CENTENNIAL MANOR 240 FYFE STREET, IROQUOIS FALLS, ON, P0K-1E0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Diane Stringer

To ANSON GENERAL HOSPITAL, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:

a) Ensure all residents, including resident #001 are protected from abuse by staff member #107.

b) Ensure that staff member #107 and all other staff is re-trained and evaluated on the home's Zero Tolerance of Abuse Policy.

Grounds / Motifs :

1. The licensee failed to ensure that residents were protected from sexual abuse by a staff member #107.

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regards to this.

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The scope of this issue was determined to be pattern due to the number of residents involved. There was no ongoing non-compliance. The severity is determined to be actual harm/risk, as the home does acknowledge that an abuse did occur. [s. 19. (1)] (620)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 30th day of November, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Alain Plante

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