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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 21, 2017	2017_638609_0004	001689-17	Resident Quality Inspection

Licensee/Titulaire de permis

ST. JOSEPH'S GENERAL HOSPITAL ELLIOT LAKE
70 Spine Road ELLIOT LAKE ON P5A 1X2

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

ST. JOSEPH'S MANOR
70 SPINE ROAD ELLIOT LAKE ON P5A 1X2

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

CHAD CAMPS (609), LINDSAY DYRDA (575), SARAH CHARETTE (612)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 30-31, 2017, February 1-3 and February 6-10, 2017.

Additional logs inspected during this RQI included:

Five Critical Incidents the home submitted to the Director related to staff to resident abuse and neglect;
Two Critical Incidents the home submitted to the Director related to resident falls and;
One Complaint submitted to the Director related to allegations of financial abuse and care to a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (Administrator/DOC), Administrative Assistant (AA), Chief Nursing Officer (CNO), Registered Dietitian (RD), Food Services Manager (FSM), Dietary Assistant, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Recreational Therapists, Dietary Aides (DAs) and Cooks.

The inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, human resource files, internal investigations, and numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care
Sufficient Staffing
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **18 WN(s)**
- **9 VPC(s)**
- **5 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. 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 has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

A Critical Incident (CI) report was submitted to the Director which outlined allegations that resident #012 was sexually abused and neglected by PSW #101.

Inspector #609 reviewed resident #012's progress notes and found that on an identified day, the resident told RPN #100 that PSW #101 had neglected them for the past five days.

During an interview with RPN #100 they verified that they had written the progress note outlining the allegations of neglect after they had informed the Administrator/DOC on the identified day.

A review of the home's policy titled "Zero Tolerance of Abuse and Neglect" last revised in June 2016 indicated that certain persons, including staff members were required to make immediate reports to the Director where there was a reasonable suspicion that neglect of a resident by staff that resulted in harm or risk of harm occurred or may occur.

A review of the CI reports submitted to the Director for 2016 and 2017 from the home found no report of the allegations of neglect of resident #012 by PSW #101 until two days after the home was made aware of additional allegations of sexual abuse.

During an interview with the Administrator/DOC The Administrator/DOC further verified that they became aware of the allegations of neglect on the identified day and did not report them to the Director until two days later when additional allegations of sexual abuse were reported by resident #012. [s. 24. (1)]

2. Inspector #575 reviewed a CI report submitted to the Director regarding an alleged incident of staff to resident neglect. The CI report described that on an identified day, PSW #112 reported to the Administrator/DOC that resident #009 was observed in bed with their incontinence pad soaked in urine. PSW #112 reported this to RPN #108 on the same day.

The home's internal investigation substantiated the allegations of neglect and PSW #123 received disciplinary action.

During an interview with the Administrator/DOC they verified that the incident was not reported to the Director immediately when they became aware of the incident on the identified day. They verified they did not notify the Director until six days after becoming aware of the incident. [s. 24. (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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

a) During the course of the inspection, Inspector #609 observed that the doors to the rooms of resident #004, #013, #014 and #015 indicated that the residents were on isolation precautions. Three of the four or 75 per cent of the rooms had no indication as to what type of isolation precautions the resident was on, what Personal Protective Equipment (PPE) was required or any other instructions to assist staff, residents or visitors with infection control precautions.

Inspector #609 reviewed the home's policy titled "Infection Prevention and Control (IPAC) Program" last revised January 2014, which outlined that signage indicating the infection control precautions to be used should be visibly displayed. Only one of four or 25 per cent of the resident doors had signage displayed.

During an interview the Chief Nursing Officer (CNO) they verified that the infection prevention and control policies of the home were to be complied with, and that 75 per cent of the residents observed did not have adequate signage to instruct staff, residents or visitors on infection precautions.

b) During an interview with RPN #103 they acknowledged that three of the rooms observed did not have visibly displayed infection control precautions, but that this information would be found in each of the residents' plan of care.

A review of the current plan of care for all four residents #004, #013, #014 and #015 failed to document what type of isolation precautions the residents were on, or

precautions to be used to protect staff, residents and visitors.

A review of the home's policy titled "Care Plan Development and Monitoring- III-10" last reviewed May 2008 indicated that an infection was a change in the resident's condition that warranted immediate change in the resident's care plan. The policy further outlined that the care plan would identify preventative aspects of care, appropriate actions and who was to carry out those actions.

During an interview with the CNO they verified that if a resident was on isolation precautions for any reason, the plan of care was to be updated to instruct staff and subsequently residents and visitors on the home's infection control precautions. [s. 8. (1)]

2. During the entrance conference with the Administrator/DOC they stated to Inspector #609 that controlled substances for destruction were stored in a locked cabinet drawer in the desk of their office.

During the tour of the home Inspector #612 noted that the Administrator/DOC's office was not locked.

On a particular day, Inspector #612 observed the Administrator/DOC's office door opened for 15 minutes prior to the DOC returning.

Ontario Regulation (O. Reg) 79/20 s. 136 (2) 2. states that the drug destruction policy must provide for the following:

Any controlled substance that was to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurred.

The Inspector reviewed the home's policy titled, "Surplus Prescribed Drug Sheet - 3.3.7", last revised January 17, 2011, which stated that surplus narcotics and controlled drugs shall be stored in a double locked storage area specifically designated for that purpose with their Narcotic and Controlled Drug Count sheet attached. Only the Director of Nursing and Personal Care (or designee) and the Consultant Pharmacist shall have a key to this area.

During an interview with the Administrator/DOC they verified that they stored discontinued controlled substances in their office for disposal, had left their door open

when it should have been closed and locked. They stated that the Administrative Assistant has a key to open their door but not the filing cabinet where the discontinued controlled substances were kept. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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 has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that was reported was immediately investigated.

A CI report was submitted to the Director which outlined allegations that resident #012 was sexually abused and neglected by PSW #101.

The LTCH Act, 2007, defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Inspector #609 reviewed resident #012's progress notes and found that on an identified day, the resident told RPN #100 that PSW #101 neglected them for the past five days.

During an interview with RPN #100 they verified that they had written the progress note outlining the allegations of neglect after they had informed the Administrator/DOC on the same identified day.

During an interview with the Administrator/DOC they verified that they became aware of the allegations of neglect on the identified day.

A review of the home's policy titled "Zero Tolerance of Abuse and Neglect" last revised in June 2016 indicated that the home was to immediately investigate reports of abuse and neglect by residents and staff and that if staff were involved in the incident, they were to be dismissed from work pending the outcome of the investigation. The policy also outlined that records were to be kept of the investigation.

The Administrator/DOC failed to produce any documentation to support that they immediately investigated resident #012's allegations of neglect by PSW #101 when they became aware of the allegations on the identified day.

During the interview with the Administrator/DOC they verified that they did not initiate an investigation into the allegations of neglect until two days after RPN #100 made the Administrator/DOC aware. [s. 23. (1) (a)]

2. The licensee has failed to ensure that appropriate action was taken in response to every alleged, suspected or witnessed incident of abuse and neglect of a resident that the licensee knew of.

Inspector #575 reviewed a CI report submitted to the Director regarding an alleged incident of staff to resident neglect. The CI report described that on an identified day PSW #112 reported to the Administrator/DOC that resident #009 was observed in bed with their incontinence pad soaked in urine.

The CI report indicated that the Administrator/DOC met with PSW #123 six days later and during that meeting, PSW #123 was relieved from work until the investigation was completed.

Inspector #575 reviewed the staffing schedule and noted that PSW #123 worked four

shifts between when the home became aware of the allegations and PSW #123's dismissal.

The Inspector reviewed the PSW's personnel file which identified performance concerns over a specified period of time.

During an interview with the Administrator/DOC, they verified that PSW #123 was not relieved from duties until six days after becoming aware of the allegations because they wanted further proof before relieving PSW #123 of their duties.

The home's investigation substantiated the allegations of neglect and PSW #123 received disciplinary action. [s. 23. (1) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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 written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A CI report was submitted to the Director which outlined allegations by resident #012 that they were sexually abused by PSW #101 on an identified day, several weeks previous to the CI submission.

Inspector #609 reviewed the home's internal investigation of the incident which found that PSW #104 had witnessed PSW #101 sexually abusing resident #012. PSW #104 did

not report the witnessed abuse to the home until several weeks later.

The LCTH Act 2007, defines sexual abuse 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.

During an interview with resident #012 they verified that PSW #101 sexually abused them at least three times, without requesting or consenting to the act.

During an interview with PSW #104 they verified that they were present and working on the identified day and witnessed PSW #101 sexually abuse resident #012. PSW #104 verified that they did not comply with the home's Zero Tolerance of Abuse and Neglect policy when they did not immediately report the witnessed sexual abuse to registered staff.

Inspector #609 reviewed the home's policy titled "Zero Tolerance of Abuse and Neglect" last revised June 2016, which indicated that all residents had the right to live in a home environment that treated them with dignity, respect and was free from any form of abuse or neglect at all times, and in all circumstances. The policy further indicated that anyone who witnessed, suspected or alleged abuse or neglect of a resident were to immediately report the information to the home and staff were to follow a reporting chain of command (PSW to RPN to RN to Administrator/DOC) in order to report any witnessed, suspected, or alleged abuse or neglect of a resident to a supervisor immediately.

During an interview with the Administrator/DOC they verified that PSW #104 witnessed abuse to resident #012 by PSW #101 and did not make the home aware of it until 39 days later. [s. 20. (1)]

2. A CI report was submitted to the Director which outlined allegations of staff to resident neglect of resident #016 on an identified day.

Inspector #609 reviewed the home's internal investigation found that three days after the incident, PSW #122 reported to the Administrator/DOC that resident #016 was found in a brief without clothes on, incontinent of a large amount of urine and crying.

During an interview with the Administrator/DOC they verified that PSW #122 waited three days before notifying the home of the allegations of neglect of resident #016. The Administrator/DOC indicated that all allegations of witnessed or suspected abuse and

neglect were to be immediately reported to the home. [s. 20. (1)]

3. Inspector #575 reviewed a CI report submitted to the Director regarding an alleged incident of staff to resident neglect. The CI report described that on an identified day PSW #112 reported to the Administrator/DOC that seven days previously, resident #009 was observed in bed with their incontinence pad soaked in urine. PSW #112 reported this to RPN #108 on the same day.

Ontario Regulation (O. Reg.) 79/10, s. 5 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and included inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

a) The home's internal investigation substantiated the allegations of neglect and PSW #123 received disciplinary action. The investigation indicated that resident #009 was totally dependent for all continence care and positioning and that PSW #123 neglected to provide the resident with care and assistance. The investigation also uncovered that multiple residents were neglected during PSW #123's shift. The home's investigation substantiated the allegations of neglect and PSW #123 received disciplinary action.

A review of PSW #123's human resources file identified performance concerns over a specified period of time.

b) During an interview with the Administrator/DOC they verified that the incident was not reported to the Director immediately. They stated that RPN #108 should have reported the allegations to their supervisor when they became aware of the neglect on November 3, 2016. [s. 20. (1)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: 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 has failed to ensure that all residents were protected from abuse by anyone and were not neglected by the licensee or staff.

A CI report was submitted to the Director which outlined allegations that resident #012 was sexually abused by PSW #101.

Inspector #609 reviewed the home's internal investigation of the incident which found that PSW #104 had witnessed PSW #101 sexually abuse resident #012 on an identified day.

During an interview with PSW #104 they verified that they were present and working on the identified day and saw PSW #101 sexually abuse resident #012.

During an interview with resident #012 they verified that PSW #101 sexually abused them.

Inspector #609 reviewed the human resources file for PSW #101 which outlined PSW #101's documented history of disciplinary actions related to their work performance.

a) During an interview with the Administrator/DOC a review of PSW #101's human resources file was conducted. The Administrator/DOC indicated they had not reviewed PSW #101's human resources file following allegations of sexual abuse that were brought forward regarding PSW #101, despite PSW #101's history of performance concerns in the home.

b) During an interview with RPN #100 they verified that they had written the progress note outlining the allegations of neglect after they had informed the Administrator/DOC on the identified day.

During an interview with the Administrator/DOC they verified that they were notified of

allegations of neglect of a resident by PSW #101 on the identified day.

A review of the home's policy titled "Zero Tolerance of Abuse and Neglect" last revised in June 2016 indicated if staff were involved in the incident they must be dismissed from work, pending the outcome of the investigation.

A review of the schedule for PSW #101 found that after the home was made aware of allegations of neglect, PSW #101 was permitted to continue their shift on the identified day as well as work two additional shifts before PSW #101 was dismissed from the home following additional sexual abuse allegations made two days later.

c) During an interview with the Administrator/DOC a review of the home's internal investigation of the CI was conducted. The Administrator/DOC verified they closed the home's internal investigation of the sexual abuse allegations, finding no evidence that abuse occurred.

A review of the home's policy titled "Zero Tolerance of Abuse and Neglect" last revised in June 2016 indicated that the Administrator/DOC was to fully investigate incidents and complete the documentation of all known details of the reported incident.

The Administrator/DOC told the inspector that they had not interviewed all PSWs involved prior to closing the internal investigation and had they done this they would have verified from witnesses, PSW #101's sexually abusive conduct toward resident #012 on the identified day.

d) Additional non-compliances were found related to the licensee's failure to protect resident #012 from abuse as follows:

-Written Notification (WN) #1 LTCHA, 2007, s. 24. (1). Whereby the Administrator/DOC did not immediately report allegations of abuse of the resident to the Director;
-WN #4 LTCHA, 2007, s. 20. (1). Whereby PSW #104 did not immediately report to the home, the witnessed abuse of the resident by PSW #101 and PSW #101 did not follow the licensee's abuse policy and sexually abused resident #012;
-WN #5 LTCHA, 2007, s. 3. (1) 11. i. Whereby the Administrator/DOC changed the resident's plan of care without consent; as well as
-WN #15 O. Reg. 79/10, s. 99. Whereby analyses of abuse and neglect incidents were not a part of the home's annual abuse program evaluation. [s. 19. (1)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident had the right to be treated with courtesy and respect in a way that fully recognized the resident's individuality and dignity was fully respected and promoted.

Inspector #575 reviewed a CI report submitted to the Director by the home. The CI report described an alleged incident of verbal abuse whereby PSW #118 made inappropriate comments to resident #008 on an identified day.

According to the home's investigation, PSW #118 admitted that they raised their voice and were angry towards resident #008 when the resident displayed responsive behaviours. The investigation also indicated PSW #112 heard yelling during the alleged incident.

A disciplinary action was issued to PSW #118 for raising their voice when resident #008 displayed responsive behaviours, which left the resident feeling anxious and upset. [s. 3. (1) 1.]

2. The licensee has failed to ensure that every resident had the right to participate fully in the development, implementation, review and revision of his or her plan of care.

A CI report was submitted to the Director which outlined allegations that resident #012 was sexually abused and neglected by PSW #101.

Inspector #609 reviewed resident #012's current plan of care which found that on an identified day, the Administrator/DOC significantly changed the resident's care requirements.

During an interview with resident #012 they verified that they make their own personal care choices. The resident went on to explain that they did not participate in the decision to change their plan of care. Resident #012 described how since the change they wait long periods for care assistance.

During an interview with RPN #103 they verified that resident #012 made their own personal care choices.

A further review of resident #012's current plan of care found that the resident made their own decisions.

During an interview with the Administrator/DOC they verified that seven days after resident #012 brought forward allegations of sexual abuse, they significantly revised the resident's plan of care. The Administrator/DOC further stated that the change in the resident's plan of care was for the resident's safety. The Administrator/DOC stated "no"

when asked if the resident had a history of making unsubstantiated allegations of abuse against other staff and residents.

A review of resident #012's progress notes found that just one day after to the resident brought forward allegations of sexual abuse and eight days prior to the resident's plan of care being revised, the quarterly physiotherapy assessment was completed which identified no concerns with the resident's current safety plan of care.

During the same interview with the Administrator/DOC they verified that they had revised resident #012's plan of care without the participation of the resident in the changes. [s. 3. (1) 11. i.]

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 every resident has the right to participate fully in the development, implementation, review and revision of his or her plan of care, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

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 has failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

Inspector #612 reviewed a CI report which indicated that on a particular day resident #010 experienced a fall which resulted in an injury.

On a particular day, Inspector #612 observed resident #010 in bed, with bed rails engaged in the guard position with one having a device applied to it.

The Inspector reviewed the resident's current plan of care and was unable to locate any focus, goals or interventions related to the device.

During an interview with PSW #117 they stated that resident #010 was to have the device applied related to their care needs.

During an interview with the Administrator/DOC they stated that resident #010's care needs required the device be applied. The Administrator/DOC stated the information should have been included in the resident's plan of care. [s. 6. (1) (a)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that different aspects of care were integrated, were consistent with and complemented each other.

During stage one of the inspection, it was identified during a staff interview that resident #001 had change in body mass index (BMI) and was not receiving nutrition interventions.

Inspector #575 reviewed resident #001's plan of care and medication review indicated the resident was to receive a supplement and other interventions. The nutrition sheet for the resident did not include the supplement.

During an interview, RPN #111 stated stated that the resident's supplement was administered by PSWs and documented on Point of Care (POC).

A review of the POC documentation indicated that the resident did not receive or refuse the supplement.

During an interview, RPN #108 verified that the nutrition sheet did not include the supplement.

The Inspector reviewed a progress note entered by the RD which indicated that the resident often refused the the supplement but that their weight was stable with other interventions and therefore, they were removing the supplement from the resident #001's plan of care.

During an interview with the RD they verified that they removed the supplement from the nutrition sheet and plan of care, however, they did not discontinue the order.

During an interview with the Administrator/DOC they verified that the RD should have discontinued the order for the supplement, and that this should have been caught by the Registered staff during the medication review. [s. 6. (4) (b)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Inspector #612 reviewed a CI report which indicated that on a particular day, resident #010 experienced a fall which resulted in an injury.

A review of the resident's current plan of care indicated that resident #010 was a very high risk for falls and that the resident had a red leaf at the bedside to alert staff of the resident's high risk for falls.

On a particular day, the Inspector did not observe a red leaf at the bedside.

The Inspector interviewed PSW #117 and RPN #125 who stated that resident #010 was at high risk for falls and that the red leaf should be posted to notify staff that the resident was at high risk for falls.

During an interview with the Administrator/DOC, they stated that the red leaf should be posted at the bed side of resident #010 to indicate to staff they were at high risk of falls. [s. 6. (7)]

4. The licensee has failed 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 the resident's care needs changed or care set out in the plan was no longer necessary.

a) On a particular day, Inspector #609 observed outside the room of resident #017, newly placed infection signage and supplies were noted.

A review of resident #017's plan of care found that on the same day, RN #105 updated the plan of care with infection interventions.

A review of the health care records for resident #017 found that the resident required infection interventions over a specified period of time previously.

A review of the home's policy titled "Care Plan Development and Monitoring- III-10" last reviewed May 2008 indicated that an infection was a change in the resident's condition that warranted immediate change in the resident's care plan. The policy further outlined that the care plan would identify preventative aspects of care, appropriate actions and who was to carry out those actions.

During an interview with RN #105 they verified that resident #017's plan of care was revised with infection interventions as well as placed signage and supplies outside the resident's room because the resident's requirement for infection interventions was missed for over a specified period of time.

b) A review of the home's Infection Surveillance report (line listing) indicated that resident #017 exhibited infectious symptoms.

During an interview with RN #106 they verified that resident #017 was also being monitored for a potential infection with specific interventions.

A review of resident #017's plan of care failed to document any possible infection or specific interventions.

As well, a review of the signage outside of resident #017's room indicated that the resident had a different set of interventions to follow than what was specified by the line listing and registered staff.

During the same interview with RN #106 they verified that resident #017's specific interventions should have been included in the resident's plan of care. [s. 6. (10) (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 resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

During the initial tour of the home, Inspector #612 observed the following doors unlocked and unattended:

- Cleaning closet, room #114 which contained hazardous substances and;
- Soiled utility, room #137, which contained garbage and a machine to sterilize items.

Inspector #612 interviewed the home's AA who verified that the two doors should be locked at all times and residents should not have access to them. They stated that the door doesn't latch properly, and staff need to pull it hard to lock the door.

On a particular day, Inspector #609 observed the soiled utility room #137, unlocked and unattended.

On another day, Inspector #609 observed that the soiled utility room #137 was again, unlocked and unattended.

Inspector #609 interviewed the home's AA and they verified that the door to room #137 should be locked when not in use.

On a particular day, the door to the Administrator/DOC's office was unlocked, open and unattended.

Despite the the Administrator/DOC being aware one week previously of the door not locking after use, room #137 was found again, unlocked and unattended.

Inspector #612 interviewed the Administrator/DOC who stated that the door to the housekeeping closet, the soiled utility room and their office should be kept locked when unattended. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with prevailing practices, to minimize the risk to the resident.

Inspector #612 reviewed a CI report which described that on a particular day resident #010 had a fall which resulted in an injury. As a result of the fall, the home implemented a bed rail intervention for the resident.

During an interview with PSW #117 they stated that resident #010 had a device also applied to a bed rail.

The Inspector interviewed RN #105 and RPN #103 who stated that there was no bed system assessment for entrapment and that they only assessed the use of bed rails through a restraint assessment.

Inspector #612 interviewed the Administrator/DOC who they stated that they were not aware of the requirement to assess the resident as well as evaluate the resident's bed system for bed rail use. The Inspector referred the Administrator/DOC to the memo sent out from the Ministry of Health and Long- Term Care (MOHLTC) dated August21, 2012.

That memo was sent to all Long-Term Care (LTC) Home Administrators indicating that all LTC homes should use the Health Canada guidance document "Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" as a best practice document in their homes. This document referenced the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings" as a prevailing practice for assessing the use of bed rails.

The document indicated that automatic use of bed rails may pose unwarranted hazards to resident safety and an evaluation of the bed system was needed to assess the relative risk of using the bed rail. The document further indicated that the use of bed rails should also have been based on a resident's assessed needs, documented clearly and approved by the interdisciplinary team. [s. 15. (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 to ensure that where bed rails are used, the resident is assessed and his or her bed system evaluated in accordance with prevailing practices, to minimize the risk to the resident, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids, (a) labelled within 48 hours of admission and of acquiring, in the case of new items.

During the initial tour of the home, Inspector #612 observed in the first floor tub room, a used bottle of Nexus Shampoo, black comb and white soap bar unlabeled. In the second floor tub room, Inspector #612 observed a used pink loofa, hair brush and nail clippers all unlabeled.

On February 9, 2017, the Inspector interviewed the Administrator/DOC who stated that resident's personal items were to be labeled and not left in the tub rooms. [s. 37. (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 to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, (a) labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the food production system provided for standardized recipes for all menus.

Inspector #575 observed the dinner meal service on a particular day. The daily menu indicated that the first choice was cabbage rolls, buns, mashed potatoes, and vegetables; the second choice was a cheese and fruit plate. The first choice was available in regular, minced and pureed textures.

The Inspector asked Dietary Aide (DA) #116 if the alternative option was available in minced and pureed texture, DA #116 indicated that the alternative option was not available in minced or pureed textures, however, they could mince or puree upon request.

During an interview with the RD they stated that there were no standardized recipes for texture modified diets. The RD indicated that the diet textures were regular, mechanical soft, minced and puree and that all four diet textures should have had corresponding recipes.

During an interview with the FSM and the Dietary Assistant they verified that there were no standardized recipes for texture modified diets. They indicated that there were standardized recipes for the regular texture and the cooks were able to add thickener or blend to the required texture type. They indicated that the cooks would add the thickener according to visual appearance and also according to the thickener package directions.

During an interview with Cook #113 and #114, they indicated that they added thickener to entrees based on visual appearance and not on a standardized recipe. [s. 72. (2) (c)]

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 food production system provides for standardized recipes for all menus, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have received retraining annually related to the home's policy to promote zero tolerance of abuse and neglect of residents.

During an interview with the home's AA they indicated to Inspector #609 that all staff were required to perform retraining in the home's zero tolerance of abuse and neglect of residents policy in 2016.

During an interview with DA #120 they were asked what steps were required if they witnessed or suspected allegations of neglect of a resident? DA #120 indicated that they would intervene on behalf of the resident at the time of the incident but failed to indicate that they would report the incident to the home or to the Director.

A review of the home's staff list for 2016-2017 found 71 staff members who were actively working in the home during the 2016 calendar year.

A review of the home's annual retraining of staff on the zero tolerance of abuse and neglect of residents policy found 11 or 15 per cent of the staff did not complete the retraining for 2016, which included DA #120. [s. 76. (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 to ensure that all staff receive retraining annually related to the home's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances in the home were labelled properly and were kept inaccessible to residents at all times.

During the initial tour of the home, Inspector #612 observed that the housekeeping closet, room #114, was unlocked and unattended. The Inspector noted the following substances accessible in the room:

-Redi-Pro, which displayed a Workplace Hazardous Materials Information System (WHIMIS) symbol for Poisonous and Infectious Material (Class D) and Materials causing other toxic effects (Division 2-B Toxic Material) and;
-Reliable Exit All Purpose Neutral Cleaner, which was opened and had a WHIMIS symbol for Corrosive Material (Class E).

The Inspector interviewed the AA who stated that that door should be kept locked at all times.

The Inspector reviewed the home's policy titled, "Chemicals HSK", last reviewed August 2005, which stated that all chemicals were to be stored in locked storage rooms, and kept inaccessible to residents.

On February 9, 2017, the Inspector interviewed the Administrator/DOC who verified that the door to the housekeeping closet should be kept locked at all times and inaccessible to residents. [s. 91.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all hazardous substances in the home are labelled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

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

Inspector #575 reviewed a CI report which was submitted to the Director regarding an alleged incident of staff to resident neglect. The CI report described that on an identified day, PSW #112 reported to the Administrator/DOC that seven days previously, resident #009 was observed in bed with their incontinence pad soaked in urine. The CI report indicated that the resident's SDM was notified on a specific date.

The Inspector reviewed the home's internal investigation notes which indicated that the resident's SDM was notified of the alleged incident six days after the home was made aware of the allegations. The home's investigation substantiated the allegations of neglect and PSW #123 received disciplinary action.

During an interview with the Administrator/DOC they verified that resident #009's SDM was not notified of the alleged staff to resident neglect until six days after they became aware of the incident. [s. 97. (1) (a)]

2. A CI report was submitted to the Director which outlined allegations of staff to resident neglect of resident #016 on a particular day.

Inspector #609 reviewed the home’s internal investigation and found that three days later, PSW #122 reported to the Administrator/DOC that resident #016 was found in a brief without clothes on, incontinent of a large amount of urine, crying.

A review of the home’s policy titled “Zero Tolerance of Abuse and Neglect” last revised in June 2016 indicated that the SDM was to be immediately notified of allegations of abuse and neglect of a resident that resulted in injury, pain or distress.

During an interview with the Administrator/DOC they verified that a crying resident would have been considered in distress and the situation potentially detrimental to their well-being. The Administrator/DOC acknowledged that despite becoming aware of allegations of neglect of resident #016, they did not notify the resident’s SDM for over 24 hours. [s. 97. (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 to ensure that the resident's SDM and any other person specified by the resident are immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident' s health or well-being, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the analysis undertaken of every incident of abuse or neglect of a resident at the home were considered in the evaluation.

Inspector #609 reviewed the home's policy titled "Zero Tolerance of Abuse and Neglect" last revised in June 2016 which indicated that the number of incidents of alleged and proven resident abuse/neglect, reoccurrences and trends were to be assessed in the annual evaluation of the prevention of abuse and neglect program.

During an interview with the Administrator/DOC on February 7, 2017, a review of the home's 2016 Abuse program evaluation was conducted. The review consisted of training and retraining of staff as well an abuse policy review. The Administrator/DOC indicated that there was no other documentation to support that the evaluation occurred. What was provided to the inspector did not contain any analysis of any incident of alleged or proven abuse or neglect of a resident. [s. 99. (c)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following requirements were met where a resident was being restrained by a physical device under section 31 of the LTCH Act, 2007, that staff only apply the physical device that was ordered or approved by a physician or registered nurse in the extended class (RNEC).

Inspector #612 reviewed a CI report which indicated that resident #010 experienced a fall on a particular day, which resulted in an injury.

Inspector #612 reviewed resident #010's health care records and noted that the resident had a previous fall and that after this fall, a restraint was implemented. Consent for the restraint was obtained from the SDM one day after the restraint was implemented.

The Inspector reviewed the physicians order section in the resident's paper chart, and noted that the order for the restraint was not obtained until five days after implementing the restraint.

The Inspector reviewed the Restraint Observation Form which stated that there "must be a physician's order". It identified the date the physician ordered the restraint five days after implementing the restraint.

The Inspector reviewed resident #010's chart with RN #105. The RN stated that they do not always obtain an order from the physician prior to applying a restraint, and they will note it for the physician in the Doctor's Communications book to order the next time they were in the building.

The Inspector reviewed the home's policy titled, "Restraints: Physical & Chemical - VII-55," last reviewed March 2016. The policy stated that a physician or RNEC, in collaboration with the interdisciplinary team may prescribe a physical restraint. The prescribing clinician should ensure that alternatives had been considered and informed consent was obtained for the treatment from the resident and/or the SDM.

The Inspector interviewed the Administrator/DOC who stated that staff were to complete all the required restraint assessments, obtain a physician order and resident/SDM consent prior to application of the restraint. [s. 110. (2) 1.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

Inspector #612 observed the medication pass on a particular day. The Inspector noted that when RPN #108 entered resident #017's room to provide medications the medication cart was left unlocked in the hallway. The medication cart was not within RPN #108's line of sight while they were administering medications to resident #017.

On a subsequent observation, Inspector #612 observed that the medication cart, which contained controlled substances, was left unlocked in the nurses' station and the door to the nurse's station was left open. The Inspector was unable to find RPN #108 in the nurses' station or the dining room. Five minutes later, RPN #108 returned to the dining room and stated that they were down the hallway bringing resident #017 food in their room. Inspector #612 brought RPN #108 to the nurses' station where the medication cart was left unlocked. RPN #108 verified that the medication cart should be locked when not in sight of the registered staff member.

The Inspector interviewed RN #106 and RPN #103 who stated that the medication cart should be locked when it was not in direct sight of the registered staff member or when it was kept at the nurses' station.

The Inspector reviewed the home's policy titled, "Medication Cart - 3.2.1", last revised January 17, 2011, which stated that nursing staff shall ensure that the medication cart was locked at all times, unless under the direct supervision of the staff administering medications.

Inspector #612 interviewed the Administrator/DOC who stated that the medication cart should be locked when left at the nurses' station or not in the line of sight of the registered staff member. [s. 129. (1) (a)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the Infection Prevention and Control (IPAC) program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

During an interview with the Administrative Assistant (AA) they indicated to Inspector #609 that the home was had recently been lifted out of an infectious outbreak.

During the course of the inspection non-compliances related to the home's IPAC program were noted related to infection control policies and procedures as well as infection control care planning.

A review of the home's policy titled "Infection Prevention and Control (IPAC) Program" was found to be last revised three years ago in January 2014. The policy indicated that the program should have been reviewed and updated at least annually.

During an interview with the Administrator/DOC they were unable to provide any annual evaluation of the home's IPAC program for 2016. The Administrator/DOC stated that there has not been an annual evaluation of the program for years and that the entire program needed "to be overhauled". [s. 229. (2) (d)]

Issued on this 20th day of July, 2017

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHAD CAMPS (609), LINDSAY DYRDA (575), SARAH CHARETTE (612)
Inspection No. / No de l'inspection :	2017_638609_0004
Log No. / Registre no:	001689-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 21, 2017
Licensee / Titulaire de permis :	ST. JOSEPH'S GENERAL HOSPITAL ELLIOT LAKE 70 Spine Road, ELLIOT LAKE, ON, P5A-1X2
LTC Home / Foyer de SLD :	ST. JOSEPH'S MANOR 70 SPINE ROAD, ELLIOT LAKE, ON, P5A-1X2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cynthia Farquhar

To ST. JOSEPH'S GENERAL HOSPITAL ELLIOT LAKE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The licensee shall:

a) Ensure that any person who has reasonable grounds to suspect that abuse or neglect of a resident by the licensee or staff immediately reports the suspicion and the information upon which it is based to the Director.

b) Ensure that the Administrator/DOC is retrained in the home's zero tolerance of abuse and neglect of residents policy and procedure.

Grounds / Motifs :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #575 reviewed a CI report submitted to the Director regarding an alleged incident of staff to resident neglect. The CI report described that on an identified day, PSW #112 reported to the Administrator/DOC that resident #009 was observed in bed with their incontinence pad soaked in urine. PSW #112 reported this to RPN #108 on the same day.

The home's internal investigation substantiated the allegations of neglect and PSW #123 received disciplinary action.

During an interview with the Administrator/DOC they verified that the incident was not reported to the Director immediately when they became aware of the incident on the identified day. They verified they did not notify the Director until six days after becoming aware of the incident. (575)

2. A Critical Incident (CI) report was submitted to the Director which outlined allegations that resident #012 was sexually abused and neglected by PSW #101.

Inspector #609 reviewed resident #012's progress notes and found that on an identified day, the resident told RPN #100 that PSW #101 had neglected them for the past five days.

During an interview with RPN #100 they verified that they had written the progress note outlining the allegations of neglect after they had informed the Administrator/DOC on the identified day.

A review of the home's policy titled "Zero Tolerance of Abuse and Neglect" last revised in June 2016 indicated that certain persons, including staff members were required to make immediate reports to the Director where there was a reasonable suspicion that neglect of a resident by staff that resulted in harm or risk of harm occurred or may occur.

A review of the CI reports submitted to the Director for 2016 and 2017 from the home found no report of the allegations of neglect of resident #012 by PSW #101 until two days after the home was made aware of additional allegations of sexual abuse.

During an interview with the Administrator/DOC The Administrator/DOC further verified that they became aware of the allegations of neglect on the identified day and did not report them to the Director until two days later when additional allegations of sexual abuse were reported by resident #012.

The scope of this issue was determined to have been a pattern of late or no reporting of allegations of witnessed or suspected abuse and neglect of

residents to the Director. There was a previous Compliance Order (CO) issued related to this provision during inspection #2015_331595_0003 on May 29, 2015. Another CO with an accompanying Director's Referral (DR) was issued during inspection #2015_264609_0053 on November 30, 2015. This was followed by a Voluntary Plan of Correction (VPC) during inspection #2016_463616_0004 on March 21, 2016 and then on September 28, 2016, during inspection #2016_269627_0015 a Written Notification (WN) was issued. The severity was determined to have been potential for actual harm to the health, safety and well-being of residents when witnessed or suspected abuse and neglect are late reported or not reported at all to the Director. (609)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 28, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall:

a) Ensure that where the Act or the Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that it is complied with.

b) Specifically ensure that all staff of the home complies with and implements their responsibilities related to the home's policies titled:

"Infection Prevention and Control (IPAC) Program" last revised January 2014;
"Care Plan Development and Monitoring- III- 10" last reviewed May 2008; and
"Surplus Prescribed Drug Sheet- 3.3.7" last revised January 2011.

c) Conduct a review of all residents in the home to ensure that any resident requiring isolation precautions has a plan of care in place that reflects the type of precautions required and associated interventions.

d) Ensure that all staff, residents, and visitors are aware of any required infection control precautions and associated interventions within the home.

Grounds / Motifs :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

a) During the course of the inspection, Inspector #609 observed that the doors to the rooms of resident #004, #013, #014 and #015 indicated that the residents were on isolation precautions. Three of the four or 75 per cent of the rooms had no indication as to what type of isolation precautions the resident was on, what Personal Protective Equipment (PPE) was required or any other instructions to assist staff, residents or visitors with infection control precautions.

Inspector #609 reviewed the home's policy titled "Infection Prevention and Control (IPAC) Program" last revised January 2014, which outlined that signage indicating the infection control precautions to be used should be visibly displayed. Only one of four or 25 per cent of the resident doors had signage displayed.

During an interview the Chief Nursing Officer (CNO) they verified that the infection prevention and control policies of the home were to be complied with, and that 75 per cent of the residents observed did not have adequate signage to instruct staff, residents or visitors on infection precautions.

b) During an interview with RPN #103 they acknowledged that three of the rooms observed did not have visibly displayed infection control precautions, but that this information would be found in each of the residents' plan of care.

A review of the current plan of care for all four residents #004, #013, #014 and #015 failed to document what type of isolation precautions the residents were on, or precautions to be used to protect staff, residents and visitors.

A review of the home's policy titled "Care Plan Development and Monitoring-III-10" last reviewed May 2008 indicated that an infection was a change in the resident's condition that warranted immediate change in the resident's care plan. The policy further outlined that the care plan would identify preventative aspects of care, appropriate actions and who was to carry out those actions.

During an interview with the CNO they verified that if a resident was on isolation precautions for any reason, the plan of care was to be updated to instruct staff and subsequently residents and visitors on the home's infection control precautions. (609)

2. During the entrance conference with the Administrator/DOC they stated to

Inspector #609 that controlled substances for destruction were stored in a locked cabinet drawer in the desk of their office.

During the tour of the home Inspector #612 noted that the Administrator/DOC's office was not locked.

On a particular day, Inspector #612 observed the Administrator/DOC's office door opened for 15 minutes prior to the DOC returning.

Ontario Regulation (O. Reg) 79/20 s. 136 (2) 2. states that the drug destruction policy must provide for the following:

Any controlled substance that was to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurred.

The Inspector reviewed the home's policy titled, "Surplus Prescribed Drug Sheet - 3.3.7", last revised January 17, 2011, which stated that surplus narcotics and controlled drugs shall be stored in a double locked storage area specifically designated for that purpose with their Narcotic and Controlled Drug Count sheet attached. Only the Director of Nursing and Personal Care (or designee) and the Consultant Pharmacist shall have a key to this area.

During an interview with the Administrator/DOC they verified that they stored discontinued controlled substances in their office for disposal, had left their door open when it should have been closed and locked. They stated that the Administrative Assistant has a key to open their door but not the filing cabinet where the discontinued controlled substances were kept.

The scope of this issue was determined to have been widespread non-compliance with the home's own policies and procedures. There was a previous VPC issued related to this provision during inspection #2014_332575_0015 on December 12, 2014. Another VPC was issued during inspection #2015_336620_0007 on December 2, 2015. This was followed again by a VPC during inspection 2016_463616_0004 on March 21, 2016. The severity was determined to have been potential for actual harm to the health, safety and well-being of residents when staff continue to not comply with the home's policies and procedures. (612)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2017

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) appropriate action is taken in response to every such incident; and
(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).

Order / Ordre :

The licensee shall:

a) Ensure that 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.

b) Ensure that appropriate action is taken in response to every such incident.

Grounds / Motifs :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that was reported was immediately investigated.

A CI report was submitted to the Director which outlined allegations that resident #012 was sexually abused and neglected by PSW #101.

The LTCH Act, 2007, defines neglect as the failure to provide a resident with the

treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Inspector #609 reviewed resident #012's progress notes and found that on an identified day, the resident told RPN #100 that PSW #101 neglected them for the past five days.

During an interview with RPN #100 they verified that they had written the progress note outlining the allegations of neglect after they had informed the Administrator/DOC on the same identified day.

During an interview with the Administrator/DOC they verified that they became aware of the allegations of neglect on the identified day.

A review of the home's policy titled "Zero Tolerance of Abuse and Neglect" last revised in June 2016 indicated that the home was to immediately investigate reports of abuse and neglect by residents and staff and that if staff were involved in the incident, they were to be dismissed from work pending the outcome of the investigation. The policy also outlined that records were to be kept of the investigation.

The Administrator/DOC failed to produce any documentation to support that they immediately investigated resident #012's allegations of neglect by PSW #101 when they became aware of the allegations on the identified day.

During the interview with the Administrator/DOC they verified that they did not initiate an investigation into the allegations of neglect until two days after RPN #100 made the Administrator/DOC aware. (609)

2. The licensee has failed to ensure that appropriate action was taken in response to every alleged, suspected or witnessed incident of abuse and neglect of a resident that the licensee knew of.

Inspector #575 reviewed a CI report submitted to the Director regarding an alleged incident of staff to resident neglect. The CI report described that on an identified day PSW #112 reported to the Administrator/DOC that resident #009 was observed in bed with their incontinence pad soaked in urine.

The CI report indicated that the Administrator/DOC met with PSW #123 six days later and during that meeting, PSW #123 was relieved from work until the investigation was completed.

Inspector #575 reviewed the staffing schedule and noted that PSW #123 worked four day shifts between when the home became aware of the allegations and PSW #123's dismissal.

The Inspector reviewed the PSW's personnel file which identified performance concerns over a specified period of time.

During an interview with the Administrator/DOC, they verified that PSW #123 was not relieved from duties until six days after becoming aware of the allegations because they wanted further proof before relieving PSW #123 of their duties.

The home's investigation substantiated the allegations of neglect and PSW #123 received disciplinary action.

The scope of this issue was determined to have been a pattern of lack of immediate investigation as well as lack of appropriate action taken in response to allegations of abuse and neglect of residents. There was a previous VPC issued related to this provision during inspection #2015_331595_0003 on May 29, 2015. This was followed by a CO issued during inspection #2016_463616_0004 on March 21, 2016. The severity was determined to have been actual harm to the health, safety and well-being which included but was not limited to resident #012 and #009. (575)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 28, 2017

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall:

a) Ensure that all staff comply with the home's zero tolerance of abuse and neglect of residents policy.

b) Specifically ensure that staff immediately report any witnessed or suspected abuse or neglect of a resident to the home.

Grounds / Motifs :

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

Inspector #575 reviewed a CI report submitted to the Director regarding an alleged incident of staff to resident neglect. The CI report described that on an identified day PSW #112 reported to the Administrator/DOC that seven days previously, resident #009 was observed in bed with their incontinence pad soaked in urine. PSW #112 reported this to RPN #108 on the same day.

Ontario Regulation (O. Reg.) 79/10, s. 5 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and included inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

a) The home's internal investigation substantiated the allegations of neglect and PSW #123 received disciplinary action. The investigation indicated that resident

#009 was totally dependent for all continence care and positioning and that PSW #123 neglected to provide the resident with care and assistance. The investigation also uncovered that multiple residents were neglected during PSW #123's shift. The home's investigation substantiated the allegations of neglect and PSW #123 received disciplinary action.

A review of PSW #123's human resources file identified performance concerns over a specified period of time.

b) During an interview with the Administrator/DOC they verified that the incident was not reported to the Director immediately. They stated that RPN #108 should have reported the allegations to their supervisor when they became aware of the neglect on November 3, 2016. (609)

2. A CI report was submitted to the Director which outlined allegations of staff to resident neglect of resident #016 on an identified day.

Inspector #609 reviewed the home's internal investigation found that three days after the incident, PSW #122 reported to the Administrator/DOC that resident #016 was found in a brief without clothes on, incontinent of a large amount of urine and crying.

During an interview with the Administrator/DOC they verified that PSW #122 waited three days before notifying the home of the allegations of neglect of resident #016. The Administrator/DOC indicated that all allegations of witnessed or suspected abuse and neglect were to be immediately reported to the home. (609)

3. A CI report was submitted to the Director which outlined allegations by resident #012 that they were sexually abused by PSW #101 on an identified day, several weeks previous to the CI submission.

Inspector #609 reviewed the home's internal investigation of the incident which found that PSW #104 had witnessed PSW #101 sexually abusing resident #012. PSW #104 did not report the witnessed abuse to the home until several weeks later.

The LCTH Act 2007, defines sexual abuse 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.

During an interview with resident #012 they verified that PSW #101 sexually abused them at least three times, without requesting or consenting to the act.

During an interview with PSW #104 they verified that they were present and working on the identified day and witnessed PSW #101 sexually abuse resident #012. PSW #104 verified that they did not comply with the home's Zero Tolerance of Abuse and Neglect policy when they did not immediately report the witnessed sexual abuse to registered staff.

Inspector #609 reviewed the home's policy titled "Zero Tolerance of Abuse and Neglect" last revised June 2016, which indicated that all residents had the right to live in a home environment that treated them with dignity, respect and was free from any form of abuse or neglect at all times, and in all circumstances. The policy further indicated that anyone who witnessed, suspected or alleged abuse or neglect of a resident were to immediately report the information to the home and staff were to follow a reporting chain of command (PSW to RPN to RN to Administrator/DOC) in order to report any witnessed, suspected, or alleged abuse or neglect of a resident to a supervisor immediately.

During an interview with the Administrator/DOC they verified that PSW #104 witnessed abuse to resident #012 by PSW #101 and did not make the home aware of it until 39 days later.

The scope of this issue was determined to have been a pattern of staff of the home not complying with the home's zero tolerance of abuse and neglect of residents policy and procedure. There was a previous WN issued related to this provision during inspection #2015_331595_0003 on May 29, 2015. This was followed by a VPC issued during inspection #2016_282543_0006 on May 5, 2016 and an additional VPC during inspection #2016_463616_0004 on March 21, 2016. The severity was determined to have been actual harm to the health, safety and well-being of resident #009, #012 and #016 as well as all other residents of the home when staff continuously do not comply with the home's abuse policy. (609)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 19, 2017

Order # / Ordre no : 005

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 that all residents of the home are protected from abuse by anyone and not neglected by the licensee or staff.

b) Ensure that when a staff member has substantiated allegations of abuse or neglect of a resident, that all residents are protected through corrective actions, including but not limited to monitoring, retraining and evaluating of the staff member's performance. Any corrective actions taken are to be documented.

c) Ensure that the Administrator/DOC or designate conducts a comprehensive investigation of allegations of abuse or neglect of a resident including but not limited to interviewing all those involved in the incident prior to closing the investigation.

d) Ensure that no staff of the home revises a resident's plan of care without the full participation of the resident and/or the resident's SDM.

Grounds / Motifs :

1. The licensee has failed to ensure that all residents were protected from abuse by anyone and were not neglected by the licensee or staff.

A CI report was submitted to the Director which outlined allegations that resident #012 was sexually abused by PSW #101.

Inspector #609 reviewed the home's internal investigation of the incident which found that PSW #104 had witnessed PSW #101 sexually abuse resident #012

on an identified day.

During an interview with PSW #104 they verified that they were present and working on the identified day and saw PSW #101 sexually abuse resident #012.

During an interview with resident #012 they verified that PSW #101 sexually abused them.

Inspector #609 reviewed the human resources file for PSW #101 which outlined PSW #101's documented history of disciplinary actions related to their work performance.

a) During an interview with the Administrator/DOC a review of PSW #101's human resources file was conducted. The Administrator/DOC indicated they had not reviewed PSW #101's human resources file following allegations of sexual abuse that were brought forward regarding PSW #101, despite PSW #101's history of performance concerns in the home.

b) During an interview with RPN #100 they verified that they had written the progress note outlining the allegations of neglect after they had informed the Administrator/DOC on the identified day.

During an interview with the Administrator/DOC they verified that they were notified of allegations of neglect of a resident by PSW #101 on the identified day.

A review of the home's policy titled "Zero Tolerance of Abuse and Neglect" last revised in June 2016 indicated if staff were involved in the incident they must be dismissed from work, pending the outcome of the investigation.

A review of the schedule for PSW #101 found that after the home was made aware of allegations of neglect, PSW #101 was permitted to continue their shift on the identified day as well as work two additional shifts before PSW #101 was dismissed from the home following additional sexual abuse allegations made two days later.

c) During an interview with the Administrator/DOC a review of the home's internal investigation of the CI was conducted. The Administrator/DOC verified they closed the home's internal investigation of the sexual abuse allegations,

finding no evidence that abuse occurred.

A review of the home's policy titled "Zero Tolerance of Abuse and Neglect" last revised in June 2016 indicated that the Administrator/DOC was to fully investigate incidents and complete the documentation of all known details of the reported incident.

The Administrator/DOC told the inspector that they had not interviewed all PSWs involved prior to closing the internal investigation and had they done this they would have verified from witnesses, PSW #101's sexually abusive conduct toward resident #012 on the identified day.

d) Additional non-compliances were found related to the licensee's failure to protect resident #012 from abuse as follows:

-Written Notification (WN) #1 LTCHA, 2007, s. 24. (1). Whereby the Administrator/DOC did not immediately report allegations of abuse of the resident to the Director;
-WN #4 LTCHA, 2007, s. 20. (1). Whereby PSW #104 did not immediately report to the home, the witnessed abuse of the resident by PSW #101 and PSW #101 did not follow the licensee's abuse policy and sexually abused resident #012;
-WN #5 LTCHA, 2007, s. 3. (1) 11. i. Whereby the Administrator/DOC changed the resident's plan of care without consent; as well as
-WN #15 O. Reg. 79/10, s. 99. Whereby analyses of abuse and neglect incidents were not a part of the home's annual abuse program evaluation.

The scope of this issue was determined to have been a pattern of actions and inactions by the licensee and staff of the home that did not protect resident #012 from the abusive conduct of PSW #101. There was a previous CO issued related to this provision during inspection #2015_331595_0003 on May 29, 2015. This was followed by another CO with an accompanying DR issued during inspection #2015_264609_0053 on November 30, 2015. On March 21, 2016, an additional VPC was issued during inspection #2016_463616_0004. Then during inspection #2016_282543_0006 a CO was issued on May 5, 2016. The severity was determined to have been actual harm to the health, safety and well-being of resident #012 as well as all other residents in the home. (609)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 19, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 21st day of June, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Chad Camps

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