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 # / No de registre	Type of Inspection / Genre d'inspection
Jul 25, 2017	2017_566669_0005	003055-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF ESSEX
360 Fairview Ave West ESSEX ON N8M 1Y6

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

SUN PARLOR HOME FOR SENIOR CITIZENS
175 TALBOT STREET EAST LEAMINGTON ON N8H 1L9

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

ANDREA DIMENNA (669), ALICIA MARLATT (590), ALISON FALKINGHAM (518), CAROLEE MILLINER (144)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 6, 7, 8, 9, 10, 13, 14, 15 and 16, 2017.

The following critical incidents were completed with this inspection:
M579-000002-17/Log #001577-17, related to alleged abuse
M579-000023-16/Log #024414-16, related to alleged abuse
M579-000007-16/Log #008663-16, related to alleged abuse
M579-000029-14/Log #009195-14, related to improper/incompetent treatment of a resident
M579-000027-16/Log #029973-16, related to alleged abuse
M579-000014-13/Log #029927-16, related to falls
M579-000020-16/Log #020490-16, related to alleged abuse
M579-000013-17/Log #006090-17, related to alleged abuse

The following complaint was completed with this inspection:
IL-49012-LO/Log# 002079-17, related to alleged abuse

During the course of the inspection, the inspector(s) spoke with 40+ residents, a representative of Family Council, a representative of Residents' Council, Administrator, Director of Nursing (DON), Nutrition Manager, Manager of Life Enrichment, Manager of Building Services, Manager of Health and Safety and Staff Development, an Assistant Director of Nursing (ADON), eight Registered Nurses (RNs), 10 Registered Practical Nurses (RPNs), one Cook/Food Service Worker, two Housekeeping Aides, two Life Enrichment Aides, two Health Care Aides (HCAs), and 17 Personal Support Workers (PSWs).

During the course of the inspection, the inspectors: toured all resident home areas; reviewed clinical records, posting of required information, infection prevention and control practices, and relevant policies and procedures; and observed general maintenance and cleanliness, dining service, the provision of care to residents, medication administration, and staff-to-resident interactions.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to protect residents from abuse by anyone and from neglect by the licensee or staff.

This inspection was conducted as a result of two Critical Incident System (CIS) reports, both related to alleged resident-to-resident abuse.

Section 2(1) of Ontario Regulation 79/10 defines sexual abuse as "any consensual or nonconsensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member" or "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by person other than a licensee or staff member."

The home's policy, Zero Tolerance of Abuse and Neglect0104-08, was last revised August 21, 2013, and stated:
The Sun Parlor Home has a "zero tolerance" of abusive behaviour which is strictly enforced. Any employee or volunteer will be disciplined up to and including discharge for any confirmed incident of abuse.
Part A:
Definition of Abuse and Neglect
1. This policy uses the definition of "abuse" and "neglect" from the Long-Term Care Homes Act, 2007. The terms "abuse" and "neglect" in this policy have the same meaning as those terms in the LTCHA.

DON provided a copy of the home's draft policy which addressed non-consensual touching and behaviours between residents, and explained that this policy was still in draft form and had not been disseminated to staff.

A review of one of the identified resident's clinical record revealed that on eight specified dates, the identified resident engaged in potentially non-consensual touching or behaviours with two other residents.

A physician’s note from a specified date, stated that the identified resident had specific behaviours directed at staff and residents, and that a specific intervention had been initiated.

A physician assessment on a specified date, noted that new treatment changes had helped the identified resident’s behaviours.

During interviews, two PSWs, two RNs and one RPN all stated that the behaviors exhibited by the identified resident were inappropriate, were abusive, were not invited or enjoyed by the two affected residents, and that both affected residents would not be able

to provide consent based on their cognitive abilities.

Administrator acknowledged that the identified resident’s behaviour was abusive and the home's expectation was that all residents were protected from abuse by anyone.

The licensee failed to ensure that two affected residents were protected from abuse by the identified resident. [s. 19. (1)]

2. This inspection was conducted as a result of a Complaint report related an identified resident's behaviours.

The identified resident had a Cognitive Performance Scale (CPS) score of zero, and the affected resident had a CPS score of three.

The home's policy, Zero Tolerance of Abuse and Neglect0104-08, was last revised August 21, 2013, and stated:
The Sun Parlor Home has a "zero tolerance" of abusive behaviour which is strictly enforced. Any employee or volunteer will be disciplined up to and including discharge for any confirmed incident of abuse.
Part A:
Definition of Abuse and Neglect
1. This policy uses the definition of "abuse" and "neglect" from the Long-Term Care Homes Act, 2007. The terms "abuse" and "neglect" in this policy have the same meaning as those terms in the LTCHA.

A review of the identified resident’s clinical records included documentation stating the identified resident and the affected resident were witnessed engaging in specific behaviours on a specified date, in the identified resident’s room. The documentation stated that staff explained to the identified resident that the affected resident's ability to consent was unclear due to their cognitive state, and the identified resident’s vocalized that their actions were wrong. The DON was called and the affected resident was given a specific care intervention to ensure their safety.

A progress note on a specific date stated that staff were looking for the affected resident and suspected that they were in the identified resident’s room. The note continued that the identified resident’s door was closed and staff members felt they had to respect the identified resident’s privacy, so they felt they were unable to check the room for the affected resident.

Progress notes were reviewed for both the identified resident and the affected resident, and included documented incidents of both residents alone in a room together on four separate occasions.

The affected resident's chart was reviewed and it was noted that the resident did not have an appreciation for consequences, had impaired cognitive skills for daily decision-making, and had periods of altered perception or awareness.

The identified resident recounted that they intended to engage in specific behaviours with the affected resident. The identified resident reported that they attempted to speak with the affected resident regarding the inappropriateness of the specific behaviours but the affected resident could not comprehend what the identified resident was saying.

A PSW was interviewed and stated that the affected resident was cognitively impaired and that, overall, the resident could not make rational decisions. The PSW stated that they had not personally witnessed any incidents, but they were aware that the identified resident had engaged in specific behaviours with the affected resident.

Two registered staff members were interviewed and explained that the affected resident was often disoriented, confused and needed direction. One of the staff members stated that the affected resident was unable of consenting to specific behaviours. The other staff member acknowledged that they felt the affected resident's safety was at risk was they were in a room alone with the identified resident if the residents were engaging in high-risk behaviours.

DON was interviewed and acknowledged that the witnessed incident between the identified resident and the affected resident on a specific date should have been considered suspected abuse. DON stated that there had been no further incidents between the two residents, but shared that staff still felt incidents were occurring. DON stated that when the identified resident and the affected resident were alone in a room together, the affected resident's safety may be at risk.

Administrator told an inspector that the home's expectation was that all residents were protected from abuse by anyone.
The licensee failed to ensure that affected resident was protected from abuse by the identified resident.
The severity of this issue was determined to be a level three as there was actual harm or

risk, and the scope was widespread during the course of this inspection. The home's compliance history was reviewed and this legislation was issued on January 11, 2016 as a Compliance Order (CO) in a complaint inspection, and complied with on March 21, 2016. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 knew of, or that was reported to the licensee was 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.

This inspection was conducted as a result of two CIS reports, both related to alleged abuse by an identified resident.

The home's policy, Zero Tolerance of Abuse and Neglect#0104-08, last revised August 21, 2013, stated:
Part A: Investigation and Reporting of Abuse and Neglect
1. Staff and management must report all alleged, suspected or witnessed incidents of
(a) Abuse of a resident by anyone, and
(b) Neglect of a resident by a staff member of the home.
3. The home will immediately investigate reports by staff under this policy, and third party reports of abuse or neglect, in accordance with the investigated procedures in Part B Part Two: Reporting and Notifications.

A review of one of the identified resident's clinical record revealed that on five specified dates, the identified resident engaged in potentially non-consensual touching or behaviours with two other residents; a record review showed no documentation to support that any of five incidents were immediately investigated by the home.

During interviews, two PSWs, two RNs, an RPN, DON, and Administrator all stated that the behaviors exhibited by the identified resident were inappropriate, were abusive and should have been investigated by the management team.

The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone was immediately investigated.

The severity of the issue was determined to be a level three as there was actual harm or risk, and the scope was widespread during the course of this inspection. The home's compliance history was reviewed and there was no related non-compliance in the last three years. [s. 23. (1) (a)]

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. 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 any of the following had occurred or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

This inspection was conducted as a result of two CIS reports, both related to alleged abuse by an identified resident.

The home's policy, Zero Tolerance of Abuse and Neglect#0104-08, last revised August 21, 2013, stated:
Part A: Investigation and Reporting of Abuse and Neglect
1. Staff and management must report all alleged, suspected or witnessed incidents of
(a) Abuse of a resident by anyone, and

(b) Neglect of a resident by a staff member of the home.
Part A: Mandatory Reporting under the LTCHA
Section 24(1) of the LTCHA requires certain persons, including the home and certain staff members, to make immediate reports to the Director where there is a reasonable suspicion that certain incidents occurred or may occur. Staff should immediately report under the home's staff reporting policy any incidents that may lead to a mandatory report under section 24(1). Staff should also understand that it is an offence under the LTCHA to discourage or suppress a mandatory report.
Part B: Procedures
Section Two: Reporting and Notifications about Incidents of Abuse or Neglect Reporting Notifications:
All incidents of physical abuse that cause physical injury, and non-consensual sexual behaviour must be reported to the Ministry of Health and Long-Term Care (MOHLTC).
Section Three: Actions to be taken by staff role and responsibilities
Administrator or Designate:
The Administrator is accountable for overseeing that the proper reporting to MOHLTC has been undertaken.

A review of one of the identified resident's clinical record revealed that on five specified dates, the identified resident engaged in potentially non-consensual touching or behaviours with two other residents, and none of the five incidents of suspected abuse were reported to the MOHLTC.

During interviews, two PSWs, two RNs, and one RPN all stated that the behaviors exhibited by the identified resident were inappropriate, were abusive and had been going on for a long period of time.

During an interview, DON and Administrator stated that the aforementioned incidents were abusive in nature and should have been reported to the MOHLTC.

2. This inspection was conducted as a result of a Complaint report related an identified resident's behaviours.

A review of the identified resident’s clinical records included documentation stating the identified resident and the affected resident were witnessed engaging in specific behaviours on a specified date, in the identified resident’s room. The documentation stated that staff explained to the identified resident that the affected resident's ability to consent was unclear due to their cognitive state, and the identified resident’s vocalized

that their actions were wrong. The documentation continued that the affected resident denied any pain, injury, or complaints, and that DON was called and that the affected resident was given a specific care intervention to ensure their safety.

The home's policy, Zero Tolerance of Abuse and Neglect#0104-08, last revised August 21, 2013, stated:
Part A: Investigation and Reporting of Abuse and Neglect
1. Staff and management must report all alleged, suspected or witnessed incidents of
(a) Abuse of a resident by anyone, and
(b) Neglect of a resident by a staff member of the home.
Part A: Mandatory Reporting under the LTCHA
Section 24(1) of the LTCHA requires certain persons, including the home and certain staff members, to make immediate reports to the Director where there is a reasonable suspicion that certain incidents occurred or may occur. Staff should immediately report under the home's staff reporting policy any incidents that may lead to a mandatory report under section 24(1). Staff should also understand that it is an offence under the LTCHA to discourage or suppress a mandatory report.
Part B: Procedures
Section Two: Reporting and Notifications about Incidents of Abuse or Neglect Reporting Notifications:
All incidents of physical abuse that cause physical injury, and non-consensual sexual behaviour must be reported to the MOHLTC.
Section Three: Actions to be taken by staff role and responsibilities
Administrator or Designate:
The Administrator is accountable for overseeing that the proper reporting to MOHLTC has been undertaken.

The identified resident was interviewed and recounted that on a specified date, they intended to engage in specific behaviours with the affected resident, but did not because staff entered the room.

During interviews, an RN and DON explained that a nurse manager or management was responsible for calling the MOHLTC’s after-hours line and completing critical incident reports after incidents of suspected, alleged or witnessed abuse.

DON was interviewed and acknowledged that the witnessed incident between the identified resident and the affected resident on a specific date should have been considered suspected abuse and should have been reported to the MOHLTC.

The licensee failed to ensure that a person who had reasonable grounds to suspect abuse of the affected residents by the identified resident immediately reported the suspicion and the information upon which it was based to the Director.

The severity of this issue was determined to be a level three as there was actual harm or risk, and the scope was widespread during the course of this inspection. The home's compliance history was reviewed and this legislation was issued on November 26, 2014, as a Written Notification (WN) in critical incident inspection. [s. 24. (1)]

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

During the Resident Quality Inspection, a resident was observed on three separate occasions using a mobility device.

The home’s policy related to a specific intervention included directions for registered staff to initiate a schedule for residents who were at risk and to document the completion of specific intervention in Point of Care (POC) located within the Point Click Care (PCC). The policy further identified that a resident was at risk if they were unable to carry out the specific intervention themselves and/or if they scored high-risk on a specific assessment.

The clinical record for the resident stated the resident was dependent on staff for the specific intervention. The clinical record further stated the specific assessment completed for the resident on a specified date concluded the resident was at high risk.

A PSW, HCA, and RN all stated that the identified resident received the specific intervention as per the schedule and that each task was documented in POC. The RN accessed the POC module to display the documentation, and there was no documentation related to the specific intervention being provided for the resident.

DON reviewed the POC module and acknowledged that it did not include documentation related to the resident receiving the specific intervention over a specified period of time. DON said that the specific intervention for the resident should have been documented in POC.

The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

The severity of this issue was determined to be a level two as there was minimal harm or potential for actual harm, and the scope was isolated during the course of this inspection. The home's compliance history was reviewed and this legislation was issued on March 9, 2016, as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection, and it was issued on February 3, 2015, as a Compliance Order (CO) in a Resident Quality Inspection, and complied with May 27, 2015. [s. 6. (9) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the provision of care set out in the plan of care is documented, to be implemented voluntarily.

WN #5: 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 evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

A resident's bed was observed in stage one of this Resident Quality Inspection to have two half rails elevated at the head of the bed.

Review of the home's document, Bed System Safety and Entrapment Prevention Program, dated April 1, 2015, stated the following:
a) To ensure that any decision to utilize or remove rails occurs within the framework of a documented individual resident assessment.
b) Each resident must have a formal bed rail risk assessment on admission and be reassessed on readmission, at significant condition changes and following any incident

related to safety in bed.
c) If a bed rail of any size is used for the purpose of assisting a resident with a routine of activity of daily living (such as turning themselves independently), the device is considered to be a Personal Assistance Services Device (PASD).
d) Evaluation is needed to assess the relative risk of using the bed rail compared with not using it for an individual resident.
e) Decisions to use or to discontinue the use of a bed rail should be made in the context of an individualized resident assessment using an interdisciplinary team with input from the resident and family or the resident's legal guardian.
f) Use of bed rails should be based on the resident's assessed medical needs and should be documented clearly and approved by the interdisciplinary team.
g) Re-assess the resident's needs and re-evaluate the equipment if an episode of entrapment or near-entrapment occurs, with or without serious injury. This should be done immediately because fatal 'repeat' events can occur within minutes of the first episode.

A review of the resident's progress notes included an incident on a specified date where the resident’s safety was at risk and sent to hospital for assessment. The resident did not sustain any injuries.

A resident-specific assessment was unable to be located for the use of bed rails in the resident's documentation.

In an interview with the resident, they shared that they used the side rails at night when in bed to help them turn.

Manager of Building Services (MBS) was interviewed and shared that the nursing staff was responsible for completing the resident-specific assessments to determine the need for side rails. MBS stated that they were responsible for ensuring the bed system entrapment assessments were all completed and produced evidence that the resident's bed system had passed an entrapment assessment on a specified date.

DON was interviewed and stated that if the bed safety analysis form was not in the MBS's binder or in the resident's chart, it was not completed and should have been. DON reported that the resident should have had an assessment completed after the incident on a specified date where the resident’s safety was at risk.

The licensee has failed to ensure that where bed rails are used, the resident was

assessed and their bed system evaluated to minimize risk to the resident.

The severity of this issue was determined to be a level two as there was minimal harm or potential for actual harm, and the scope was isolated during the course of this inspection. The home's compliance history was reviewed and this legislation was issued on September 4, 2015, as a Voluntary Plan of Correction (VPC) in a critical incident inspection, and it was issued on February 3, 2015, as a Compliance Order (CO) in a Resident Quality Inspection, and complied with May 27, 2015. [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 is evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for a resident was based on, at a minimum, interdisciplinary assessment of the resident's health conditions including pain.

This inspection was conducted as a result of CIS report related to alleged ineffective pain control for the resident.

Review of the clinical record for the resident stated that the resident had multiple diagnoses and was discharged from the home on a specified date.

During the time the resident resided at the home, they were prescribed and administered medication multiple times daily for pain.

Further review of the clinical record stated that the resident Minimum Data Set assessments identified that the resident experienced moderate pain on three specified dates.
The resident care plans that were developed on multiple dates did not include pain management interventions.

DON acknowledged that the resident experienced pain during their residency at the home and that the resident's care plan did not include pain management interventions from the time of admission to discharge.

The licensee has failed to ensure that the plan of care for the resident was based on an interdisciplinary assessment of the resident's health conditions including pain.

The severity of this issue was determined to be a level two as there was minimal harm or potential for actual harm, and the scope was isolated during the course of this inspection. The home's compliance history was reviewed and there was no related non-compliance in the last three years. [s. 26. (3) 10.]

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 plan of care for a resident is based on, at a minimum, interdisciplinary assessment of the resident's health conditions including pain, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a Personal Assistance Services Device (PASD) to assist a resident with a routine activity of daily living was included in a resident's plan of care only if the following was satisfied: the use of the PASD had been consented to by the resident or, if the resident was incapable, a Substitute Decision-Maker (SDM) of the resident with authority to give that consent.

During the Resident Quality Inspection, the resident was observed on multiple occasions using a mobility device with PASDs engaged.

The home's policy, Use of PASDs, last revised February 25, 2011, included a directive for registered staff to obtain and record consent from the SDM for use of the PASD.

The resident's clinical record was reviewed and stated there was a physician's order for use of a specific PASD. The clinical record did not include documented consent from the SDM for use of this specific PASD.

Two PSWs and an RN said that the specific PASD was often engaged for this resident.

DON shared that registered staff should have followed the home's PASD policy and obtained and documented consent from the SDM for the resident prior to use of the specific PASD.

The licensee has failed to ensure that the resident's SDM consented to use of a PASD prior to including the PASD in the resident's plan of care.

The severity of this issue was determined to be a level one as there was minimal risk, and the scope was isolated during the course of this inspection. The home's compliance history was reviewed and this legislation was issued on March 9 2016, as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection. [s. 33. (4) 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 the use of a Personal Assistance Services Device (PASD) to assist a resident with a routine activity of daily living is included in a resident's plan of care only if the following is satisfied:the use of the PASD is consented to by the resident or, if the resident is incapable, a Substitute Decision-Maker (SDM) of the resident with authority to give that consent, to be implemented voluntarily.

WN #8: 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 failed to ensure that all staff had received retraining annually relating to the following: the home's policy to promote zero tolerance of abuse and neglect of residents.

The list of staff members who completed mandatory annual training in 2016, related to abuse was reviewed, and indicated that 14 staff members had not completed the training in 2016.

A PSW and an RN were interviewed by an inspector and both staff members reported that they had not completed their annual abuse training in 2016.

Manager of Health and Safety and Staff Development (MHSSD) was interviewed and explained that a proportion of the 14 staff who were documented as having not completed the education in 2016, may have completed it through an online module. MHSSD was unable to report the actual number of staff who did not complete abuse education in 2016, but acknowledged that there were likely four or five that had not completed it. MHSSD explained that staff members who did not complete the mandatory education were sent multiple reminder letters, with the last letter stating that education that was not completed would result in disciplinary action.

MHSSD and DON both acknowledged that no staff members were disciplined for failing to complete their mandatory annual abuse education in 2016.

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

The severity of this was determined to be a level two as there was minimal harm or potential for actual harm, and the scope was isolated during the course of this inspection. The home's compliance history was reviewed and this legislation was issued on June 24, 2015, as a Voluntary Plan of Correction (VPC) in a critical incident inspection. [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 receives retraining annually relating to the following: the home's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contained procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected.

The home's policy, Zero Tolerance of Abuse and Neglect#0104-08, last revised August 21, 2013, was reviewed and contained neither procedures nor interventions to assist and support residents who had been abused or neglected or allegedly abused or neglected.

DON was interviewed and stated that procedures and interventions to support residents who had been abused were not addressed in the home's abuse policy nor in other policies.

Administrator was interviewed and acknowledged that the home's abuse policy did not include procedures and interventions to support residents who had been abused.

The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse contained procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected. [s. 96. (a)]

2. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identified the training and retraining requirements for all staff including: training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care.

The home's policy, Zero Tolerance of Abuse and Neglect#0104-08, last revised August 21, 2013, was reviewed and did not address the relationship between power imbalances between staff and residents.

DON was interviewed and reported that the home's abuse policy did not address power imbalances between staff and residents. DON explained that the home had drafted a new document, "Therapeutic Relationships," which addressed power imbalances between staff and residents, but that the document was still in draft form and had not been disseminated to staff.

Administrator was interviewed and acknowledged that the home's abuse policy did not address power imbalances between staff and residents.

The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identified the relationship between power imbalances between staff and residents.

The severity of this was determined to be a level two as there was minimal harm or potential for actual harm, and the scope was isolated during the course of this inspection. The home's compliance history was reviewed and there was no related non-compliance in the last three years. [s. 96. (e)]

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 home's written policy to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to assist and support residents who are abused or neglected or allegedly abused or neglected, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident was reported to the resident, the resident's SDM, if any, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident, and the pharmacy service provider.

During the Resident Quality Inspection, the home's medication incidents were reviewed over a three-month period.

The home’s policy, Medication Incidents #4.15, last revised March 1, 2016, did not reflect the requirements under this regulation related to notification of the resident, the SDM and the prescriber of the drug for every medication incident involving a resident.

The home’s medication incident reports were reviewed over a three-month period, with the following results:
- there were 13 incidents where the resident or the resident’s SDM, the prescriber of the drug, the physician, and the pharmacy service provider were not notified
- there were six incidents where the pharmacy service provider was not notified
- there was one incident where the resident or the resident’s SDM, the pharmacy service provider, and the physician were not notified
- there was one incident where the resident or the resident’s SDM, and the pharmacy service provider were not notified.

DON acknowledged that the home’s policy for medication incidents did not reflect the requirements under this regulation related to notification to the resident or resident's SDM, and prescriber of the drug for every medication incident involving a resident.

DON further acknowledged the results of the medication incident reports and said that registered staff were responsible for ensuring that the resident, if capable, or the resident’s SDM, the physician, and pharmacist should have been notified of each medication incident.

The licensee has failed to ensure that every medication incident involving a resident was reported to the resident or the resident’s SDM, the prescriber of the drug, the resident's attending physician, and the pharmacy service provider.

The severity of this issue was determined to be a level two as there was minimal harm or potential for actual harm, and the scope was widespread during the course of this inspection. The home's compliance history was reviewed and there was no related non-compliance in the last three years. [s. 135. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident is reported to the resident, the resident's SDM, if any, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident, and the pharmacy service provider, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 123. Emergency drug supply
Every licensee of a long-term care home who maintains an emergency drug supply for the home shall ensure,
(a) that only drugs approved for this purpose by the Medical Director in collaboration with the pharmacy service provider, the Director of Nursing and Personal Care and the Administrator are kept;
(b) that a written policy is in place to address the location of the supply, procedures and timing for reordering drugs, access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply;
(c) that, at least annually, there is an evaluation done by the persons referred to in clause (a) of the utilization of drugs kept in the emergency drug supply in order to determine the need for the drugs; and
(d) that any recommended changes resulting from the evaluation are implemented. O. Reg. 79/10, s. 123.

Findings/Faits saillants :

1. The licensee has failed to ensure that there was tracking and documentation of the emergency drugs maintained in the emergency drug supply for the home.

The home's policy, Emergency Stock Box #3.9, last revised March 1, 2016, included direction for:

- the pharmacy service provider to monitor the inventory of all medications held in the emergency stock box during their routine Medication Management Audit
- the home to monitor the inventory on a monthly basis and re-order medications that are missing or have expired
- the home to notify the DON to investigate and initiate a medication incident report if stock is missing from the emergency stock box

Review of the emergency medication inventory with an RN on March 16, 2017, produced the following results:
A) availability of 27 amoxicillin 250 milligram (mg) capsules; required inventory stated 36 capsules
B) availability of six macrodantin 50 mg tablets; required inventory stated 12 tablets
C) availability of 10 prednisone 5 mg tablets; required inventory stated 30 tablets
D) availability of 36 amoxicillin 500 mg capsules; required inventory stated 24 capsules.

Review of the October 4, 2016, Medication Management Committee Minutes revealed the pharmacy service provider completed an audit of the emergency medication supply on that date and that there were no actions required.

Review of the emergency box medications inventory for January 24, 2017, completed by Assistant Director of Nursing revealed that three expired medications were removed from the supply and reordered. The reordered medications did not include amoxicillin 250 mg, macrodantin 50 mg or prednisone 5 mg. The emergency drug inventory did not include drug count discrepancies.

DON said that emergency drug supply inventory audits were completed by the pharmacist after the Medication Management Committee Meetings and quarterly by registered staff. DON shared that discrepancies with the January 24, 2017, emergency drug inventory had not been reported to them. DON further acknowledged that emergency drug supply inventories should have reflected individual medication discrepancies, if any, and should have been reported to them.

The licensee has failed to ensure that there was tracking and documentation of the emergency drugs maintained in the emergency drug supply for the home.

The severity of this issue was determined to be a level two as there was minimal harm or potential for actual harm, and the scope was isolated during the course of this inspection. The home's compliance history was reviewed and there was no related non-compliance

in the last three years. [s. 123. (b)]

Issued on this 23rd day of August, 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) :	ANDREA DIMENNA (669), ALICIA MARLATT (590), ALISON FALKINGHAM (518), CAROLEE MILLINER (144)
Inspection No. / No de l'inspection :	2017_566669_0005
Log No. / No de registre :	003055-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 25, 2017
Licensee / Titulaire de permis :	THE CORPORATION OF THE COUNTY OF ESSEX 360 Fairview Ave West, ESSEX, ON, N8M-1Y6
LTC Home / Foyer de SLD :	SUN PARLOR HOME FOR SENIOR CITIZENS 175 TALBOT STREET EAST, LEAMINGTON, ON, N8H-1L9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lynda Monik

To THE CORPORATION OF THE COUNTY OF ESSEX, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

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:
i) review and implement the home's draft policy #0101-14, "Resident Intimacy and Sexuality"
ii) develop and implement a method for determining, on an individual basis, the ability for cognitively impaired residents to consent to sexual relations
iii) educate all staff members, volunteers, and management on items i) and ii)

Grounds / Motifs :

1. The licensee has failed to protect residents from abuse by anyone and from neglect by the licensee or staff.

This inspection was conducted as a result of two Critical Incident System (CIS) reports, both related to alleged resident-to-resident abuse.

Section 2(1) of Ontario Regulation 79/10 defines sexual abuse as "any consensual or nonconsensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member" or "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by person other than a licensee or staff member."

The home's policy, Zero Tolerance of Abuse and Neglect0104-08, was last revised August 21, 2013, and stated:
The Sun Parlor Home has a "zero tolerance" of abusive behaviour which is strictly enforced. Any employee or volunteer will be disciplined up to and including discharge for any confirmed incident of abuse.
Part A:

Definition of Abuse and Neglect
1. This policy uses the definition of "abuse" and "neglect" from the Long-Term Care Homes Act, 2007. The terms "abuse" and "neglect" in this policy have the same meaning as those terms in the LTCHA.

DON provided a copy of the home's draft policy which addressed non-consensual touching and behaviours between residents, and explained that this policy was still in draft form and had not been disseminated to staff.

A review of one of the identified resident's clinical record revealed that on eight specified dates, the identified resident engaged in potentially non-consensual touching or behaviours with two other residents.

A physician's note from a specified date, stated that the identified resident had specific behaviours directed at staff and residents, and that a specific intervention had been initiated.

A physician assessment on a specified date, noted that new treatment changes had helped the identified resident's behaviours.

During interviews, two PSWs, two RNs and one RPN all stated that the behaviors exhibited by the identified resident were inappropriate, were abusive, were not invited or enjoyed by the two affected residents, and that both affected residents would not be able to provide consent based on their cognitive abilities.

Administrator acknowledged that the identified resident's behaviour was abusive and the home's expectation was that all residents were protected from abuse by anyone.

The licensee failed to ensure that two affected residents were protected from abuse by the identified resident.

2. This inspection was conducted as a result of a Complaint report related an identified resident's behaviours.

The identified resident had a Cognitive Performance Scale (CPS) score of zero, and the affected resident had a CPS score of three.

The home's policy, Zero Tolerance of Abuse and Neglect0104-08, was last

revised August 21, 2013, and stated:
The Sun Parlor Home has a "zero tolerance" of abusive behaviour which is strictly enforced. Any employee or volunteer will be disciplined up to and including discharge for any confirmed incident of abuse.
Part A:
Definition of Abuse and Neglect
1. This policy uses the definition of "abuse" and "neglect" from the Long-Term Care Homes Act, 2007. The terms "abuse" and "neglect" in this policy have the same meaning as those terms in the LTCHA.

A review of the identified resident's clinical records included documentation stating the identified resident and the affected resident were witnessed engaging in specific behaviours on a specified date, in the identified resident's room. The documentation stated that staff explained to the identified resident that the affected resident's ability to consent was unclear due to their cognitive state, and the identified resident's vocalized that their actions were wrong. The DON was called and the affected resident was given a specific care intervention to ensure their safety.

A progress note on a specific date stated that staff were looking for the affected resident and suspected that they were in the identified resident's room. The note continued that the identified resident's door was closed and staff members felt they had to respect the identified resident's privacy, so they felt they were unable to check the room for the affected resident.

Progress notes were reviewed for both the identified resident and the affected resident, and included documented incidents of both residents alone in a room together on four separate occasions.

The affected resident's chart was reviewed and it was noted that the resident did not have an appreciation for consequences, had impaired cognitive skills for daily decision-making, and had periods of altered perception or awareness.

The identified resident recounted that they intended to engage in specific behaviours with the affected resident. The identified resident reported that they attempted to speak with the affected resident regarding the inappropriateness of the specific behaviours but the affected resident could not comprehend what the identified resident was saying.

A PSW was interviewed and stated that the affected resident was cognitively impaired and that, overall, the resident could not make rational decisions. The PSW stated that they had not personally witnessed any incidents, but they were aware that the identified resident had engaged in specific behaviours with the affected resident.

Two registered staff members were interviewed and explained that the affected resident was often disoriented, confused and needed direction. One of the staff members stated that the affected resident was unable of consenting to specific behaviours. The other staff member acknowledged that they felt the affected resident's safety was at risk was they were in a room alone with the identified resident if the residents were engaging in high-risk behaviours.

DON was interviewed and acknowledged that the witnessed incident between the identified resident and the affected resident on a specific date should have been considered suspected abuse. DON stated that there had been no further incidents between the two residents, but shared that staff still felt incidents were occurring. DON stated that when the identified resident and the affected resident were alone in a room together, the affected resident's safety may be at risk.

Administrator told an inspector that the home's expectation was that all residents were protected from abuse by anyone.

The licensee failed to ensure that affected resident was protected from abuse by the identified resident.

The severity of this issue was determined to be a level three as there was actual harm or risk, and the scope was widespread during the course of this inspection. The home's compliance history was reviewed and this legislation was issued on January 11, 2016 as a Compliance Order (CO) in a complaint inspection, and complied with on March 21, 2016. (669)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 29, 2017

Order # / Ordre no : 002

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 ensure that the home immediately investigates, takes appropriate action, and complies with any requirements that are provided in the regulations for investigating and responding for every alleged, suspected or witnessed incident of abuse of a resident by anyone.

Grounds / Motifs :

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

This inspection was conducted as a result of two CIS reports, both related to alleged abuse by an identified resident.

The home's policy, Zero Tolerance of Abuse and Neglect#0104-08, last revised August 21, 2013, stated:
Part A: Investigation and Reporting of Abuse and Neglect

1. Staff and management must report all alleged, suspected or witnessed incidents of
(a) Abuse of a resident by anyone, and
(b) Neglect of a resident by a staff member of the home.
3. The home will immediately investigate reports by staff under this policy, and third party reports of abuse or neglect, in accordance with the investigated procedures in Part B Part Two: Reporting and Notifications.

A review of one of the identified resident's clinical record revealed that on five specified dates, the identified resident engaged in potentially non-consensual touching or behaviours with two other residents; a record review showed no documentation to support that any of five incidents were immediately investigated by the home.

During interviews, two PSWs, two RNs, an RPN, DON, and Administrator all stated that the behaviors exhibited by the identified resident were inappropriate, were abusive and should have been investigated by the management team.

The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone was immediately investigated.

The severity of the issue was determined to be a level three as there was actual harm or risk, and the scope was widespread during the course of this inspection. The home's compliance history was reviewed and there was no related non-compliance in the last three years.
(518)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 28, 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. 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 ensure that the home immediately reports the suspicion and the information in which it is based to the Director when a person has reasonable grounds to suspect that abuse of a resident by anyone occurred.

Grounds / Motifs :

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

This inspection was conducted as a result of two CIS reports, both related to alleged abuse by an identified resident.

The home's policy, Zero Tolerance of Abuse and Neglect#0104-08, last revised August 21, 2013, stated:
Part A: Investigation and Reporting of Abuse and Neglect
1. Staff and management must report all alleged, suspected or witnessed incidents of
(a) Abuse of a resident by anyone, and

(b) Neglect of a resident by a staff member of the home.

Part A: Mandatory Reporting under the LTCHA Section 24(1) of the LTCHA requires certain persons, including the home and certain staff members, to make immediate reports to the Director where there is a reasonable suspicion that certain incidents occurred or may occur. Staff should immediately report under the home's staff reporting policy any incidents that may lead to a mandatory report under section 24(1). Staff should also understand that it is an offence under the LTCHA to discourage or suppress a mandatory report.
Part B: Procedures
Section Two: Reporting and Notifications about Incidents of Abuse or Neglect
Reporting Notifications:
All incidents of physical abuse that cause physical injury, and non-consensual sexual behaviour must be reported to the Ministry of Health and Long-Term Care (MOHLTC).
Section Three: Actions to be taken by staff role and responsibilities Administrator or Designate: The Administrator is accountable for overseeing that the proper reporting to MOHLTC has been undertaken.

A review of one of the identified resident's clinical record revealed that on five specified dates, the identified resident engaged in potentially non-consensual touching or behaviours with two other residents, and none of the five incidents of suspected abuse were reported to the MOHLTC.

During interviews, two PSWs, two RNs, and one RPN all stated that the behaviours exhibited by the identified resident were inappropriate, were abusive and had been going on for a long period of time.

During an interview, DON and Administrator stated that the aforementioned incidents were abusive in nature and should have been reported to the MOHLTC.

2. This inspection was conducted as a result of a Complaint report related an identified resident's behaviours.

A review of the identified resident's clinical records included documentation stating the identified resident and the affected resident were witnessed engaging in specific behaviours on a specified date, in the identified resident's room. The documentation stated that staff explained to the identified resident that the

affected resident's ability to consent was unclear due to their cognitive state, and the identified resident's vocalized that their actions were wrong. The documentation continued that the affected resident denied any pain, injury, or complaints, and that DON was called and that the affected resident was given a specific care intervention to ensure their safety.

The home's policy, Zero Tolerance of Abuse and Neglect#0104-08, last revised August 21, 2013, stated:
Part A: Investigation and Reporting of Abuse and Neglect

1. Staff and management must report all alleged, suspected or witnessed incidents of
(a) Abuse of a resident by anyone, and
(b) Neglect of a resident by a staff member of the home.
Part A: Mandatory Reporting under the LTCHA Section 24(1) of the LTCHA requires certain persons, including the home and certain staff members, to make immediate reports to the Director where there is a reasonable suspicion that certain incidents occurred or may occur. Staff should immediately report under the home's staff reporting policy any incidents that may lead to a mandatory report under section 24(1). Staff should also understand that it is an offence under the LTCHA to discourage or suppress a mandatory report.
Part B: Procedures
Section Two: Reporting and Notifications about Incidents of Abuse or Neglect Reporting
Notifications: All incidents of physical abuse that cause physical injury, and non-consensual sexual behaviour must be reported to the MOHLTC.
Section Three: Actions to be taken by staff role and responsibilities Administrator or Designate: The Administrator is accountable for overseeing that the proper reporting to MOHLTC has been undertaken.

The identified resident was interviewed and recounted that on a specified date, they intended to engage in specific behaviours with the affected resident, but did not because staff entered the room.

During interviews, an RN and DON explained that a nurse manager or management was responsible for calling the MOHLTC's after-hours line and completing critical incident reports after incidents of suspected, alleged or witnessed abuse. DON acknowledged that the witnessed incident between the identified resident and the affected resident on a specific date should have been

considered suspected abuse and should have been reported to the MOHLTC.

The licensee failed to ensure that a person who had reasonable grounds to suspect abuse of the affected residents by the identified resident immediately reported the suspicion and the information upon which it was based to the Director.

The severity of this issue was determined to be a level three as there was actual harm or risk, and the scope was widespread during the course of this inspection. The home's compliance history was reviewed and this legislation was issued on November 26, 2014, as a Written Notification (WN) in critical incident inspection. (669)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 28, 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 25th day of July, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Andrea DiMenna

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