Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
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347 rue Preston bureau 420
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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Nov 23, 2020	2020_505103_0018 (A1)	017081-20, 018941-20, 019453-20, 019894-20	Complaint

Licensee/Titulaire de permis

Arch Long Term Care LP by its General Partner, Arch Long Term Care MGP, by its partners, Arch Long Term Care GP Inc. and Arch Capital Management Corporation
161 Bay Street Suite 2100 TORONTO ON M5J 2S1

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

Perth Community Care Centre
101 Christie Lake Road, R. R. #4 PERTH ON K7H 3C6

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

Amended by DARLENE MURPHY (103) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee report and CO #002 have been amended to reflect the information provided by the home, following the completion of the inspection, regarding an RPN's completion of abuse training.

Issued on this 23rd day of November, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Amended by DARLENE MURPHY (103) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 14-16, 19-22, 2020.

Log #017081-20 and Log #019453-20-complaints related to resident care,

Log #018941-20-complaint related to short staffing,

Log #019894-20-complaint related to alleged resident abuse/neglect.

During the course of the inspection, the inspector(s) spoke with complainants, family members, residents, Personal Support Workers (PSW), Behavioural support staff (BSO), Registered Practical Nurses (RPN), Registered Nurses (RN), Clinical Manager, Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector made observations related to resident care and dining, reviewed resident health care records, the licensee's abuse policy, "Zero tolerance to Resident Abuse and Neglect", #02-01-02, revised October 2018, staffing schedules, and the licensee's staffing/back up plan.

The following Inspection Protocols were used during this inspection:

Dining Observation
Falls Prevention
Hospitalization and Change in Condition
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.
- **11 WN(s)**
- **4 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

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

A resident was observed in the common area beside the nursing station without their mobility aide on two separate dates. Staff members were present in the area at the time of the observations and failed to provide the resident with the outlined care related to mobility/transfer.

2. A resident was observed to be improperly positioned and was left unattended for twenty-five minutes during a meal service. During afternoon snack, the resident was provided with their snack/beverage and was left unattended which resulted in staff having to provide medical assistance to the resident. This resident was improperly positioned and did not receive the level of supervision for eating as outlined in their plan of care.

3. A resident was seated with their meal out of reach for a period of twenty-five minutes. A PSW assisted the resident with their meal for fifteen minutes at which time the meal was removed with less than fifty percent consumed. The resident was not provided with the outlined care related to eating/meal service.

4. A resident was observed with their meal for twenty minutes and had not started to eat. Staff provided the resident with assistance with the meal after the inspector inquired. The resident was not provided with the care outlined in their plan of care related to eating and the level of staff supervision required during a meal.

5. A resident stated staff have been unable to provide them with the required level of assistance for toileting in a timely manner on two recent occasions which resulted in incontinence. The resident attributed the delay in assistance to short staffing.

Sources: Resident care plans, observations made during meal service and interviews with a resident and staff. [s. 6. (7)]

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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to protect residents from an alleged incident of resident to resident sexual abuse.

Sexual abuse is defined by O. Reg 79/10, s. 2 (1) as any non-consensual touching, behaviour or remarks of a sexual nature directed towards a resident by a person other than a licensee or staff member.

A PSW witnessed two residents engaged in touching of a sexual nature. The incident was reported the following evening to the RN and subsequently to the Clinical Manager and the DOC.

The licensee failed to protect the residents from an alleged incident of abuse by failing to immediately investigate the incident. Additionally, there was no follow up with the staff regarding the failure to immediately report the incident and no measures were put into place to protect the residents from potential additional incidents of abuse.

Sources: Staff interviews and review of the resident's health care records. [s. 19. (1)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: 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 their zero tolerance of abuse policy was complied with.

The licensee failed to immediately investigate an alleged incident of resident to resident sexual abuse involving two residents. Additionally, the alleged incident of sexual abuse was not immediately reported to the Ministry of Long-Term Care (MLTC), the police, a resident's substitute decision-maker (SDM) and the medical director as required by the abuse policy.

2. An RPN was informed of an alleged incident of resident to resident sexual abuse involving two residents and failed to report the incident.

Sources: The licensee's zero tolerance of abuse policy and interviews with staff. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the licensee's zero tolerance of abuse policy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee has failed to keep a written record relating to each evaluation of the staffing plan that included the date of the evaluation, persons who participated in the evaluation and a summary of the changes made and the date the changes were implemented.

A copy of the licensee's annual evaluation of the staffing plan was requested. The DOC provided the inspector with the staffing/back up plan from February 2020 and August 2020. There was no evidence to support an evaluation of the staffing plan as outlined in the legislation.

Sources: Staffing plan/back up plan, interview with the DOC. [s. 31. (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 a written record relating to each evaluation of the staffing plan is kept in accordance with the legislative requirements, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure residents were being bathed at a minimum twice weekly by the method of their choice.

Three resident bathing records were reviewed for the period of one month and zero of the three residents were receiving their twice weekly baths by the method of their choice. Staff attributed this to staffing shortages.

Sources: Resident bathing records and interviews with staff and the DOC. [s. 33. (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 residents are bathed twice weekly by the method of their choice, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
3. Meal service in a congregate dining setting unless a resident's assessed

needs indicate otherwise. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the long-term care home met the minimum legislated requirements outlined in O. Reg 79/10, s. 73.

Dining observations were made on three of the six resident units over a period of two days. The seven-day and daily menus were not being communicated to the residents.

2. Meal service was not being provided in a congregate dining setting. Residents were seated in the hallway outside of their rooms or in their rooms.

3. Four residents were observed being provided with insufficient time to eat at their own pace.

4. Meals were not served course by course. Residents had trays delivered to them that included their entree and dessert.

5. A resident was observed unsafely positioned throughout their meal.

6. The home utilized television style trays for meal service that failed to meet the needs of three residents as they were unable to position their wheelchairs under the trays, making their food and drinks difficult to reach.

7. Four residents received their meals in advance of staff being available to provide assistance.

Sources: Dining observations. [s. 73 (1) and s. 73. (2) (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 the dining service meets the minimum legislated requirements, to be implemented voluntarily.

WN #7: 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 an alleged incident of resident to resident sexual abuse was immediately investigated.

An alleged incident of resident sexual abuse was reported to an RN and subsequently to the Clinical Manager and the DOC. An investigation into the alleged abuse was not completed.

Sources: Interviews with staff, Clinical Manager and the DOC and review of the resident health care record. [s. 23. (1) (a)]

WN #8: 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. A person who had reasonable grounds to suspect an alleged incident of resident to resident sexual abuse failed to immediately report the suspicion and information upon which it was based to the Director.

An RN failed to immediately report an alleged incident of resident to resident sexual abuse to the Director.

2. An RPN was made aware of a second alleged incident of resident to resident sexual abuse and failed to immediately report the alleged abuse to the Director.

Sources: Staff interviews and review of the resident health care records. [s. 24. (1)]

WN #9: 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. (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section. 2007, c. 8, s. 76. (1).

Findings/Faits saillants :

1. The licensee failed to ensure two PSWs received the required training related to the licensee's abuse policy and the duty under section 24 of the LTCHA to make mandatory reports.

Ontario Regulation 79/10, s. 218 (2) (a) specifies that during a pandemic, the training required under s.76 of the LTCHA must be provided within one week of when the person begins performing their responsibilities with respect to the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, and the duty under s. 24 of the LTCHA to make mandatory reports.

A PSW witnessed two residents engaged in touching of a sexual nature and failed to immediately report the incident. The PSW subsequently reported the incident to another PSW who also failed to immediately report the incident. The two PSWs had been performing their duties for approximately three months in the home and had not completed the orientation training required in these two areas.

Sources: Interviews with staff, Clinical Manager and DOC. [s. 76. (1)]

WN #10: 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 a substitute decision-maker (SDM) was notified within twelve hours upon the licensee being made aware of an alleged incident of abuse.

An alleged incident of resident sexual abuse was not reported to a resident's SDM.

Sources: Interview with staff. [s. 97. (1) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure an alleged incident of resident to resident sexual abuse involving two residents was immediately reported to the appropriate police force.

An alleged incident of resident sexual abuse was not reported to the police.

Sources: Interview with staff. [s. 98.]

Issued on this 23rd day of November, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Operations Division
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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by DARLENE MURPHY (103) - (A1)
Inspection No. / No de l'inspection :	2020_505103_0018 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	017081-20, 018941-20, 019453-20, 019894-20 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 23, 2020(A1)
Licensee / Titulaire de permis :	Arch Long Term Care LP by its General Partner, Arch Long Term Care MGP, by its partners, Arch Long Term Care GP Inc. and Arch Capital Management Corporation 161 Bay Street, Suite 2100, TORONTO, ON, M5J-2S1
LTC Home / Foyer de SLD :	Perth Community Care Centre 101 Christie Lake Road, R. R. #4, PERTH, ON, K7H-3C6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jennifer Cummings

To Arch Long Term Care LP by its General Partner, Arch Long Term Care MGP, by its partners, Arch Long Term Care GP Inc. and Arch Capital Management Corporation, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 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. 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).

Order / Ordre :

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

The licensee must be compliant with subsection 6 (7) of the Long-Term Care Homes Act, 2007.

Prepare and submit a plan to ensure the care set out in the resident plans of care will be provided as specified in the plan.

The plan must include but is not limited to:

-Specific strategies to address the ongoing staffing short falls of Personal Support Workers (PSW) as the lack of resident care was primarily identified as a result of not enough staff to provide the resident care. Include dates that the strategies will be implemented and identify who will oversee the implementation.

-Specific strategies to resume resident dining in a congregate setting to maintain resident safety/social distancing throughout the pandemic and to maximize the available staff to provide resident assistance and monitoring during meals in accordance with their plans of care. Include dates that the strategies will be implemented and identify who will oversee the implementation.

-The plan should include an auditing component identifying who will complete audits, how often audits will be completed and when the audits will be deemed no longer necessary to ensure residents are receiving their care as outlined in the plans of care.

Submit the plan by November 20, 2020 for inspection #2020_505103_0018 to Darlene Murphy, LTC home inspector, MLTC by email to OttawaSAO.MOH@ontario.ca

Please ensure the written plan does not contain any PI/PHI.

Grounds / Motifs :

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

A resident was observed in the common area beside the nursing station without their

mobility aide on two separate dates. Staff members were present in the area at the time of the observations and failed to provide the resident with the outlined care related to mobility/transfer.

2. A resident was observed to be improperly positioned and was left unattended for twenty-five minutes during a meal service. During afternoon snack, the resident was provided with their snack/beverage and was left unattended which resulted in staff having to provide medical assistance to the resident. This resident was improperly positioned and did not receive the level of supervision for eating as outlined in their plan of care.

3. A resident was seated with their meal out of reach for a period of twenty-five minutes. A PSW assisted the resident with their meal for fifteen minutes at which time the meal was removed with less than fifty percent consumed. The resident was not provided with the outlined care related to eating/meal service.

4. A resident was observed with their meal for twenty minutes and had not started to eat. Staff provided the resident with assistance with the meal after the inspector inquired. The resident was not provided with the care outlined in their plan of care related to eating and the level of staff supervision required during a meal.

5. A resident stated staff have been unable to provide them with the required level of assistance for toileting in a timely manner on two recent occasions which resulted in incontinence. The resident attributed the delay in assistance to short staffing.

Sources: Resident care plans, observations made during meal service and interviews with a resident and staff. [s. 6. (7)]

The decision to issue this non-compliance as an order was based on the following:
Severity: Residents had actual harm/risk as a result of their care not being provided as specified in their plan.
Scope: The issue was widespread as it affected three of the three resident units inspected.
Compliance history: In the past 36 months, the licensee was found non-compliant with LTCHA, s. 6 (7) and received two Written Notifications (WN) and two Voluntary Plans of Correction (VPC).

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

(103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jan 08, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 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. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the Long-Term Care Homes Act, 2007.

The licensee shall ensure residents are protected from abuse.

-Prior to resuming resident care, ensure PSW #104 and PSW #105 have completed training on the home's abuse policy and the duty under section 24 to make mandatory reports.

-Upon the completion of the training, the Administrator and the DOC shall conduct a separate meeting with PSW #104, and PSW #105 to review their reporting obligations related to alleged, suspected or witnessed incidents of resident abuse and to outline the actions that will be taken for future non-compliance with these obligations.

-Administrator shall meet with the Clinical Manager and the DOC to review their obligations to investigate all alleged, suspected and witnessed incidents of resident abuse and measures to safeguard the residents throughout the investigation from subsequent abuse.

-Keep a record of all meetings, training/retraining provided including the dates and the persons who attended.

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Grounds / Motifs :

(A1)
1. The licensee failed to protect residents from an alleged incident of resident to resident sexual abuse.

Sexual abuse is defined by O. Reg 79/10, s. 2 (1) as any non-consensual touching, behaviour or remarks of a sexual nature directed towards a resident by a person other than a licensee or staff member.

A PSW witnessed two residents engaged in touching of a sexual nature. The incident was reported the following evening to the RN and subsequently to the Clinical Manager and the DOC.

The licensee failed to protect the residents from an alleged incident of abuse by failing to immediately investigate the incident. Additionally, there was no follow up with the staff regarding the failure to immediately report the incident and no measures were put into place to protect the residents from potential additional incidents of abuse.

An order was made taking the following factors into account:
Severity: The residents were separated at the time of the witnessed incident and resulted in minimal harm and minimal risk to the residents.
Scope: This issue was identified as isolated.
Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA, s. 19 and one Written Notification (WN) and one Voluntary Plan of Correction (VPC) was issued.
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(103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 20, 2020

Order(s) of the Inspector

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REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

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Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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.

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RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

Issued on this 23rd day of November, 2020 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by DARLENE MURPHY (103) - (A1)

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