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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 21, 2017	2017_603194_0004	000663-17	Resident Quality Inspection

Licensee/Titulaire de permis

TRENT VALLEY LODGE LIMITED
195 Bay Street TRENTON ON K8V 1H6

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

TRENT VALLEY LODGE LIMITED
195 BAY STREET TRENTON ON K8V 1H9

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

CHANTAL LAFRENIERE (194), KELLY BURNS (554), PATRICIA MATA (571)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 16, 18, 19, 20, 23, 24 and 25, 2017 (on-site). February 6 and 7, 2017 (off-site), February 13 and 14, 2017(on site).

Inspectors completed Critical incident Inspections; Log #019817-16, #003242-17, #003065-17 related to allegations of resident to resident sexual abuse

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), RAI Coordinator, Clinical Care Coordinator (CCC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Unit Nurse, Housekeeper, Maintenance Manager (MM), Environmental Services Manager (ESM), and Residents.

The inspectors completed a tour of the building, observed the provision of meals, medication administration, infection control practices, housekeeping practices and staff to resident provision of care. Reviewed identified residents clinical health records, staff educational records, maintenance records and assessments, relevant policies related to abuse, falls, bed rails, and housekeeping.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 8. (1)	CO #001	2016_389601_0025	194
O.Reg 79/10 s. 90. (2)	CO #002	2016_389601_0025	194

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that vulnerable, cognitively impaired residents were protected from alleged, suspected or witnessed sexual abuse by other residents, pursuant to s. 19 of the LTCHA, 2007.

The licensee's "Abuse and Neglect of a Resident – Actual or Suspected" VII-G-10.00 defines sexual abuse as: a) any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Re: Log #019817-16:

A Critical Incident (CI) was submitted to the Director for an alleged sexual abuse of resident #041 by resident #008. The CI indicated that resident #008 was sexually inappropriate towards resident #041. Resident #041 was upset by the incident.

Re: Alleged sexual abuse of resident #041 and #040 by resident #008:

A review of the clinical health record by Inspector #571 indicated that resident #008 is cognitively impaired, wheelchair bound but can self-propel at times.

Resident #041 is able to direct his/her own care with some assistance from staff in new situations. Resident #041 is also wheelchair bound.

Resident #040 is cognitively impaired, is wheelchair bound and can self-propel.

The progress notes for resident #008 for a period of 12 months were reviewed by Inspector #571. In interviews PSW's #111 and #112, indicated that they have observed resident #008 being sexually inappropriate with resident #036, #043, #040, and #035. Inspector #571 and #194 reviewed the progress notes for these residents for the same time period in order to attempt to identify the recipients of the inappropriate sexual behaviour and whether consent was given. The inspectors were unable to identify all residents involved.

-on an identified date : resident #008 observed by RPN #118 being sexually inappropriate towards resident #040.
-on an identified date: RPN #126 documented resident #008 being sexually inappropriate towards resident #040.
-on an identified date: RPN #118 documented resident #008 being sexually inappropriate towards unidentified resident.
-on an identified date: RPN #102 documented resident #008 being sexually inappropriate towards unidentified resident.
-on an identified date: CI submitted to report, resident #008 being sexually inappropriate towards resident #041.
-on an identified date: Physiotherapist #127 documented resident #008 being sexually inappropriate towards unidentified resident.
-on an identified date: RPN #104 documented resident #008 being sexually inappropriate towards resident #040; resident #040 being sexually inappropriate towards resident #008.
-on an identified date : RPN #118 documented resident #008 being sexually inappropriate towards unidentified resident.
-on an identified date: RN #124 documented resident #008 being sexually inappropriate towards resident #043'.

A review of resident #008's plan of care :

-Problem: Inappropriate Socially due to cognitive impairment
-Expected Outcomes: Incidence of inappropriate sexual behaviour will decrease
-Interventions: set limits for acceptable behaviour; protect other residents, never leave resident #008 alone with other confused residents; explain the effect of the behaviour on other residents; avoid any conversations that may encourage or initiate inappropriate behaviour; two person physical assist at all times due to inappropriate touching of staff members; 30 minute checks to ensure the behaviour is not being exhibited towards residents.

In an interview with Inspector #571, RPN #118 indicated that resident #008 has a behaviour of being sexually inappropriate; resident #008 is monitored every 30 minutes and staff are to separate the resident from other residents after an incident. RPN #118 indicated not considering the behaviour to be sexual abuse as resident #008 is cognitively impaired.

In an interview with Inspector #571, the DOC indicated that she was not aware of the aforementioned allegations of sexual abuse except for the incident that occurred and was reported through the CIS system. The CCC, also present during the same interview, indicated that the DOC, several staff did not consider the behaviour exhibited to be sexual abuse but rather intimacy therefore the aforementioned incidents were not investigated, or reported to the Director except for the incident that was reported through CIR. The DOC also indicated that they do not have a procedure for notifying staff, of residents that are at risk of harm from residents displaying responsive behaviours.

In a separate interview, the ADOC indicated to Inspector #571 that if sexual abuse is suspected then the PSWs would report to the unit RPN. The RPN will inform the charge RN who would complete an investigation including a post abuse investigation form. After the RN in charge completes the licensee's post abuse investigation form, the RN submits the investigation form to the DOC who then forwards it to the ADOC.

The ADOC did not receive a post abuse investigation form for any of the aforementioned incidents with the exception of the incident that was reported through CIR. The ADOC indicated the exhibited behaviour of resident #008 was not considered sexual abuse except for the incident that was reported to the Director. This incident was reported because of resident #041's negative response to the exhibited behaviour by resident #008. The ADOC reviewed the current plan of care for resident #008 and indicated that the only interventions added or modified in 2016 were completed when the resident was put on every 15 minute checks after a CI was submitted to Director for a previously reported sexual abuse involving resident #040. Then, two months later the plan of care was modified to every 30 minute checks as no further sexually inappropriate behaviours were evident at that time. The other interventions under socially inappropriate for sexual behaviours were initiated and unchanged since 2015. CI indicated that resident #008 would be referred to the external sources for assessment. The ADOC indicated that this referral has never been done.

In an interview , RPN #103 indicated to Inspector #571 that staff would be informed

about residents whose behaviours pose a risk to other residents or staff by reading the shift report. If staff had been off for several days, staff could read previous reports. The RPN would share information from the reports with the PSW's during shift report.

PSW #128 and #129 indicated in separate interviews with Inspector #571, that they were not aware that resident #008 had any sexual inappropriate behaviour.

Re: Alleged sexual abuse of resident #043 by resident #008:

A review of the clinical record for resident #043 by Inspector #571 indicated that resident #043 is cognitively impaired and is immobile.

A review of the progress notes by Inspector #571 indicated that on an identified date, charge RN #124 documented being informed by the unit RPN that resident #008 was observed being sexually inappropriate towards resident #043.

On January 25, 2017, the ADOC indicated in an interview with Inspector #571 of not having received a post abuse investigation form for the incident occurring between resident #008 and #043 from RN #124, concluding that no investigation into the incident had occurred. This incident was not reported to the Director.

Re: Alleged sexual abuse of resident #029 by resident #040:

A review of the clinical record by Inspector #571 indicated that resident #040 was cognitively impaired, wheelchair bound and can self-propel. Resident #029 did not have any cognitive impairments.

A review of the progress notes indicated that on an identified date, resident #029 indicated to RPN #125 that resident #040 had been in the resident's room and was sexually inappropriate towards resident #029.

After a review of the clinical record for resident #040 and #029, Inspector #571 was unable to locate documentation supporting that an investigation was completed by RPN #125 or that the charge RN or the licensee were made aware of this allegation of alleged sexual abuse. There was no evidence to support that this incident was reported to the Director.

Re: Alleged sexual abuse of several unidentified male residents by resident #040:

A review of the progress notes of resident #040 by Inspector #571 indicated that resident #040 displayed sexually inappropriate behaviour:
-on an identified date: RPN #118 documented that resident #040 was sexually inappropriate towards an unidentified resident.
-on an identified date: RPN #103 documented that resident #040 was sexually inappropriate towards an unidentified resident.
-on an identified date: RPN #118 documented that resident #040 was sexually inappropriate towards an unidentified resident.

A review of resident #040's current plan of care indicated the following:

-Behaviour: Wandering
-Expected Outcomes: to maintain safety and comfort in the environment
-Interventions: 30 minute checks for falls; monitor whereabouts while self-propelling in wheelchair; determine if there is a reason for wander (i.e. bathroom);

-Behaviour: Inappropriate Socially (cognitive impairment, lack of appropriate partner)
-Expected Outcomes: incidence of inappropriate sexual behaviour will decrease over the next three months
-Interventions: sexual behaviour- resident #040 told a staff member that a resident on the unit reminds the resident of the residents spouse. Resident #040 has been observed and removed from this resident's room on several occasions. Staff will explain to resident that the advances are not welcomed by this resident and that the resident needs to stay out of the other resident's room. Resident #040 is on 30 minute checks for self-transferring out of the wheelchair and the resident's whereabouts due to wandering into other rooms. Resident #040 has a personal alarm attached to clothing when the resident is up in the wheelchair and a bed alarm to alert staff if the resident is trying to get out of bed. Staff are to redirect the resident away from these incidences with distractions of snacks or activities; talk to resident about the unwanted visits

In an interview on January 25, 2017, the DOC indicated to Inspector #571 any investigations for any of the aforementioned allegations of sexual abuse of co-residents by resident #040 and any allegations of sexual abuse towards resident #040 may be found in resident #040's progress notes. The DOC did not receive post abuse investigation reports for any of the aforementioned incidents. The DOC indicated that resident #040 was to be monitored for sexual behaviours every 30 minutes as part of the plan of care.

After review of the clinical record for resident #040, Inspector #571 was unable to locate documentation supporting that investigation was completed after any of the aforementioned incidents; or if the sexual behaviour was consensual. There was no evidence to support that the incidents were reported to the Director.

On an identified date a CI was submitted to report sexual abuse involving resident #008 towards resident #035. CI indicated that PSW #132 witnessed resident #008 being sexually inappropriate towards resident #035. Both residents have severe cognitive impairments.

On an identified date a CI was submitted to report sexual abuse involving resident #008 towards resident #044. CI indicated that resident #044 reported to RPN #118 that resident #008 been sexually inappropriate without consent on the previous evening. RN #130 investigated the allegations with resident #044 but did not report to the MOHLTC when resident #044 indicated not wanting to continue with the complaint of resident #008.

In addition, the DOC indicated in an interview with Inspector #571 on January 25, 2017, that no staff members employed by the home received annual retraining relating to: the home's policy to promote zero tolerance of abuse and neglect of residents; the duty to make mandatory reports under section 24; and the whistle-blowing protections for 2016.

To summarize, the licensee failed to ensure:

-ensuring that resident #008 is reassessed and the plan of care reviewed and revised when the care set out in the plan has not been effective. 6 (10)c (WN #5)

-that direct care staff were advised at the beginning of every shift of resident #008 whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. r. 55. (b) (WN #9)

-that RPN #118, #126, #102, and #104 complied with the licensee's "Abuse and Neglect of a Resident – Actual or Suspected" VII-G-10 policy by not immediately investigating the incidents or reporting the incidents of alleged sexual abuse by resident #008 towards resident #040 and several unidentified residents to charge RN or the licensee. S. 20. (1) (WN #6)
-that RPN #125 complied with the licensee's abuse policy by not immediately

investigating the alleged incident of sexual abuse of resident #029 by resident #040 or reporting the incident to the charge RN or the licensee. S. 20. (1) (WN #6)
-that RPN #118 and #103 complied with the licensee's abuse policy by not immediately investigating the alleged incident of sexual abuse of several unidentified residents by resident #040 or reporting the incidents to the charge RN or the licensee. S. 20. (1) (WN #6)
-that every alleged, suspected or witnessed incident of sexual abuse that the licensee (RN #124) knows of, or that is reported is immediately investigated. s. 23. (1) (a) (WN #7)

-that RN #124 and RN #130 who had reasonable grounds to suspect that alleged sexual abuse has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director. s. 24. (1) (WN #8)

-that employees of the home received annual retraining relating to: the home's policy to promote zero tolerance of abuse and neglect of residents; the duty to make mandatory reports under section 24; and the whistle-blowing protections for 2016. s. 76. (4) (WN #3)

Therefore, the licensee failed to protect resident #35, #040, #041, #043 and #044 from sexual abuse by resident #008. The licensee also failed to protect resident #029 and #008 from sexual abuse by resident #040. [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 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 steps were taken to prevent resident entrapment, taking into consideration all identified zones of entrapment.

During interviews with inspector #194 on January 20, 2017 , ESM and Maintenance Manager indicated that all bed systems were evaluated in the home in December 2016. The ESM and Maintenance Manager indicated to inspector #194 during this interview that the home did not have a current policy related to bed entrapment, and that best practice documentation "Clinical Guidance for the assessment and Implementation of bed Rails in Hospitals, Long Term Care Homes, and Home Care settings (U.S.F.D.A. April 2003) recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document and Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards." had been referred to for the bed system evaluation. Results of the bed system evaluation completed in December 2016 on the "Facility Entrapment Inspection Sheets" indicated that 49 out of 102 beds failed one or more entrapment zones on the assessments sheets. ESM and Maintenance Manager indicated to inspector #194 during the same interview that 5 new beds and mattresses had been ordered, and two beds had been addressed related to entrapment risks identified on the assessment at the time of the interview.

During interview with resident #004 on January 19, 2017 it was observed by inspector #194 that a 3-4 inch gap was present at the foot of the bed. On January 20, 2017 observation of resident #004 bed indicated that a blanket had been rolled up and placed at the end of the bed to fill the gap. Resident #004 indicated to inspector #194 that

when the resident laid down in the afternoon the resident pulled up the blanket to cover up while napping. Resident #004's bed was identified on the Facility Entrapment Inspection Sheet as having failed zones 4, 6 and 7.

During interview with resident #010 on January 19, 2017, inspector #194 observed a 4 inch gap at the head of the resident's bed. Review of the Facility Entrapment Inspection Sheet completed by home in December 2016 identifies that resident #010's bed failed zone 7.

During interview with resident #019 on January 19, 2017, inspector #194 observed a 3-4 inch gap at the foot of the resident's bed. Review of the Facility Entrapment Inspection Sheet completed by home in December 2016 identifies that resident #019's bed failed zone 4 ,6 and 7.

During interview with resident #036 on January 19, 2017, inspector #194 observed a 4 inch gap at the head foot of the resident's bed. Review of the Facility Entrapment Inspection Sheet completed by home in December 2016 identifies that resident #036's bed failed zone 4, 6 and 7.

ESM and Maintenance Manager indicated during interview with inspector #194 on January 20, 2017 that no interventions had been implemented to address the identified entrapment zones for resident #004, #010, #19, #036. [s. 15. (1) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff received annual retraining related to the following: the home's policy "Abuse and Neglect of a Resident – Actual or Suspected" VII-G-10.00 ,to promote zero tolerance of abuse and neglect of residents; the duty to make mandatory reports under section 24; and the whistle-blowing protections.

The DOC indicated in an interview with Inspector #571 on January 25, 2017, that none of the staff members employed by the home received annual retraining relating to: the home's policy to promote zero tolerance of abuse and neglect of residents; the duty to make mandatory reports under section 24; and the whistle-blowing protections in 2016. [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 by ensuring 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., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures identified under the organized housekeeping program at the home, were implemented.

Residents #004 and #033 indicated to Inspector #194 during stage one of the Resident Quality Inspection on January 16, 17 and 19, 2017 that the home was not clean.

Observations completed by inspector #194 on January 18, 23 and 24, 2017 indicated the carpets in the home were in need of vacuuming, cobwebs noted on the lighting fixtures in the TV lounge on all three floors and dining room floors were not mopped after every meal.

Review of policies "Daily Resident Room Cleaning - housekeeping" #XII-F-10.40 dated April 2015, "Deep Cleaning Of Common Areas - Housekeeping" XII-F-10.70 dated April 2011, "Dining Room - Daily Specifications - Housekeeping" XII-G-10.30, dated April 2011, "Rotational Cleaning - Housekeeping", XII-F-10.60 dated September 2013 and "Housekeeping cleaning Frequency Schedule" was completed by inspector #194 and ESM on January 23, 2017.

-Daily Resident Room Cleaning - housekeeping #XII-F-10.40 dated April 2015 indicated that resident room and bathroom floors are to be mopped daily.
-Dining Room - Daily Specifications – Housekeeping #XII-G-10.30, dated April 2011 indicated that dining rooms are to be swept and wet mop floors after each meal. Sweep and wet mop floors after each meal.

-Rotational Cleaning - Housekeeping, XII-F-10.60 dated September 2013 indicated;
All areas within the resident rooms and common areas will be scheduled and cleaned at least once per month;
- Week 1 of the month: High dusting - vents display units, cabinets, louver doors, doors and picture frames, mirrors, lamp and shades, check for cobwebs (clean as applicable)
-Week 2 of the month: Low dusting - baseboards, window ledges, tracks, doors, walls, switches, check for finger prints on wood work and painted surfaces (clean as applicable) check that windows do not open more than 6 inches.
-Week 3 of the month: Ornaments (only ornaments residents wants dusting), windows if required
-Week 4 of the month: Furniture - vacuum chairs, sofas, under cushions, move furniture where possible.
-Housekeeping cleaning Frequency Schedule indicated that carpets were to be vacuumed daily, dining room floors were to be swept and mopped after each meal.

On January 23 and 24, 2017 interviews with housekeeping staff #114, #115 and #121

were completed by inspector #194 related to cleaning of the home. Staff #115 and staff #121 indicated to inspector #194 that the dining room floors were not mopped after every meal. Staff #115 also indicated during same interview with vacuuming of the carpeted areas in the hallways of the home was completed by the housekeeper that worked 12:00 – 19:00 hour shift. Staff #115 indicated to inspector #194 that vacuuming of the carpeted areas was completed over a three day period, one floor per day only. Staff #115 and #114 indicated that resident rooms and bathrooms were mopped every other day.

Interview with ESM was conducted on January 20 and 24, 2017 related to housekeeping routines and cleaning schedules. ESM has indicated to inspector #194 during interview that there was no rotational cleaning in place at this time, as directed under policy "Rotational Cleaning - Housekeeping", XII-F-10.60 dated September 2013. [s. 87. (2) (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 ensuring that procedures are developed and implemented for, (a) cleaning of the home., to be implemented voluntarily.

WN #5: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised when the care set out in the plan has not been effective.

Re: Log #019817-16:

A CI was submitted to the Director for an alleged sexual abuse of resident #041 by resident #008. The CI indicated that resident #008 was sexually inappropriate towards resident #041. Resident #041 was upset by the incident.

A review of the clinical health record by Inspector #571 indicated that resident #008 is cognitively impaired and wheelchair bound but can self-propel at times.

As outlined in WN #1, resident #008 was observed demonstrating inappropriate sexual behaviour on at least nine occasions in the period reviewed. Resident #008's plan of care indicated that the following interventions were currently in place to help manage resident #008's inappropriate sexual behaviour: set limits for acceptable behaviour; protect other residents, never leave resident #008 alone with other confused residents; explain the effect of the behaviour on other residents; avoid any conversations that may encourage or initiate inappropriate behaviour ; two person physical assist at all times due to inappropriate touching of staff members; 30 minute checks to ensure the behaviour is not being exhibited towards co-residents.

In an interview on January 25, 2017, the ADOC reviewed the current plan of care for resident #008 and indicated that the only interventions added or modified in 2016 were when the resident was put on checks every 15 minute after a Critical Incident Report (CIR) which was submitted to Director for a previously inspected incident of sexual abuse involving resident #040. Then two months later the plan of care was modified to checks every 30 minute as no further sexually inappropriate behaviour was evident at that time. Other care plan interventions for sexual behaviours were initiated and have remained unchanged since 2015. CI indicated that resident #008 would be referred to the external sources for assessment. The ADOC indicated during a telephone interview with Inspector #571 that this referral had not been completed.

On an identified date a CI was submitted to report sexual abuse involving resident #008 towards resident #035. CI indicated that PSW #132 witnessed resident #008 being sexually inappropriate towards resident #035. Both residents have severe cognitive impairments. After this incident the ADOC indicated to inspector #571 in a telephone interview that the following changes had been implemented to resident #008's plan of care;
Checks increased to every 15 minutes
Relocated to an all same gender table in the dining room

Referral to external source was initiated

On an identified date a CI was submitted to report sexual abuse involving resident #008 towards resident #044. CI indicated that resident #044 reported to RPN #118 that resident #008 had been sexually inappropriate towards resident #044. RN #130 investigated that allegations with resident #044 but did not report to the MOHLTC when resident #044 indicated not wanting to continue with the complaint of resident #008.

Interview with resident #044 was completed by inspector #194 and DOC. Resident #044 had no cognitive impairment and indicated that on the identified date of being in a common area, speaking to a co resident when resident #008 became sexually inappropriate towards the resident. During the same interview with inspector #194, Resident #044 indicated physically stopping resident #008. Resident #044 indicated to inspector #194 that resident #008 had been sexually inappropriate on two previous occasions in the common areas. Resident #044 was unable to provide specific dates, but indicated to inspector that when the sexually inappropriate behaviour was occurring that resident #044 moved away from resident #008. Resident #044 indicated not previously reporting resident #008's behaviour to staff.

Although some revisions to the plan of care have been initiated for resident #008 it is evident that the plan of care for resident #008 continues to be ineffective. [s. 6. (10) (c)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that their policy to promote zero tolerance of abuse and neglect was complied with.

The licensee's "Abuse and Neglect of a Resident – Actual or Suspected" VII-G-10.00 defines sexual abuse as: a) any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

In addition, when a staff member becomes aware of potential or actual abuse, be it by a staff member, volunteer, family member, or co-worker, Policy VII-G-10.00 directs the following: Charge Nurse to notify the RN in charge; the DOC/Administrator; review the MOHLTC decision tree; initiate the Nursing Checklist for reporting and investigating alleged abuse. The charge RN is directed to notify the physician and SDM; interview all witnesses that have knowledge regarding the allegation, including the victim if possible; and continue completion of nursing checklist for reporting and investigating the alleged abuse. The Administrator or designate is instructed to: assume investigative lead for the incident investigation; review all steps taken ensuring the safety of the alleged abuse victims; notify the MOH immediately; complete a CIS; and continue completing the nursing checklist for reporting and investigating.

Re: Alleged sexual abuse of resident #040 and unidentified residents by resident #008:

A review of the clinical health record by Inspector #571 indicated that resident #008 is cognitively impaired, wheelchair bound but can self-propel at times.

Resident #040 is cognitively impaired, wheelchair bound and can self-propel.

A review of the progress notes for resident #008 for a period of one year indicated the following:

-on an identified date: resident #008 observed by RPN #118 being sexually inappropriate towards resident #040.
-on an identified date : RPN #126 documented that resident #008 was being sexually inappropriate towards resident #040.
-on an identified date : RPN #118 documented that resident #008 was being sexually inappropriate towards an unidentified resident.
-on an identified date: RPN #102 documented that resident #008 was being sexually inappropriate towards an unidentified resident.
-on an identified date: Physiotherapist #127 documented that resident #008 was being

sexually inappropriate towards unidentified resident. Nurse notified.
-on an identified date: RPN #104 documented that resident #008 was observed being sexually inappropriate towards resident #040; resident #040 was being sexually inappropriate towards resident #008.
-on an identified date: RPN #118 documented that resident #008 was being sexually inappropriate towards an unidentified resident.

In an interview with Inspector #571, RPN #118 indicated that resident #008 has sexually inappropriate behaviour ; the resident is monitored every 30 minutes and staff are to separate the resident from other co-residents after an incident. RPN #118 indicated that she/he did not consider this behaviour to be sexual abuse as resident #008 is cognitively impaired and therefore had not reported or investigated the behaviours.

After review of the clinical record for resident #040, Inspector #571 was unable to locate documentation supporting an investigation was completed for any of the aforementioned incidents or that the charge RN or the licensee were made aware of these allegations of alleged sexual abuse.

Re: Alleged sexual abuse of several unidentified male residents and resident #008 by resident #040:

A review of the progress notes of resident #040 by Inspector #571 indicated that resident #040 displayed sexually inappropriate behaviour :
-on an identified date: RPN #118 documented that resident #040 was being sexually inappropriate towards an unidentified resident.
-on an identified date: RPN #103 documented that resident #040 was being sexually inappropriate towards an unidentified resident.
-on an identified date: RPN #118 documented that resident #040 has been observed being sexually inappropriate towards an unidentified resident..
-on an identified date: RPN #104 documented that resident #008 was observed being sexually inappropriate towards resident #040; resident #040 was sexually inappropriate towards resident #008.

Re: Alleged sexual abuse of resident #029 by resident #040:

A review of the clinical record by Inspector #571 indicated that resident #029 is not cognitively impaired.

A review of the progress notes indicated that on an identified dated, resident #029 indicated to RPN #125 that resident #040 had been sexually inappropriate towards resident #029

After review of the clinical record for resident #008, #040 and #029, Inspector #571 was unable to locate documentation supporting an investigation was completed for any of the previously mentioned incidents or that the charge RN or the licensee were made aware of these allegations of sexual abuse.

In an interview on January 25, 2017, the DOC indicated to Inspector #571 that resident #040 was to be monitored for sexual behaviours every 30 minutes as part of the plan of care and any investigations for the aforementioned allegations of sexual abuse of co-residents by or towards resident #040 would be found in resident #040's progress notes. The DOC did not receive post abuse investigation reports for any of the aforementioned incidents.

On an identified date resident #044 reported an allegation of sexual abuse by resident #008 to RPN# 118. RPN #118 reported the allegations of sexual abuse to RN #130, who investigated the incident. During interview with inspector #194 resident #044 indicated that resident #008 had been sexually inappropriate. Resident #044 indicated physically stopping resident #008 also indicating that there had been two other incidents when resident #008 had been sexually inappropriate, but was unable to remember exact dates. RN #130 did not report the allegation of sexual abuse to the Director when resident #044 indicated not wanting to continue with the complaint against resident #008. A CIR was submitted to the Director two days later.

Therefore, the licensee failed to ensure that RPN # 102, #103, #104, #118, 125 and 126 complied with the licensee's "Abuse and Neglect of a Resident – Actual or Suspected" policy by reporting the witnessed allegations of sexual abuse to the charge RN or initiating an investigation and RN #130 did not immediately report sexual abuse to the MOHLTC. [s. 20. (1)]

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. A review of the clinical record by resident #571 indicated that resident #043 is cognitively impaired and immobile. Resident #008 is cognitively impaired, wheelchair bound but can self-propel at times.

The progress notes reviewed by Inspector #571 did not identify the resident who was the recipient of the sexually inappropriately behaviour by resident #008 on an identified date. After cross referencing resident #043's progress notes with resident #008's notes, it was determined that resident #043 had been the recipient of inappropriate sexual behaviour by resident #008. The progress notes indicated that on an identified, charge RN #124 was informed by the unit RPN that resident #008 was observed being sexually inappropriate towards resident #043.

On January 25, 2017, the ADOC indicated in an interview with Inspector #571 that she did not receive a post abuse investigation form for the incident occurring between resident #008 and #043 from RN #124 concluding that no investigation into the incident had occurred.

After review of the clinical record for resident #008 and #043, Inspector #571 was unable to locate documentation supporting an investigation was completed by the charge RN or any other staff members for this allegation sexual abuse.

A review of the clinical record by Inspector #571 indicated that resident #040 is

cognitively impaired wheelchair bound and can self-propel on the unit. Resident #029 is not cognitively impaired.

A review of the progress notes indicated that on an identified date, resident #029 indicated to RPN #125 that resident #040 had been sexually inappropriate towards resident #029.

After a review of the clinical record for resident #040 and #029, Inspector #571 was unable to locate documentation supporting an investigation was completed by RPN #125 or that the charge RN or the licensee were being made aware of this allegation of alleged sexual abuse. There was no evidence to support that this incident was reported to the Director.

Re: Alleged sexual abuse of several unidentified male residents by resident #040:

A review of the progress notes of resident #040 by Inspector #571 indicated that resident #040 displayed sexually inappropriate behaviour:
-on an identified date: RPN #118 documented that resident #040 was sexually inappropriate towards an unidentified resident.
-on an identified date: RPN #103 documented that resident #040 was sexually inappropriate towards an unidentified resident.
-on an identified date: RPN #118 documented that resident #040 has been observed being sexually inappropriate towards an unidentified resident

In an interview on January 25, 2017, the DOC indicated to Inspector #571 any investigations for any of the aforementioned allegations of sexual abuse of co-residents by resident #040 and any allegations of sexual abuse towards resident #040 may be found in resident #040's progress notes. The DOC did not receive post abuse investigation reports for any of the aforementioned incidents. The DOC indicated that resident #040 was to be monitored for sexual behaviours every 30 minutes as part of the plan of care.

After review of the clinical record for resident #040, Inspector #571 was unable to locate documentation supporting that any investigation was completed related to the aforementioned incidents; or if the sexual behaviour was consensual. No evidence was provided to support these incidents were reported to the Director. [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. The licensee has failed to ensure that charge RN #124 immediately reported an allegation of sexual abuse to the Director.

A review of the clinical record by resident #571 indicated that resident #043 is cognitively impaired and is immobile. Resident #008 is cognitively impaired, is wheelchair bound but can self-propel at times.

The progress notes reviewed by Inspector #571 did not identify the resident who was the recipient of the inappropriately sexually behaviour by resident #008 on an identified date. After cross referencing resident #043's progress notes with resident #008's notes, it was determined that resident #043 had been the recipient of inappropriate sexual behaviour by resident #008 as identified in WN #1. The progress notes indicated that on an identified date, charge RN #124 was informed by the unit RPN that resident #008 was observed being sexually inappropriate towards resident #043.

On January 25, 2017, the ADOC indicated in an interview with Inspector #571 that she did not receive a post abuse investigation form for the incident occurring between resident #008 and #043. This incident was not reported to the Director.

On an identified date resident #044 reported to RPN #118 that resident #008 had been sexually inappropriate towards resident #044 . RPN #118 reported the incident to RN #130 who investigated the allegations, but did not report to the MOHLTC when resident #044 indicated not wanting to continue with the complaint of resident #008.

On an identified date MOHLTC was notified of the allegations sexual abuse involving resident #008 and resident #044, through the after hours number. Two days after the reported allegations to RN #130.

During an interview with inspector #194 on February 14, 2017 DOC indicated that RN #130 should have notified the MOHLTC when resident #044 reported the allegations of sexual abuse. [s. 24. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff were advised at the beginning of every shift of resident #008's sexually inappropriate behaviours that require heightened monitoring because those behaviours posed a potential risk to residents.

Re: Log #019817-16:

Critical Incident (CI) was submitted to the Director for an alleged sexual abuse of resident #041 by resident #008. The CI indicates that resident #008 was sexually inappropriate towards resident #041. Resident #041 was upset by the incident.

As outlined in WN #1, resident #008 was observed demonstrating inappropriate sexual behaviour on at least nine occasions.

In an interview on January 24, 2017, RPN #103 indicated to Inspector #571 that staff would be informed about residents whose behaviours pose a risk to other residents or staff by reading the shift report. If staff had been off for several days, staff could read previous reports. The RPN would share information from report with the PSW's during shift report.

PSW #128 and #129 indicated in separate interviews with Inspector #571, that they were not aware that resident #008 had a sexually inappropriate behaviour. [s. 55. (b)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the required information was posted in the home in a conspicuous and easily accessible location.

The LTCHA, 2007, s. 79. (3) states the following is the required information to be posted:

(3) The required information for the purposes of subsections (1) and (2) is,

(a) the Residents' Bill of Rights;

(b) the long-term care home's mission statement;

(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;

(d) an explanation of the duty under section 24 to make mandatory reports;

(e) the long-term care home's procedure for initiating complaints to the licensee;

(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints;

(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained;

(g.1) a copy of the service accountability agreement as defined in section 21 of the Commitment to the Future of Medicare Act, 2004 entered into between the licensee and a local health integration network;

(h) the name and telephone number of the licensee;

(i) an explanation of the measures to be taken in case of fire;

(j) an explanation of evacuation procedures;

(k) copies of the inspection reports from the past two years for the long-term care home;

(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years;

(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years;

(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council;

(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council;

(p) an explanation of the protections afforded under section 26; and

(q) any other information provided for in the regulations.

A tour was conducted of the home on January 16, 2017 by Inspector #571. The following information was not observed posted in a conspicuous and easily accessible location:
-the home's policy to promote zero tolerance of abuse and neglect of residents was posted in a locked glass cupboard on cedar unit with only the first page visible;
-the most recent minutes of the Residents' Council meetings was posted in a locked glass cupboard on cedar unit
-an explanation of the protections afforded under section 26 and an explanation of the duty under section 24 to make mandatory reports was posted behind the licensee's policy to promote zero tolerance of abuse and neglect in the locked glass cupboard and

therefore was not visible nor accessible;
-notification of the long-term care home’s policy to minimize the restraining of residents, and how a copy of the policy can be obtained was not posted

In an interview on January 23, 2017, the DOC indicated that the licensee's restraint policy was not posted and that the policy to promote zero tolerance of abuse and neglect and section 24 and 26 were inaccessible as they were in a locked cupboard behind glass on one of the resident home areas. [s. 79. (1)]

Issued on this 23rd day of February, 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) :	CHANTAL LAFRENIERE (194), KELLY BURNS (554), PATRICIA MATA (571)
Inspection No. / No de l'inspection :	2017_603194_0004
Log No. / Registre no:	000663-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 21, 2017
Licensee / Titulaire de permis :	TRENT VALLEY LODGE LIMITED 195 Bay Street, TRENTON, ON, K8V-1H6
LTC Home / Foyer de SLD :	TRENT VALLEY LODGE LIMITED 195 BAY STREET, TRENTON, ON, K8V-1H9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bill Weaver

To TRENT VALLEY LODGE LIMITED, 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 prepare, submit and implement a plan that addresses how the home shall become compliant with the following:

1. Immediately reassess the responsive behaviours and triggers, including sexually inappropriate behaviour, of resident #008 and #040 and revise the plan of care so that other residents are protected from potential sexual abuse by either resident.

2. Develop and implement a procedure to ensure that all direct care staff are advised at the beginning of every shift of resident #008 and #040's sexually inappropriate behaviours that require heightened monitoring because those behaviours posed a potential risk to resident.

3. Develop and implement a monitoring process to ensure all residents demonstrating responsive behaviours of a sexual nature are identified and assessed by members of the health care team (including direct care staff) using a multidisciplinary approach.

4. Ensure that all staff and managers complete a mandatory, comprehensive and interactive education session offered in various formats to meet the learning needs of adult learners specific to Zero Tolerance of Abuse. The education should include, but not limited to:
-definitions of abuse as defined by Ontario Regulation 79/10, s. 2 with a heightened emphasis of the definition of sexual abuse;
-the meaning of "consent" and how it is determined for residents who are cognitively impaired and where cognition fluctuates depending on the situation;
-an explanation of the "duty to report" as it relates to the LTCHA 2007, s. 24 and

the requirements relating to making mandatory reports, including s. 26 whistle-blowing protection;
-the use of the MOHLTC Abuse Decision Tree Algorithms (as a guide)
-immediately investigate any reported suspicion, allegation or witnessed incidents of abuse ensuring a process is in place to identify who the recipient residents are;
-taking appropriate actions to safe-guard identified residents in incidences of alleged, suspected or witnessed abuse. Ensuring the residents are assessed, and the incidents and assessment are documented;
-a review of the home's specific policies related to resident abuse by persons other than staff (including resident to resident abuse), and any other home related policies specific to resident abuse (investigating and reporting), Resident Bill of Rights and mandatory reporting;

5. Assess the effectiveness of the education provided to ensure sustained compliance relating to reporting specific to s. 24; notification of required individuals in incidence of alleged, suspected or witnessed abuse, specifically sexual abuse; and the need to ensure appropriate interventions are taken to safe-guard residents at risk and any other residents who may be vulnerable, are protected from abuse by anyone; and

6. Ensure that the zero tolerance of abuse and neglect and responsive behaviour program is monitored, reviewed and analyzed on an ongoing basis to determine the need for further corrective actions as part of the licensee's quality improvement program.

7. Furthermore, the licensee shall maintain a detailed written account of all the steps taken and the results achieved during each of the planning, implementation and evaluation phases of this education strategy and monitoring process.

The plan is to be faxed to Ottawa Service Area Office at 1-613-569-9670, Attention Patricia Mata by February 28, 2017.

Grounds / Motifs :

1. The licensee's "Abuse and Neglect of a Resident – Actual or Suspected" VII-G-10.00 defines sexual abuse as: a) any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or b) any non-

consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Re: Log #019817-16:

A Critical Incident (CI) was submitted to the Director for an alleged sexual abuse of resident #041 by resident #008. The CI indicated that resident #008 was sexually inappropriate towards resident #041. Resident #041 was upset by the incident.

Re: Alleged sexual abuse of resident #041 and #040 by resident #008:

A review of the clinical health record by Inspector #571 indicated that resident #008 is cognitively impaired, wheelchair bound but can self-propel at times.

Resident #041 is able to direct his/her own care with some assistance from staff in new situations. Resident #041 is also wheelchair bound.

Resident #040 is cognitively impaired, is wheelchair bound and can self-propel.

The progress notes for resident #008 for a period of 12 months were reviewed by Inspector #571. In interviews PSW's #111 and #112, indicated that they have observed resident #008 being sexually inappropriate with resident #036, #043, #040, and #035. Inspector #571 and #194 reviewed the progress notes for these residents for the same time period in order to attempt to identify the recipients of the inappropriate sexual behaviour and whether consent was given. The inspectors were unable to identify all residents involved.

-on an identified date : resident #008 observed by RPN #118 being sexually inappropriate towards resident #040.
-on an identified date: RPN #126 documented resident #008 being sexually inappropriate towards resident #040.
-on an identified date: RPN #118 documented resident #008 being sexually inappropriate towards unidentified resident.
-on an identified date: RPN #102 documented resident #008 being sexually inappropriate towards unidentified resident.
-on an identified date: CI submitted to report, resident #008 being sexually inappropriate towards resident #041.

-on an identified date: Physiotherapist #127 documented resident #008 being sexually inappropriate towards unidentified resident.
-on an identified date: RPN #104 documented resident #008 being sexually inappropriate towards resident #040; resident #040 being sexually inappropriate towards resident #008.
-on an identified date : RPN #118 documented resident #008 being sexually inappropriate towards unidentified resident.
-on an identified date: RN #124 documented resident #008 being sexually inappropriate towards resident #043'.

A review of resident #008's plan of care :

-Problem: Inappropriate Socially due to cognitive impairment
-Expected Outcomes: Incidence of inappropriate sexual behaviour will decrease
-Interventions: set limits for acceptable behaviour; protect other residents, never leave resident #008 alone with other confused residents; explain the effect of the behaviour on other residents; avoid any conversations that may encourage or initiate inappropriate behaviour; two person physical assist at all times due to inappropriate touching of staff members; 30 minute checks to ensure the behaviour is not being exhibited towards residents.

In an interview with Inspector #571, RPN #118 indicated that resident #008 has a behaviour of being sexually inappropriate; resident #008 is monitored every 30 minutes and staff are to separate the resident from other residents after an incident. RPN #118 indicated not considering the behaviour to be sexual abuse as resident #008 is cognitively impaired.

In an interview with Inspector #571, the DOC indicated that she was not aware of the aforementioned allegations of sexual abuse except for the incident that occurred and was reported through the CIS system. The CCC, also present during the same interview, indicated that the DOC, several staff did not consider the behaviour exhibited to be sexual abuse but rather intimacy therefore the aforementioned incidents were not investigated, or reported to the Director except for the incident that was reported through CIR. The DOC also indicated that they do not have a procedure for notifying staff, of residents that are at risk of harm from residents displaying responsive behaviours.

In a separate interview, the ADOC indicated to Inspector #571 that if sexual abuse is suspected then the PSWs would report to the unit RPN. The RPN will

inform the charge RN who would complete an investigation including a post abuse investigation form. After the RN in charge completes the licensee's post abuse investigation form, the RN submits the investigation form to the DOC who then forwards it to the ADOC.

The ADOC did not receive a post abuse investigation form for any of the aforementioned incidents with the exception of the incident that was reported through CIR. The ADOC indicated the exhibited behaviour of resident #008 was not considered sexual abuse except for the incident that was reported to the Director. This incident was reported because of resident #041's negative response to the exhibited behaviour by resident #008. The ADOC reviewed the current plan of care for resident #008 and indicated that the only interventions added or modified in 2016 were completed when the resident was put on every 15 minute checks after a CI was submitted to Director for a previously reported sexual abuse involving resident #040. Then, two months later the plan of care was modified to every 30 minute checks as no further sexually inappropriate behaviours were evident at that time. The other interventions under socially inappropriate for sexual behaviours were initiated and unchanged since 2015. CI indicated that resident #008 would be referred to the external sources for assessment. The ADOC indicated that this referral has never been done.

In an interview , RPN #103 indicated to Inspector #571 that staff would be informed about residents whose behaviours pose a risk to other residents or staff by reading the shift report. If staff had been off for several days, staff could read previous reports. The RPN would share information from the reports with the PSW's during shift report.

PSW #128 and #129 indicated in separate interviews with Inspector #571, that they were not aware that resident #008 had any sexual inappropriate behaviour.

Re: Alleged sexual abuse of resident #043 by resident #008:

A review of the clinical record for resident #043 by Inspector #571 indicated that resident #043 is cognitively impaired and is immobile.

A review of the progress notes by Inspector #571 indicated that on an identified date, charge RN #124 documented being informed by the unit RPN that resident #008 was observed being sexually inappropriate towards resident #043.

On January 25, 2017, the ADOC indicated in an interview with Inspector #571 of not having received a post abuse investigation form for the incident occurring between resident #008 and #043 from RN #124, concluding that no investigation into the incident had occurred. This incident was not reported to the Director.

Re: Alleged sexual abuse of resident #029 by resident #040:

A review of the clinical record by Inspector #571 indicated that resident #040 was cognitively impaired, wheelchair bound and can self-propel. Resident #029 did not have any cognitive impairments.

A review of the progress notes indicated that on an identified date, resident #029 indicated to RPN #125 that resident #040 had been in the resident's room and was sexually inappropriate towards resident #029.

After a review of the clinical record for resident #040 and #029, Inspector #571 was unable to locate documentation supporting that an investigation was completed by RPN #125 or that the charge RN or the licensee were made aware of this allegation of alleged sexual abuse. There was no evidence to support that this incident was reported to the Director.

Re: Alleged sexual abuse of several unidentified male residents by resident #040:

A review of the progress notes of resident #040 by Inspector #571 indicated that resident #040 displayed sexually inappropriate behaviour:
-on an identified date: RPN #118 documented that resident #040 was sexually inappropriate towards an unidentified resident.
-on an identified date: RPN #103 documented that resident #040 was sexually inappropriate towards an unidentified resident.
-on an identified date: RPN #118 documented that resident #040 was sexually inappropriate towards an unidentified resident.

A review of resident #040's current plan of care indicated the following:

-Behaviour: Wandering
-Expected Outcomes: to maintain safety and comfort in the environment
-Interventions: 30 minute checks for falls; monitor whereabouts while self-

propelling in wheelchair; determine if there is a reason for wander (i.e. bathroom);

-Behaviour: Inappropriate Socially (cognitive impairment, lack of appropriate partner)
-Expected Outcomes: incidence of inappropriate sexual behaviour will decrease over the next three months
-Interventions: sexual behaviour- resident #040 told a staff member that a resident on the unit reminds the resident of the residents spouse. Resident #040 has been observed and removed from this resident's room on several occasions. Staff will explain to resident that the advances are not welcomed by this resident and that the resident needs to stay out of the other resident's room. Resident #040 is on 30 minute checks for self-transferring out of the wheelchair and the resident's whereabouts due to wandering into other rooms. Resident #040 has a personal alarm attached to clothing when the resident is up in the wheelchair and a bed alarm to alert staff if the resident is trying to get out of bed. Staff are to redirect the resident away from these incidences with distractions of snacks or activities; talk to resident about the unwanted visits

In an interview on January 25, 2017, the DOC indicated to Inspector #571 any investigations for any of the aforementioned allegations of sexual abuse of co-residents by resident #040 and any allegations of sexual abuse towards resident #040 may be found in resident #040's progress notes. The DOC did not receive post abuse investigation reports for any of the aforementioned incidents. The DOC indicated that resident #040 was to be monitored for sexual behaviours every 30 minutes as part of the plan of care.

After review of the clinical record for resident #040, Inspector #571 was unable to locate documentation supporting that investigation was completed after any of the aforementioned incidents; or if the sexual behaviour was consensual. There was no evidence to support that the incidents were reported to the Director.

On an identified date a CI was submitted to report sexual abuse involving resident #008 towards resident #035. CI indicated that PSW #132 witnessed resident #008 being sexually inappropriate towards resident #035. Both residents have severe cognitive impairments.

On an identified date a CI was submitted to report sexual abuse involving resident #008 towards resident #044. CI indicated that resident #044 reported

to RPN #118 that resident #008 been sexually inappropriate without consent on the previous evening. RN #130 investigated the allegations with resident #044 but did not report to the MOHLTC when resident #044 indicated not wanting to continue with the complaint of resident #008.

In addition, the DOC indicated in an interview with Inspector #571 on January 25, 2017, that no staff members employed by the home received annual retraining relating to: the home's policy to promote zero tolerance of abuse and neglect of residents; the duty to make mandatory reports under section 24; and the whistle-blowing protections for 2016.

To summarize, the licensee failed to ensure:

-ensuring that resident #008 is reassessed and the plan of care reviewed and revised when the care set out in the plan has not been effective. 6 (10)c (WN #5)

-that direct care staff were advised at the beginning of every shift of resident #008 whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. r. 55. (b) (WN #9)

-that RPN #118, #126, #102, and #104 complied with the licensee's "Abuse and Neglect of a Resident – Actual or Suspected" VII-G-10 policy by not immediately investigating the incidents or reporting the incidents of alleged sexual abuse by resident #008 towards resident #040 and several unidentified residents to charge RN or the licensee. S. 20. (1) (WN #6)
-that RPN #125 complied with the licensee's abuse policy by not immediately investigating the alleged incident of sexual abuse of resident #029 by resident #040 or reporting the incident to the charge RN or the licensee. S. 20. (1) (WN #6)
-that RPN #118 and #103 complied with the licensee's abuse policy by not immediately investigating the alleged incident of sexual abuse of several unidentified residents by resident #040 or reporting the incidents to the charge RN or the licensee. S. 20. (1) (WN #6)
-that every alleged, suspected or witnessed incident of sexual abuse that the licensee (RN #124) knows of, or that is reported is immediately investigated. s. 23. (1) (a) (WN #7)

-that RN #124 and RN #130 who had reasonable grounds to suspect that alleged sexual abuse has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director. s. 24. (1) (WN #8)

-that employees of the home received annual retraining relating to: the home's policy to promote zero tolerance of abuse and neglect of residents; the duty to make mandatory reports under section 24; and the whistle-blowing protections for 2016. s. 76. (4) (WN #3)

Therefore, the licensee failed to protect resident #35, #040, #041, #043 and #044 from sexual abuse by resident #008. The licensee also failed to protect resident #029 and #008 from sexual abuse by resident #040. [s. 19. (1)]

A compliance order is being issued related to severity and scope of the evidence, the licensee failed to protect resident #35, #040, #041, #043, and #044 from sexual abuse by resident #008. The licensee also failed to protect resident #029 and #008 from sexual abuse by resident #040. Abuse education was not provided to staff in 2016 and the abuse police was not complied with related to reporting and investigation requirements. The Compliance history indicated that a previous Compliance order was issued to the home for s. 19 under inspection report # 2015_396103_0004 in February 2015. (571)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 05, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(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).

Order / Ordre :

The Licensee is hereby ordered to complete the following:

-Implement measures to eliminate the risk of entrapment identified in the "Facility Entrapment Inspection Sheets" completed at the home in December 2016.

- An interdisciplinary team shall re-assess all residents who use one or more bed rails, if the resident's bed or health condition has changed and if any part of the bed was modified including the side rails or and the mattress.

-Steps shall be taken to prevent resident entrapment, taking into consideration all potential zones of entrapment when resident's bed or health condition has changed and/or if any part of the bed modified including the side rails or/and the mattress.

-Develop and implement an education and information package for staff, families and residents identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risk s of bed rails use, whether beds pass or fail entrapment zone testing, the role of the SDM and licensee with respect to resident assessments and any other relevant facts or myths associated with bed systems and use of bed rails.

Grounds / Motifs :

1. During interviews with inspector #194 on January 20, 2017 , ESM and Maintenance Manager indicated that all bed systems were evaluated in the home in December 2016. The ESM and Maintenance Manager indicated to inspector #194 during this interview that the home did not have a current policy related to bed entrapment, and that best practice documentation "Clinical Guidance for the assessment and Implementation of bed Rails in Hospitals, Long Term Care Homes, and Home Care settings (U.S.F.D.A. April 2003) recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document and Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards." had been referred to for the bed system evaluation. Results of the bed system evaluation completed in December 2016 on the "Facility Entrapment Inspection Sheets" indicated that 49 out of 102 beds failed one or more entrapment zones on the assessments sheets. ESM and Maintenance Manager indicated to inspector #194 during the same interview that 5 new beds and mattresses had been ordered, and two beds had been addressed related to entrapment risks

identified on the assessment at the time of the interview.

During interview with resident #004 on January 19, 2017 it was observed by inspector #194 that a 3-4 inch gap was present at the foot of the bed. On January 20, 2017 observation of resident #004 bed indicated that a blanket had been rolled up and placed at the end of the bed to fill the gap. Resident #004 indicated to inspector #194 that when the resident laid down in the afternoon the resident pulled up the blanket to cover up while napping. Resident #004's bed was identified on the Facility Entrapment Inspection Sheet as having failed zones 4,6 and 7.

During interview with resident #010 on January 19, 2017, inspector #194 observed a 4 inch gap at the head of the resident's bed. Review of the Facility Entrapment Inspection Sheet completed by home in December 2016 identifies that resident #010's bed failed zone 7.

During interview with resident #019 on January 19, 2017, inspector #194 observed a 3-4 inch gap at the foot of the resident's bed. Review of the Facility Entrapment Inspection Sheet completed by home in December 2016 identifies that resident #019's bed failed zone 4,6 and 7.

During interview with resident #036 on January 19, 2017, inspector #194 observed a 4 inch gap at the head foot of the resident's bed. Review of the Facility Entrapment Inspection Sheet completed by home in December 2016 identifies that resident #036's bed failed zone 4,6 and 7.

ESM and Maintenance Manager indicated during interview with inspector #194 on January 20, 2017 that no interventions had been implemented to address the identified entrapment zones for resident #004, #010, #19, #036.

A compliance order is being issued related to the severity and scope of the evidence. Bed system evaluation completed in December 2016 identified 46 our 102 bed failed one or more entrapment zones with minimal measures being implemented to eliminate the risk to residents. (194)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 05, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 21st day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Chantal Lafreniere

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