Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d’inspection prévue le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l’inspection	Log #/ Registre no	Type of Inspection / Genre d’inspection
Mar 08, 2016;	2016_360111_0002 (A1)	012529-15	Follow up

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF KAWARTHA LAKES
26 Francis Streeet LINDSAY ON K9V 5R8

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

VICTORIA MANOR HOME FOR THE AGED
220 ANGELINE STREET SOUTH LINDSAY ON K9V 4R2

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

LYNDA BROWN (111) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

Hi Pam,
Here is the amended Order and Inspection report (Licensee) to the dates as agreed.
Thanks
Lynda Brown,
LTC Inspector (Nursing)

Issued on this 8 day of March 2016 (A1)

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

Original report signed by the inspector.

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LYNDA BROWN (111) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): January 18-21 & 25-29, 2016

This follow up inspection (log #012529-15) for resident to resident abuse was completed concurrently with:

-critical incident inspections (log #020518-15, 031929-15, 020762-15 and 027184-15 related to falls resulting in transfer to hospital; critical incident inspections (log # 014718-15, 031929-15, 031927-15, 33599-15, 025375-15, 028518-15, 001019-16, and 036165-15 for resident to resident alleged abuse); critical incident inspections (log# 025591-15 & 032760-15 related to alleged neglect of resident & improper care); critical incident inspections (log # 030387-15 & 033526-15 for medication incidents); and critical incident inspection (log # 034107-15 related to missing property.

-Complaint inspections (log#000328-16 related to resident care) and complaint inspections (log # 000124-16 for resident to resident abuse)

During the course of the inspection, the inspector(s) spoke with Residents, families, the Administrator, Acting Director of Care (A-DOC), Acting Assistant Director of Care (A-ADOC),Resident and Family Services Manager (RFSM), Human Resources (HR), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist(PT), Behavioural Support Ontario (BSO) staff.

There was also observation of residents and a review of current & deceased resident health records, review of the home's investigations, and review of the following home's policies (falls prevention, complaints, responsive behaviours, prevention of abuse and neglect of residents, restraints, and lifts and transfers).

The following Inspection Protocols were used during this inspection:

Falls Prevention

Medication

Minimizing of Restraining

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

14 WN(s)
3 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #024 was protected from physical abuse by resident #023, pursuant to s.19 of the LTCHA.

Under O. Reg. 79/10, s.2 (1)Physical abuse means, (c) the use of physical force by a

resident that causes physical injury to another resident.

Related to log #001019-16 for resident #023 & #024:

A review of the clinical records for resident #023 & #024 for a two month period indicated resident #024 was not cognitively impaired but resident #023 was. There were four documented instances where resident #024 was the recipient of either suspected or actual physical abuse from resident #023. For every documented instance, resident #023 had entered resident #024's bedroom where the incidents took place.

On a specified date and time, the first incident occurred and no injuries were noted. There was no further documentation until two days later, when staff noted injuries to specified areas. The Director, police and Substitute Decision Maker (SDM) were notified at this time of the physical abuse incident.

Approximately one month later, the second incident occurred and the SDM of resident #024 was not notified as the resident requested the SDM not be notified of the incident. There were no immediate actions identified to prevent recurrence.

Two days later, the third incident occurred and resident #024 requested the SDM be contacted the following day. The only action taken by the home to prevent a recurrence included using a locking device to resident #024 door. The Director, police and SDM were notified the following day of the incident. Actions taken to prevent a recurrence included medication changes for resident #023 and a referral to psycho-geriatric resources.

Approximately two weeks later, the fourth incident occurred. No injuries were noted at that time. The only action taken was a reminder to resident #024 to utilize a locking device. The police were not notified and the incident and it was not reported to the Director.

The home also received a verbal complaint by the SDM of resident #024 after the last incident.

During an interview with resident #024, the resident recalled all four incidents and expressed being "fearful" of resident #023, and "did not feel safe" in the home.

During interview with the acting DOC, she confirmed that the four incidents that

occurred were considered alleged or suspected physical abuse and should have been immediately reported to the Director. The acting DOC also indicated the home failed to protect resident #024 from resident #023.

Therefore, the licensee failed to protect resident #024 from ongoing physical abuse by resident #023 as identified by the following:
-when resident #023 demonstrated ongoing physical abuse and/or physical aggression towards resident #024, the behavioural triggers were not identified, and strategies and actions takes to respond to these responsive behaviours were not developed and implemented, where possible, as identified under O.Reg. 79/10, s.53(4)(a)(b)(c) under WN#9.
-The home did not immediately investigate the incidents of suspected physical abuse between resident #023 and resident #024, as identified under LTCHA, 2007, s. 23(1)(a), under WN#7.
-The home did not immediately report all the allegations of resident to resident physical abuse between resident #023 and #024, as identified under LTCHA, 2007, s.24(1) under WN#9.
-The home did not immediately report all the allegations of resident to resident physical abuse between resident #023 and #024 to the police, as identified under LTCHA, 2007, s.98 under WN#12. [s. 19. (1)](623)

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

Under O. Reg. 79/10, s.2 (1) Sexual abuse means, (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.

Related to log #000124-16 & log #036165-15 for resident #003 & #004:

Note: a critical incident report (CIR) was submitted to the Director on a specified date, for a resident to resident sexual abuse that occurred by resident #004 towards another resident. This incident was inspected by Inspector #155. This incident was not identified on the second CIR that was submitted.

The third CIR was submitted two months after the first CIR, and indicated there were 4 incidents of resident to resident sexual abuse involving resident #004 (but only 3 CIR's were received by the Director).

Review of the health care record for resident #003 indicated the resident was the recipient of previous sexual abuse by resident #001 and by resident #005.

A second CIR was submitted to the Director (two months after the first CIR), indicating on a specified date, resident #004 was witnessed by staff engaging in suspected sexual abuse towards resident #003. Both residents were cognitively impaired.

A third CIR was submitted to the Director (a week later) indicating on a specified date, resident #004 was witnessed by a staff engaging in suspected sexual abuse towards resident #003.

Review of the progress notes for resident #003 (for a three month period) indicated a week before the second CIR was submitted to the Director, the resident was found on a specified date and time, with resident #004's demonstrating inappropriate sexual responsive behaviour. There was no documented evidence to indicate the resident was assessed.

Review of the progress notes for resident #004 (for the same three month period) indicated:
-There were 3 incidents of suspected sexual abuse and/or sexually inappropriate responsive behaviours demonstrated by resident #004 towards resident #003 and other unidentified residents.
-The first incident was noted on a specified date and time and recipient resident was not identified. The second incident occurred a week later towards resident #003 and was reported to the Director.
-The third incident occurred two days later but was not reported by staff to the charge nurse until two days later, when the SDM of resident #004 reported it. The recipient resident was also not identified and this incident was not reported to the Director. The actions taken included 1:1 supervision.
-Six days later, the resident was relocated to another unit. Later the same day (after being relocated), the resident was found by staff demonstrating sexually inappropriate responsive behaviours towards an unidentified co-resident. Both SDM's were contacted and staff documented "Both SDM's and residents" were agreeable to the responsive behaviour.
-11 days later, the resident was found demonstrating sexually inappropriate responsive behaviour towards another unidentified co-resident and the co-resident was removed.
-Three days later, the resident was witnessed demonstrating suspected sexual abuse

towards another unidentified co-resident. Both residents were separated and no injuries noted. A call placed to CIATT indicated the co-resident was resident #011.

Therefore, the licensee failed to protect resident #003 (and other unidentified residents) from sexual abuse by resident #004 as identified by the following:
-When resident #004 demonstrated ongoing sexually abusive responsive behaviours towards resident #003 and other vulnerable, cognitively impaired female residents, there was no investigations completed, as indicated under LTCHA, 2007, s.23(1)(a) under WN#7.
-When resident #004 demonstrated ongoing sexually inappropriate responsive behaviours towards resident #003 and other vulnerable, cognitively impaired female residents, the plan of care did not identify triggers and strategies to manage the risk, as indicated under O.Reg. 79/10, s.53(4)(a)(b), under WN#9.
-When resident #004 demonstrated ongoing sexually inappropriate responsive behaviours towards resident #003 and other vulnerable, cognitively impaired female residents, the home did not refer to BSO Team or external Psycho geriatric resources, as identified under O.Reg. 79/10, s.55(a) under WN#10(623).

3.Related to log #025375-15 & #028518-15 for resident #005:

Review of the health record for resident #005 indicated the resident was admitted on a specified date with a diagnosis of dementia. The resident died approximately six months later. The progress notes for a three month period indicated the resident demonstrated ongoing sexually inappropriate responsive behaviours and sexual abuse towards co-resident's and staff.

Note: a follow-up inspection was also being conducted (log #036165-15) related to a previous CIR where resident #003 was the recipient of sexual abuse by resident #005. A previous CIR for a resident to resident sexual abuse incident was submitted by the home on a specified date, which occurred two weeks before the second CIR was submitted and was inspected by Inspector #155. The second CIR (submitted two weeks later) indicated suspected sexual abuse by resident #005 towards resident #007. This CIR indicated there were no previous incidents of sexual abuse involving resident #005. The third CIR (submitted approximately three weeks later), indicated suspected sexual abuse by resident #005 towards resident #006. This CIR indicated there were 4 incidents of resident to resident sexual abuse involving resident #005 (but only three incidents were reported to the Director).Resident #003, #006 and #007 were also cognitively impaired.

In addition to the incidents reported to the Director, the progress notes of resident #005 indicated an additional incident of "suspected" resident to resident sexual abuse occurred four days before the last CIR was reported to the Director. The documentation indicated no physical or emotional distress noted by co-resident despite the co-resident "yelling" at resident #005 to get away from the resident and staff requesting additional staff assistance. The co-resident was not identified (or any documented evidence to indicate an assessment of the co-resident)and there was no documented investigation completed in order to determine who the recipient resident was, or whether there was any injury of emotional distress. This incident was also not reported to the Director.

The acting DOC was interviewed regarding the home’s investigations into "suspected" resident to resident sexual abuse and regarding identifying who the recipient residents were (of resident #005). The acting DOC indicated the registered nursing staff were directed by the previous DOC not to indicate who the recipient residents were in the progress notes of resident #005 “to protect their personal health information”. The acting DOC indicated the recipient resident’s names would be identified on the 'Risk Management' reports which should have been completed for each of the incidents. The acting DOC indicated she was unable to identify who the co-resident was as there was no documented 'Risk Management' report completed for that incident.

Therefore, the licensee failed to protect vulnerable, cognitively impaired female residents (resident #006, #007, and other unidentified female residents) on the secure unit from sexual abuse by resident #005 as identified by the following:
-When resident #005 was demonstrating sexually inappropriate responsive behaviours and/or sexual abuse, the triggers were not clearly identified and strategies to manage the behaviours were not developed or implemented, and actions were not taken to manage the risk to other vulnerable female residents, when the behaviours continued, as indicated under O.Reg. 79/10, s.53(4)(a)(b)(c), under WN#9.
-The licensee failed to ensure the home's prevention of abuse policy was complied with as there was no documentation for any of the female recipients of the sexual abuse and/or sexually inappropriate responsive behaviours to determine if an assessment of those residents was completed. There was no indication a documented record was kept of the investigations to determine who the recipients of the suspected sexual abuse were, and no referral to Psycho geriatric Resource Consultant was completed until after the third CIR was submitted to the Director as identified under LTCHA, 2007, s. 20(1), under WN#5.
-There was no indication the SDM’s of the female recipient residents were notified regarding the incidents that were not reported to the Director, as identified under

O.Reg. 79/10, s.97(1), under WN #11.
-There was no indication the police were notified of the incident of suspected resident to resident sexual abuse that occurred on October 6, 2015, as identified under O.Reg. 79/10, s.98, under WN#12.
-There was no indication the Director was notified of suspected resident to resident sexual abuse for the incident that occurred on October 6, 2015, by Resident #005, as identified under LTCHA, 2007, s.24(1), under WN#8.

The home was issued a Compliance Order for LTCHA, 2007, s.19 on February 4, 2015 during inspection #2015_293554_0003 with a compliance date of October 26, 2015. [s. 19. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (5) The licensee shall ensure that the resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident’s plan of care. 2007, c. 8, s. 6 (5).

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

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

Related to log # 000328-16 for resident #012:

Review of the health record for resident #012 indicated:
- the resident was admitted on a specified date with diagnosis of a cardiac condition which required anticoagulant medication therapy. The resident also had an admission physician order for initial diagnostic treatment to determine effectiveness of the anticoagulant therapy. The initial diagnostic treatment indicated the anticoagulant therapy was within therapeutic levels. A week prior to admission, the resident's diagnostic treatment indicated the anticoagulant therapy was not within therapuetic levels. There was no further diagnostic treatments ordered or completed. Two weeks after admission, the resident developed an infection which was treated with antibiotics. A week later, the resident developed a change in skin condition to specified areas and

"a note" was left for the physician to assess. The following day, the resident sustained injuries to skin to specified areas of unknown cause. Ten days later, the resident complained of pain to a specified area and received an analgesic. The resident also developed nausea and vomiting later the same day. The following day, at a specified time, the RPN noted a significant change in the residents condition. The RN assessed the resident and indicated "Note in MD book to have Resident assessed next MD day". Approximately three hours later, another RN assessed the resident and noted injuries to specified areas. The RN noted the resident was receiving anticoagulant therapy and was unable to locate a current diagnostic treatment to determine current therapeutic levels. The RN indicated family was present and requested the resident be transferred to hospital for assessment. The resident was transferred to hospital for assessment and diagnosed with complications related to anticoagulant therapy. The resident subsequently died.

Review of the home's policy "Anticoagulant Therapy" (VIII-D-20.20-revised January 2015) indicated:
-the Registered staff will: verify that a schedule of appropriate blood work is ordered (e.g.INR for warfarin) and monitor for any of the following: severe pain such as a headache or stomach ache, unusual bruising (unknown cause or grows in size), painful rash with skin discolouration and raised bumps, and report all side effects to the physician.
-The Warfarin tip sheet also indicated under considerations for increased bleeding risk: petechiae & excessive bruising; Under caution regarding Warfarin: many drug interactions-therefore important to monitor INR routinely when on Warfarin (especially when new antibiotics).

Interview of the acting DOC indicated the physician should have been contacted to obtain further orders for more frequent monitoring of the anticoagulant therapy, and even after the initiation of the antibiotic.

Therefore, the plan was not based on the resident's assessed needs as: the resident was admitted on anticoagulant therapy, had a prior history of anticoagulant therapy outside of therapeutic levels, was started on an antibiotic for an infection, and developed symptoms consistent with the home's policy on anticoagulant therapy that the resident was to be monitored for. The physician was not contacted regarding these symptoms and the resident did not have diagnostic testing completed to ensure the anticoagulant therapy was within therapeutic levels, as per the home's policy for anticoagulant therapy. [s.6(2)](111)

2. The licensee has failed to ensure that the SDM and the designate of the resident had been provided the opportunity to participate fully in the development and implementation of the plan of care.

Related to log #000328-16 for resident #012:

A complaint was received from the family of Resident #012 indicating while visiting the resident on a specified date, noted injuries to specified areas on the resident as well as a significant change in condition.

Review of progress notes for Resident #012 indicated the staff noted the injuries of unknown cause to specified areas and reported the injuries to the RN approximately 11 days prior and the SDM was not notified. The day before the resident went to hospital and sustained a significant change in condition, the resident was demonstrating symptoms consistent with the home's anticoagulant therapy policy to be monitored for. There was no indication SDM was notified. The day after, approximately after lunch, the resident was noted to have a significant change in condition and the SDM was not notified until approximately three hours later, when the SDM came to visit the resident noted the injuries to the resident and the significant change in condition. [s.6(5)](111)

3. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #022, as specified in the plan, related to toileting.

Related to log #032760-15 for resident #022:

A Critical Incident Report (CIR)was reported to the Director on a specified date regarding an improper transfer incident that occurred two days earlier at a specified time.

A review of the plan of care for resident #022 indicated the resident was to be toileted with assistance of two staff and a mechanical lift. The interventions also indicated the resident was not to be left unattended on the toilet due to risk for falls. The health care record also indicated the resident was a high risk for falls as the resident had a history of ongoing falls and sustained 10 falls in a three month period prior to the incident. On the specified date, resident #022 was assisted to the toilet with two staff and the use of the mechanical lift but was left unattended. The resident subsequently fell and sustained an injury to a specified area.[s.6(7)](571)

4. The licensee failed to ensure that when the resident was reassessed, and the plan of care was revised, that different approaches were considered in the revision of the plan, when the care set out in the plan was not effective in reducing falls.

Related to log #025375-15 & 028518-15 for resident #005:

Review of the progress notes, Record of Falls and health record for resident #005 indicated the resident was admitted on a specified date, and sustained 17 falls during a three month period.

Review of the care plan for resident #005 that was in place prior to the falls indicated the resident was at high risk for falls related to history of falls/injury, multiple risk factors and wandered. Additional interventions were added after the fifth fall which included: transfer and change position slowly, analyze previous falls to determine whether pattern/trend can be addressed, bed alarm, and bed in lowest position. The plan was revised again two months later to provide a possible trigger for the falls. The care plan was revised again after 17th fall and indicated the use high/low bed or place drop mat/mattress in the floor to prevent falls from bed.

Therefore, other interventions were not considered in the revision of the plan, when the interventions were not effective, as the resident continued to fall. [s.6(11)(b)](111)

5. Related to log #031929-15 for resident #018:

A Critical Incident report (CIR) was reported to the Director on a specified date for an injury resulting in transfer to hospital. The CIR indicated resident #018 sustained a fall resulting in an injury to a specified area.

Review of the health record for resident #018 indicated the resident was admitted to the home on a specified date with diagnosis of cognitive impairment and impaired vision. Resident #018's pharmacological regime included psychotropics, antidepressants and anti-anxiety medications.

Review of the progress notes (for a 10 month period) for resident #018 indicated the resident sustained 10 falls on the following dates and six of the falls resulted in pain or injury to a specified area.

A review of the care plan for resident #018 related to risk for falls indicated additional interventions were added after the third fall (bed alarm); the resident was assessed by

physiotherapy and the use of a mobility aide "was considered" after the fifth fall. There were no other interventions considered until after the resident sustained four more falls and had a significant change in condition.

Therefore, when the plan of care was revised, other interventions were not considered when the interventions were not effective, as the resident continued to fall. [s.6(11)(b)] (571)

6. Related to log #027184-15 for resident #21:

Critical Incident report (CIR) was submitted to the Director on a specified date for a transfer to hospital with injury. The CIR indicated four days earlier, at a specified time, resident #021 sustained an injury resulting in a significant change in condition as a result of a fall.

A review of the health record for resident #021 indicated the resident has a medical history that includes impaired vision and is at risk for falls.

Review of the progress notes for resident #021 indicated (for a four month period) indicated the resident sustained eight falls. The progress notes also indicated the resident approached the physiotherapist on a specified date (after the first fall) and requested the use of a different mobility aide due to pain and unsteady gait.

Review of the plan of care for resident #021 related to falls prevention included reminders to slow down and use mobility aid. The care plan also indicated the resident was started on an antibiotic for an infection on two separate dates (after the third and sixth fall) due to falls.

Therefore, different approaches were not considered in the revision of resident #021's plan of care despite sustaining eight falls and the last fall sustaining an injury to a specified area and resulted in a significant change in condition.(571)

7. Related to log #032760-15 for resident #022:

Critical Incident (CIR) was submitted to the Director on a specified date for incompetent care resulting in a injury. The CIR indicated resident #022 sustained an injury to a specified area as a result of an unsafe transfer and positioning incident that occurred two days prior.

A review of the clinical records for resident #022 indicated the resident required the use of a mobility aide to get around the unit.

Review of the progress notes (for an eight month period)for resident #022 indicated the resident sustained 22 falls. Eight of the falls resulted in pain or injury to specified areas.

A review of the plan of care for resident #022 related to falls risk(in place at time of the falls) indicated the a (PASD) was in place in the mobility aide, an alarming device in place on bed and mobility aide, toilet to reduce agitation; bed in the lowest position; two quarter bed rails and then a restraint to the mobility aide was added after the 21st fall.

Therefore, additional interventions were not considered until after the 21st fall when the restraint was added and no other interventions were considered when the resident continued to fall and sustained injuries. [s.6(11)(b)](571)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents who are at moderate to high risk for falls, when the plan of care is reviewed, other interventions are considered in the revision of the plan, when the interventions are not effective in reducing the incidents of falls,, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a physician's order and SDM consent was obtained prior to applying a restraint to resident #017.

Related to log #027062-15 for resident #017:

A review of the clinical record for resident #017 indicated that on a specified date, the Power of Attorney (POA) for resident #017 indicated to S#117 that they were "upset" after observing a physical trunk restraint in place on the resident over two separate dates. S#117 assessed resident #017 and determined the resident could not remove the physical restraint and confirmed a physician order, consent and restraint monitoring were to be in place prior to applying the restraint. The clinical records also indicated a physician's order, POA consent, and an assessment was not completed until after the family concern was brought forward (approximately three days later).

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 not physically restrained without a physician's order and SDM consent, prior to application, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is an interdisciplinary falls prevention and management program was implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

Review of the home's "Falls Prevention" policy (VII-G-30.00) revised January 2015 indicated:
- the DOC or designate will lead and coordinate the implementation of the falls prevention and management program, determine a communication process by which residents at moderate or high risk for falling are easily identified to the entire care team, review all fall incidents, and identify action plans to address trends.
-When a fall occurs, the registered staff will initiate a head injury routine if a head injury is suspected or if the resident falls is un-witnessed, complete a through

investigation of fall incident including all contributing factors, complete a post fall assessment by using the post fall huddle or fall incident report, update resident's care plan, and complete referral to appropriate discipline if required (i.e. PT, OT). A falls prevention kit should be accessible to the front line staff at all times and includes various items that can help prevent a resident fall: non-slip socks, chair and bed alarm, night light, hip protectors, crash mats, helmet, etc.
Under "Falls: Risk Factors & related interventions" indicated: risk factors for falls included: history of falls, gait changes, and medications. Interventions included: collaborate with PT, OT and Recreation. Therapist, investigate history of falls, identify if possible number of falls, types of injury, time of day, medication regime, falls risk level, use of restraints, assist unsteady individuals with ambulation, and collaborate with physician and pharmacists to minimize use of benzodiazepines, number of medications required, and use of drugs with high risk for adverse side effects.

Interview of the acting DOC indicated she took over the role in November 2015 and is the designated lead for Fall Prevention. Indicated that PT monitors all falls within the home and provides a monthly report and is to provide recommendations.

Interview of PT indicated their role related to falls included:
-daily checks of PCC under risk management for any residents who have fallen,
-send a monthly report to Acheiva and the management of the home related to all residents who have fallen during that month, as well as a quarterly statistical report related to falls in the home.
-Complete post fall referrals when received from nursing by assessing the resident and provide recommendations to nursing, and document in PCC.
-indicated a "resident safety meeting" used to occur quarterly (which included Administrator, DOC, ADOC, RAI, Nursing staff, DRFS) but then a "falls committee" met weekly on Wednesdays after previous ADOC(Cathy) left, and "the home has not had any falls prevention meetings since the new acting DOC and acting ADOC took over" in November.

Interview of S#102 indicated that after a resident has fallen, an assessment of the resident and first aid is provided to the resident, a post fall assessment is completed in the progress notes and a falls risk assessment is also completed in PCC. A paper post fall huddle checklist is also completed and forwarded to the DOC/ADOC for follow up. S#102 indicated there is a RN fall watch alarm at each nursing station which also has a list of residents with a bed/chair alarm in place that would indicate those residents are at risk for falls. S#102 indicated would also notify MD (via MD book if fall with no injury or via phone if injury), notify POA and send referral to PT. Indicated no

awareness of falls prevention kit.

Review of "Weekly Falls Meeting Summary" minutes indicated only one meeting was held on November 4, 2015 and was the first weekly fall huddle meeting (with previous ADOC) and PT. The meeting was based only on review period of October 28-November 4, 2015.

Related to log #025375-15 & 028518-15 for resident #005:

Review of health record and Falls Record Review for resident #005 indicated the resident sustained 17 falls over a four month period. The fall huddle meeting only indicated resident #005 fell on a specified date and after the 14th fall. The fall huddle recommended a temporary mobility aide with physical restraint to be used as the resident already had an alarming device for their bed. There were two referrals to PT (despite sustaining 17 falls).

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 there is a interdisciplinary falls prevention and management program implemented in the home to reduce the incidence and risk of injury related to falls, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Related to log #028518-15 for resident #005 & #006:

A critical incident report (CIR) was received on a specified date for a resident to resident sexual abuse incident that occurred five days earlier at a specified time. The CIR indicated resident #005 was witnessed by staff in suspected sexual abuse towards resident #006. Both Resident's are cognitively impaired.

Review of the progress note for resident #005 and #006 indicated on the day the incident occurred, only documented "CIS report for sexual abuse filled out see RISK". There was no documented record of the actual incident or assessment of the residents involved.

Request from the acting DOC for the home's investigation into the incident that occurred on the specified date, indicated the Risk Management report and the CIR was the home's investigation.

Review of Risk Management Report indicated on the specified date and time, resident #005 was witnessed in suspected sexual abuse towards an unidentified resident who expressed "I am ok now". There was no indication who the resident was that was the recipient of suspected sexual abuse.

Review of the home's policy "Prevention of Abuse & Neglect of a Resident" (VII-G-10.00) revised January 2015 indicated under procedures: If any employee or volunteer witnesses an incident, or has any knowledge of an incident, that constitutes resident abuse or neglect, all staff are responsible to immediately take these steps:
-the charge nurse will check the resident's condition to assess his/her safety and physical well-being,and document the current resident status on the resident's record and complete a critical incident report.
Under Investigation:
-the Administrator or designate initiates the investigation by requesting that anyone aware of or involved in the situation write, sign and date a statement accurately describing the event,
-the written statements are obtained as close to the time of the event as possible
-all investigative information is kept in a separate report from the resident's record
-interviews the resident, other residents or person who may have any knowledge of

the situation
-the "Prevention of Abuse-Investigation Template" is completed only after ensure that the resident is safe and has been assessed and appropriate treatment has been initiated.

Therefore, the licensee failed to follow the home's policy on "Prevention of Abuse & Neglect of a Resident" as there was no documentation regarding the resident to resident sexual abuse incident in either of the resident's progress notes to indicated what occurred, when it occurred, who was involved, and what actions were taken. There was also no investigation completed as per the home's policy (using the investigation template) and no indication of what actions were taken regarding the recipient of the inappropriate sexual responsive behaviours. [s. 20. (1)]

2. Related to log # 031927-15 for resident #002 & #025:

Review of the Risk Management incident report and the home's investigation indicated on a specified date, S#121 had reported to S#122 witnessing S#123 engage in physical and emotional abuse towards resident #025 and #002 approximately "one to two months ago". S#121 also reported the same incident had occurred again recently by S#124. S#124 reported the alleged physical and emotional abuse the day after the incident was witnessed towards resident #025 and indicated the staff member did not intervene.

Therefore, the home's policy was not complied with, as the progress notes for resident #002 had no indication of an alleged incident of staff to resident physical and emotional abuse occurring, no indication of an assessment of the resident, no indication that SDM was notified of the incident or the outcome of the home's investigation, or that physician and police were notified, and the allegation was not immediately reported. [s. 20 (1)]

3. Related to log #033599-15 for resident #007:

Review of the home's investigation, interviews of staff, interview and observation of resident #007 & #026, and review of the health record for resident #007 & #026 indicated:
-both resident #007 & #026 are severely cognitively impaired but independently ambulatory.
-on a specified date and time, resident #007 reported to S#125 an allegation of sexual abuse that had occurred the day before but was unable to identify the person

responsible due to cognitive impairment. The resident expressed pain as a result of the alleged physical abuse. S#125 reported the allegation to S#126 but no appropriate action was taken at that time. S#125 then initiated an investigation with two other staff members (#127 & #128) before reporting the allegation to S#129. The three staff members then took resident #007 to attempt to identify the possible resident responsible for the alleged sexual abuse (despite no indication from resident #007 the abuse was by another resident). Resident #007 identified resident #026 as the alleged abuser. The three staff (S#125, #127 & #128) then reported the allegation to S#129. S#129 assessed resident #007 and no injuries were noted. S#129 interviewed both resident #007 and #026. Resident #007 did not recall who the alleged abuser was at that time and resident #026 had no recall of any abuse occurring. S#129 documented "suspected sexual abuse" and the physician would "assess resident tomorrow morning". The resident was not assessed by a physician until two days later and noted "completed a thorough examination to rule out sexual abuse" and determined no sexual abuse occurred.

Review of the home's policy "Prevention of Abuse & Neglect of a Resident" (VII-G-10.00) indicated under procedure:
-if any employee has any knowledge of an incident, that constitutes resident abuse, are responsible to immediately inform the Administrator and/or charge nurse.
-The charge nurse will check the resident's condition to assess his/her safety, emotional and physical well-being. If required, immediate medical attention must be sought either by contacting the attending physician or transferring the resident to a hospital.

The charge nurse did not immediately assess resident #007 for injuries after an allegation of sexual abuse was made, and did not immediately report the allegation to the Administrator and/or RN until approximately two hours later. The staff who initially made the allegation, also did not report the allegation to Administrator and/or RN as per the home's policy when the charge nurse failed to take appropriate action. The staff also initiated the investigation which was the responsibility of the Administrator and/or designate. There was also no documented evidence either regisitered nursing staff immediately notified the physician of an alleged sexual abuse resulting in pain and the resident was not assessed by a physician for two days. [s. 20. (1)]

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a written complaint that was received by the home concerning the care of a resident was immediately forwarded to the Director.

Related to log #000328-16 for resident #012:

Review of the home's complaints indicated a written complaint was received by home on a specified date from the family of resident #012 regarding resident care concerns. The Administrator provided a written response to the family the day after the complaint was received which indicated "it is not a complaint as per Ministry of Health requirements".

Interview of the Administrator indicated the written complaint and the response to the written complaint was not provided to the Director as "it was a concern and not a complaint".

WN #7: The Licensee has failed to comply with LTCHA, 2007, 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).

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated: (i) abuse of a resident by anyone.

Related to log # 028518-15 for resident #005 & #006:

A critical incident report (CIR) was received on a specified date for an allegation of resident to resident sexual abuse that occurred five days earlier at a specified time. The CIR indicated resident #005 was found in resident #006 room, and was witnessed engaging in sexual abuse by resident #005. Both Resident's are cognitively impaired. The CIR indicated resident #005 "had 4 incidents of sexually inappropriate" responsive behaviours towards specified residents since the resident's admission.

Review of the heath care record for resident #005 & #006 indicated both residents are cognitively impaired. Review of the progress note for resident #005(deceased) indicated on a specified date and time, "CIS report for sexual abuse filled out see RISK". Review of the progress notes for resident #006 indicated the same.

Request from the acting DOC for the home's investigation into the incident that

occurred on the specified date, indicated the "Risk Management report" was the home's investigation as well as the CIR report and a copy of the Risk Management Report was provided to the inspector.

Review of Risk Management Report indicated there was no indication who the resident was that was inappropriately touched.

Review of the home's policy "Prevention of Abuse & Neglect of a Resident" (VII-G-10.00) revised January 2015 indicated:
Under Investigation:
-the Administrator or designate initiates the investigation by requesting that anyone aware of or involved in the situation write, sign and date a statement accurately describing the event,
-the written statements are obtained as close to the time of the event as possible,
-all investigative information is kept in a separate report from the resident's record
-interviews the resident, other residents or person who may have any knowledge of the situation,
-the "Prevention of Abuse-Investigation Template" is completed only after ensure that the resident is safe and has been assessed and appropriate treatment has been initiated. The template also indicated once the investigation is completed, the Administrator and/or DOC shares the results of the investigation immediately with the resident or resident's SDM.

There was no indication when the Administrator and or designate were notified of witness resident to resident sexual abuse incident, an investigation was completed (and as per the home's policy). [s. 23. (1) (a)]

2. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or is reported is immediately investigated:(i)Abuse of a resident by anyone.

Related to log #001019-16 for resident #023 & #024:

Review of the clinical record indicated:
-on a specified date, resident #024 reported to staff that co-resident #023 had been physically abusive towards the resident. Resident #024 was assessed for injury at that time and no injuries were noted. Documentation indicated that resident #024 did not want the SDM notified of the incident. Police and POA were not notified and this incident and the incident was not reported to the Director. No immediate actions were

identified to prevent recurrence.
-approximately three weeks later, resident #024 called staff for assistance as resident #023 was physically abusive towards the resident. The resident was assessed and no injury was noted. Staff reminded resident #024 to utilize the locking device on door. The SDM was notified of the incident but the police and the Director was not notified. There were no other actions identified to prevent recurrence.

During an interview with Inspector #623, resident #024 was able to describe all the incidents that had
occurred and expressed being "fearful" of resident #023 and did "not feel safe" in the home.

An interview with the Acting DOC confirmed that the two documented incidents were alleged or suspected physical abuse and an investigation should have been completed. [s.23(1)(a)]

3. Related to log #000124-16 & log #036165-15 for resident #004:

Note: a follow up inspection was conducted related to previous CIR where resident #003 was the recipient of sexual abuse by resident #001. A critical incident inspection was also conducted for an alleged sexual abuse incident where resident #003 was the recipient of sexual abuse by resident #004.

The Director was notified on a specified date, for a resident to resident sexual abuse incident that occurred at a specified time. The CIR submitted by the home indicated a staff member witnessed resident #004 engage in suspected sexual abuse towards resident #003.

The Director was notified of a second incident seven days later of an alleged resident to resident sexual abuse incident that occurred at a specified time. The CIR submitted by the home indicated a staff member witnessed resident #004 engaging in suspected sexual abuse towards resident #003.

The Director was notified of a third incident that occurred approximately one month later of a resident to resident sexual abuse incident that occurred at a specified time. The CIR submitted by the home indicated a staff member witnessed resident #004 engaging in suspected sexual abuse towards resident #011.

Review of the progress notes for resident #004 for a three month period (when the

incidents were reported) indicated:
-Eight days before the Director was notified of the first incident, there was another incident of suspected sexual abuse towards an unidentified resident. This incident was not investigated to determine who the resident was or an assessment of the resident.
-Two days later, the SDM of resident #004 reported to the home that two days prior, witnessed an incident of suspected sexual abuse by the resident to an unidentified resident that had occurred and was reported to a staff member the day the incident occurred. The incident that occurred two days prior (that was reported to a staff member and was not reported to the charge nurse) was not investigated to determine who the recipient was.
-Approximately a month later, staff witnessed resident #004 engage in suspected sexual abuse towards an unidentified resident. There was no investigation into the incident to determine who the recipient was.

Interview with Acting DOC confirmed that there was no evidence that an internal investigation was completed to determine if abuse occurred or who the recipient residents were for all three documented instances involving resident #004.

Therefore, resident #004 had a demonstrated ongoing history of sexual abuse and sexually inappropriate responsive behaviours towards multiple, vulnerable, cognitively impaired female residents. The progress notes identified three additional instances of suspected sexual abuse and there was no documented evidence that an investigation was completed. [s. 23. (1) (a)]

4. The licensee has failed to ensure that the results of the abuse investigation were reported to the SDM.

Related to log #033599-15:

A Critical incident report (CIR) was received by the Director on a specified date for an alleged resident to resident sexual abuse incident that occurred tow days prior at a specified time. The CIR indicated resident #007 alleged a person had been sexually abusive to the resident and sustained pain as a result.

Interview of the acting DOC indicated the CIR was not updated to indicate the outcome of the investigation when the home was unable to determine whether the allegation was founded. [s. 23. (2)]

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who 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: 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.

Related to log#001019-16 for resident #023 & #024:

A review of the clinical record for resident #024 indicated:
-on a specified date, resident #024 reported being the recipient of physical abuse by resident #023. The resident was assessed at the time and "no injuries or emotional concerns were noted". A report to the Director was not submitted for the alleged physical abuse until two days later when staff noted injuries to resident #024.
-approximately one month later, resident #024 reported again being the recipient of

physical abuse by resident #023. The resident was assessed for injury and there was none reported. This incident of alleged physical abuse was not immediately reported to the Director.
-two days later, resident #024 reported again being the recipient of physical abuse by resident #023 and injuries were noted to specified areas. The incident was not immediately reported to the Director (reported the following day).
-15 days later, resident #024 had to call for staff assistance as resident #023 was engaging in physical abuse towards the resident. The resident was assessed and no injuries were noted. This incident of suspected physical abuse was not reported to the Director.

During an interview the Acting DOC confirmed that the Director had not been immediately notified of the reported resident to resident physical abuse by resident #024 because "there was no visible injury at the time of the alleged abuse" and one incident was not reported because the RN "who resident #024 reported to was unaware of the time lines for reporting".

Therefore the home failed to immediately report all incidents of alleged or suspected resident to resident physical abuse to the Director. [s. 24(1)]

2. Related to log # 025375-15 & # 028518-15 for resident #005:

Review of the progress notes for Resident #005 indicated a suspected incident of resident of resident sexual abuse and was not reported to the Director:
-On a specified date and time, a staff member was “alerted" when a resident was heard yelling at another resident in their room. The staff member witnessed resident #005 engaging in suspected sexual abuse towards an unidentified resident. The staff documented “resident was not attempting any sexual behaviours”. The staff member had to call for extra staff assistance to remove the resident from the room. Staff indicated “no physical or emotional distress was reported or noted by either resident”. The DOC was notified of the incident and 1:1 care provision was provided to monitor resident #005 for the remainder of the shift. There was no indication who the recipient resident was, despite staff indicating "no emotional distress" and despite the resident "yelling" at resident #005 to get away from the resident.

Interview of the acting DOC indicated the Director was not notified of the incident because the staff "may have thought that sexual abuse did not occur" and should have been reported. [s.24(1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the behavioural triggers were identified and strategies were developed and implemented to respond to the responsive behaviours, where possible, and actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions, and that the resident's responses to interventions are documented.

Related to log #001019-16 for resident #023:

During the course of this inspection it was identified that resident #023 demonstrated responsive behaviours of physical aggression towards resident #024.

Review of the clinical record and the plan of care for resident #023, it was determined that the plan of care in the electronic record (and on the BSO information sheet) identified the responsive behaviour of physical aggression but did not identify who the physical aggression was directed towards. There was also no triggers or strategies identified in the written plan of care for staff to respond to the responsive behaviour of physical aggression.

Interview of S#113 and S#114 indicated awareness of resident #023's physically aggressive behaviour towards resident #024, when it occurred, and one possible trigger. Both staff were aware the responsive behaviour had been "ongoing for approximately two months”. The staff were not aware of any specific strategies in place to respond to the behaviour.

Interview with the BSO Team (S#115) revealed that resident #023 is monitored by the BSO team. S#115 indicated strategies used to manage the responsive behaviour of physical aggression and stated "this information should be in the BSO intervention binder" S#115 identified two different possible triggers for the responsive behaviour.

Interview with the BSO Team (S#100 & S#101) indicated the written plan of care is updated by BSO only if BSO is monitoring the resident. Both staff indicated a referral to BSO should be initiated by the registered nursing staff at the time of an incident and stated "but that does not always happen". The BSO staff indicated residents on the units with responsive behaviours are indicated on the BSO white board as well as the BSO intervention book in the nursing station that is available to all staff.

Observations of the BSO white board on the unit that resident's #023 resided did not identify resident #023.

Therefore, the licensee failed to ensure that the behavioural triggers for resident #023 were identified where possible, and strategies were developed and implemented to respond to the responsive behaviours of physical aggression towards resident #024, where possible(623).

2. Related to log #000124-16 & log #036165-15 for resident #004:

Note: resident #003 was the recipient of previous sexual abuse by resident #001 and resident #003 was also the recipient of sexual abuse by resident #005.

A critical incident report (CIR) was submitted to the Director for a resident to resident sexual abuse incident that occurred on a specified date and time. The CIR indicated a staff member witnessed resident #004 engaged in suspected sexual abuse towards resident #003.

A second CIR was submitted to the Director for a resident to resident sexual abuse incident that occurred approximately one week later. The CIR indicated a staff member witnessed suspected sexual abuse by resident #004 towards resident #003.

Review of the progress notes for resident #003 (over a three month period) indicated an additional incident that occurred during the same time period when the CIR's were submitted. The notes indicated a staff member witnessed a suspected resident to resident sexually inappropriate responsive behaviour by resident #004's towards resident #003 but there was no further documentation regarding the incident to determine if the resident was assessed.

Review of the progress notes for Resident #004 (during the same three month period) indicated the resident demonstrated ongoing sexually inappropriate responsive behaviours and sexual abuse towards resident #003 and several targeted unidentified residents. The strategies used included: residents were redirected each time, administration of medication (when the resident accepted the medication),
use of 1:1 for a short period of time, and in one incident (while on 1:1 observation) staff did not intervene; staff noted that because SDM consented to the resident's behaviour that staff .
-Two days later, the resident was relocated to another unit. While on the new unit, the resident was found by staff demonstrating sexually inappropriate responsive behaviour towards an unidentified resident but staff did not intervene because "not in any emotional distress" and "Both POA's or resident and co-resident allow them to hold hands".
-Twelve days later, the resident was found demonstrating inappropriate sexual responsive behaviour with an unidentified resident and the co-resident was redirected.

-Three days later, the resident was witnessed in resident #011 room demonstrating sexually inappropriate responsive behaviours and both residents were separated.

Interview with the BSO (S#100 and #101) indicated that they only reviewed and revise care plans for residents on BSO caseload, and any other residents would have the care plans reviewed and revised by the registered staff. BSO staff also indicated they update the 'white board' on each unit to identify residents that BSO is notified of, and who are demonstrating high risk responsive behaviours. They both indicated there is also a "BSO intervention binder" on each unit which identifies residents with high risk responsive behaviours, triggers and interventions to manage those high risk behaviours.

Interview with S#108 indicated awareness of two incidents between resident #003 and #004. S#108 indicated a 'seven day DOS monitoring tool' was put in place for resident #004 after both incidents but a DOS was only put in place for resident #003 after the

second incident "so that staff knew" the resident's "whereabouts". S#108 indicated no other interventions were put in place for resident #003 "other than regular checks that staff do on everyone in the unit". S#108 indicated that resident #004 was relocated to a different unit after the second incident. S#108 indicates resident #003 had a history of being the recipient of sexually inappropriate responsive behaviours (by resident #001). S#108 indicated despite a history with resident #003 being the recipient of sexually inappropriate responsive behaviours (by two different residents), "there was never any strategies or monitoring put in place" to ensure resident #003's safety.

Interview with S#102 indicated that there is a BSO interventions binder that is kept in the conference room. This binder contains the BSO admission questionnaire and any recommendations for the resident from the BSO team to manage the behaviour. S#102 indicated that at this time there is no enhanced monitoring for resident #004. “This is only done if there is a DOS being completed or if it is care planned”. “All of the staff just know that they need to watch resident #004 for signs that the resident might be seeking a partner”. At this point there is no one particular resident that resident #004 favours, the behaviour continued despite being relocated. S#102 indicated that there were no triggers identified for resident #004.

Interview of S#109 indicated that resident #003 "is always in and out of everyone’s room", "always wants to look after people", the resident "goes into other residents rooms to take care of them", and "could be misinterpreted as inviting". S#109 indicated the only intervention used for resident #003 was a 7 day DOS, but once resident #004 was relocated, "we don’t watch anymore". S#109 indicated resident #003 "is very active and it is next to impossible to know where" resident #003 is at all times. S#109 indicated the resident's care plan, Kardex, or the BSO interventions binder was not reviewed each shift to determine what strategies are to be used to ensure the safety of resident #003.

A review of the current BSO white board indicated that resident #003 was not on the white board. Review of the BSO interventions binder did not identify that resident #003 was the recipient of sexually inappropriate responsive behaviours, and by whom.

Interview with S#105 indicated that when resident #004 was on the other unit, demonstrated sexually responsive behaviours and exit seeking. The exit seeking had stopped so the resident was relocated to remove the resident from specifically targeted residents. S#105 indicated that currently resident #004 is only monitored approximately 20 times in a shift. S#105 could not identify how long resident #004 would need to be out of sight before staff would go looking for the resident. S#105

indicated that “resident #007 and #011 have both been witnessed by staff, engaged in an inappropriate sexual situation with resident #004" since being relocated.

Interview of S#106 stated "there are no real problems to be aware of" for resident #004 and "no enhanced monitoring". S#106 indicated awareness that the resident was relocated due to "bothering other residents". S#106 indicated that if resident #004 was not visualized for over an hour, then S#106 "would likely start looking" for the resident. S#106 indicated that education was received in the last year about responsive behaviours, inappropriate sexual behaviour and duty to report. S#106 indicated that the Kardex on POC is reviewed for information regarding residents and to see if there have been any updates to the care plan in PCC. If the information is not in the care plan in PCC then this information would not be available on the POC and staff receive a verbal report at the beginning of the shift from the charge nurse. S#106 indicated that resident #007 and #011 have both been engaged in sexual responsive behaviours with resident #004 since being relocated to the unit.

Review of the current care plan for resident #003 indicated:
- "potential to form a relationship as per the resident's Bill of Rights". Interventions included: meet needs for touch/affection by allowing the resident to touch pets, holding hands of co-residents if co-resident POA permission granted".
-Chronic progressive decline in intellectual functioning characterized by inability to consent to sexual behaviours from others. Identify persons who routinely have contact with the resident. Interventions included: gently redirect activities when resident makes inappropriate actions, tell resident behaviour is inappropriate, "not cognitively capable of agreeing to or consenting to sexual behaviour with another resident", and "POA" does not consent to the resident engaging in sexually inappropriate behaviours with other residents.

Interview of S#109 indicated awareness that resident #004 was moved to another unit because the resident "was bothering other residents”. S#109 indicated the resident's care plan, Kardex, or the BSO interventions binder was not reviewed each shift to determine what strategies are to be used to monitor resident #004 for inappropriate sexual responsive behaviours.

A review of the current BSO white board indicated that resident #004 is identified as “sexually expressive” and interventions are “monitor" that resident is not engaging in sexually inappropriate behaviours on the white board. Review of the BSO interventions binder identifies resident #004 exhibits “sexually expressive behaviours, comments, inappropriate touching”. Interventions include: redirect away from

[specified residents] and gentle reminders.

A review of the Behavioural Assessment Tool (BAT) for resident #004 in place after first incident indicated the behaviour: sexually suggestive remarks, grabbing, touching. Related to resident #004 cognitive impairment, has difficulty identifying between appropriate and inappropriate comments in a sexual nature towards other specified co-residents. Trigger: loneliness. Interventions include; "Redirect away from inappropriate conversations. Do not participate in unnecessary touching with residents. Set boundaries with resident in regards to sexual talking or touching that is not appropriate. Inform resident #004 when acting sexually inappropriately, and redirect conversation to a more appropriate topic. SDM informed nurse (over the phone) of consent for resident #004 to engage in sexually inappropriate behavior, including "sexual relations" in the home; 15 minute check put in place after the fourth incident occurred; spouse "approves of relationships with other" specified residents; resident moved to another unit. This BAT tool is not available to the staff providing direct care to resident #004, as it was located in the BSO office.

Review of the current care plan for resident #004 indicated:
- "potential to form a relationship as per the resident's Bill of Rights". Interventions included: spouse provided consent for the resident to engage in sexually inappropriate responsive behaviours and "having sexual relations" with "consensual" residents.
-sexually inappropriate behaviour related to cognitive impairment and difficulty identifying between appropriate and inappropriate comments”. Interventions included: “inform resident #004 when "acting sexually inappropriate, and redirect conversation to a more appropriate topic.”

Therefore, when resident #004 demonstrated sexually inappropriate responsive behaviours and sexual abuse, towards cognitively impaired co-residents, the behavioural triggers were not identified where possible, and strategies to manage the risk only identified the use of 1:1 monitoring (after situations occurred), use of a 7 day DOS tool and the resident was relocated. Furthermore, there was no clear direction for staff and others who routinely care for resident #003 related to being the recipient of sexually inappropriate responsive behaviours and sexual abuse, and by whom. There was also no clear direction to manage the safety risk posed to resident #003 as the plan of care did not clearly identify triggers and strategies to manage the risk and the staff only identified the use of a 7 day DOS as a strategy(623).

3. Related to log # 025375-15 & # 028518-15 for resident #005:

Review of the health record for resident #005 indicated the resident was admitted with dementia and died approximately six months later. The progress notes indicated the resident demonstrated ongoing sexually inappropriate responsive behaviours, as well as sexual abuse towards other unidentified residents during the three month period. The resident was also was sexually inappropriate (verbally and physically) towards staff. Many of the incidents occurred either in the evening or at night. The strategies used included a “7 day DOS" (for every 15 minute checks after each incident), antibiotic for suspected infection, calling for additional staff assistance, leaving the resident alone, administering medication, referral to BSO, a bed alarm, night light in room and bathroom,and a Behavioural Assessment Tool (BAT) was initiated. The behaviours discontinued as the resident's condition deteriorated and the resident was placed in a mobility aide with restraint (due to unsteady gait).

Interview of BSO (S#100 & #101) indicated the BSO team includes “2 RPN’s (F/T & P/T), an RN (P/T), and 2 PSW's (FT & P/T). They indicated the resident is assessed by BSO upon admission and/or there is a change in the resident's responsive behaviours that staff is unable to manage/concerned. They both indicated the process is: staff completes an electronic referral to BSO, the BSO begins assessments (using BAT and/or DOS) for a period of time to determine the responsive behaviours/triggers and possible strategies to manage the behaviours. They both indicated that sometimes pharmaceutical interventions are implemented before they become involved or when they are off and they have to re-educate the staff and encourage more 1:1. Both indicated staff does not always use the electronic referral form, as some referrals are on paper or completed orally. Both indicated that the BSO will also update the care plans and document in the progress notes regarding their assessments related to the responsive behaviours if the resident is on their caseload. Indicated there is a white board on each unit where BSO documents which residents are currently being followed by BSO, the responsive behaviours, and interventions to be use. They indicated there is also BSO binders at each nursing station with the same information as well as questionnaire and assessments to be completed. Interview of BSO team and acting DOC indicated they were given direction by previous DOC to not document who the recipient of the aggression/abuse was to protect PHI. The acting DOC indicated the recipient of the responsive behaviour and/or abusive behaviour would be identified on the risk management incident report, if it was completed.

The BSO and physician indicated the resident was being treated with antibiotics for suspected infection which was contributing to responsive behaviours when diagnostic tests indicated the resident did not have an infection. Despite this, the resident was

again started on antibiotic for suspected infection "due to behaviours".

Therefore, when resident #005 demonstrated ongoing sexually inappropriate responsive behaviours towards cognitively impaired female residents, the behavioural triggers that were known, were not identified where possible but a trigger of suspected infection (despite not being a trigger). Strategies to manage the risk identified the use of an antibiotic, redirection/distraction and the administration of medications. No other strategies were considered until after the last incident when a wheelchair with table top was used and a referral to Ontario Shores. [s. 53. (4)]

WN #10: 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 procedures and interventions were implemented to assist residents who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents.

Related to log #000124-16 & log #036165-15 for resident #004:

The home’s policy “Responsive Behaviours – Management” (VII-F-10.20) Revision: January 2015, indicates the Registered Staff will:
J) Refer to available resources in the home or health care community resource such as Behavioural Support Team (BSO) of Behavioural Intervention Response Team (BIRT) if available or other similar type community team, Psycho Geriatric Resource Team and/or Psycho geriatric Resource Consultant (PRC) and RN(EC).

Documentation in the clinical record indicated that for a three month period, resident #004 demonstrated three instances of sexual abuse, three instances of suspected sexual abuse, as well as eleven instances of sexually inappropriate responsive behaviours towards multiple, vulnerable, cognitively impaired female residents.

As of the date of inspection, the home had failed to implement their policy to make a referral for resident #004 to the Psycho geriatric Resource Team and/or Psycho geriatric Resource Consultant to minimize the risk of altercations and potentially harmful interactions between and among residents as per their responsive behaviour policy.

WN #11: 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).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident, was immediately notified upon becoming aware of a suspected incident of sexual abuse of the resident that could potentially be detrimental to the resident's health or well-being.

Related to log #025375-15 & #028518-15 for resident #005:

Review of the progress notes for resident #005 indicated an incident of suspected resident to resident sexual abuse and the recipient was not identified to indicate that their SDM was notified of the suspected abuse. [s.97(1)(a)]

2. The licensee has failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse investigation immediately upon the completion.

Related to log #031927-15 for resident #002:

A critical incident report (CIR) was received on a specified date for a staff to resident physical abuse incident that occurred the same day. The CIR indicated a staff member reported witnessing staff #123 engage in resident physical abuse towards resident #025 "while providing care". The same staff member reported witnessing staff #123 "do the same thing" towards resident #002 approximately a month earlier.

Review of the Risk Management incident report, the home's investigation, and interviews with Administrator and DOC, indicated on three separate occasions, on specified dates, staff witnessed staff to resident physical abuse by staff #123 towards resident #025 and #002. These incidents were not immediately reported to the SDM and when the home's investigation was completed, and the allegation was determined to be founded, there was no indication the SDM's were notified of the outcome of the home's investigation. [s.97(1)(a),(2)]

WN #12: 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 that the appropriate police force was 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.

Related to log #001019-16 for resident #023 & #024:

The clinical record indicates that on a specified date, resident #024 reported to registered nursing staff that resident #023 had been physically abusive towards the resident. The resident was assessed for injury at the time of reporting and there were no injuries noted. Police were not immediately notified and this allegation. Approximately three weeks later, resident #024 reported to staff an allegation of physical abuse received again by resident #023. The resident was assessed and no injury noted. The police were not notified of this incident.

During an interview with Inspector #623, resident #024 was able to describe the incidents that had occurred and expressed being "fearful" of resident #023 and did "not feel safe in" the home.

An interview with the Acting DOC confirmed that the incidents that were documented on the two specified dates did meet the definition of alleged or suspected physical abuse and that despite there being no visible signs of injury, that a report should have been made to the appropriate police force.

2. Related to log #025375-15 & #028518-15 for resident #005:

Review of the health record for resident #005 indicated the resident was admitted with a diagnosis of dementia and was in the home for approximately seven months. The progress notes indicated the resident demonstrated ongoing sexually inappropriate responsive behaviours, as well as sexual abuse towards other residents in the home over a three month period. The resident was also was sexually inappropriate (verbally and physically) towards staff. The progress notes also indicated an additional incident of resident of resident suspected sexual abuse had occurred on a specified date and time but did not indicate who the recipient resident was. This incident of suspected resident to resident sexual abuse was not reported to the police.

Interview of acting DOC confirmed that police were not notified of the incidents.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident:
(i)names of all residents involved in the incident,
(ii)names of any staff members or other persons who were present at or discovered the incident, and
(iii) names of staff member who responded to the incident.

Related to log #033599-15:

A Critical incident report (CIR) was received by the Director on a specified date for an alleged resident to resident sexual abuse incident that occurred four days earlier at a specified time. The CIR indicated Resident #007 alleged sexual abuse by a male resulting in discomfort. The CIR indicated the resident could not recall who the person was due to cognitive impairment. The CIR indicated S#125 and S #129 were aware and/or discovered the incident.

Review of the home's investigation and interview of staff indicated Resident #007 had alleged that Resident #026 was the resident who was involved in the allegation, and S#127, S#128 & S#026 were also aware of and/or responded to the allegation but none of them were identified on the CIR.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Related to log #034107-15:

A Critical Incident report (CIR)was submitted to the Director on a specified date for a medication error involving resident #020.

A review of administration and clinical records indicated that on two specified dates, S#120 failed to administer a medication to resident #020 as ordered. Resident #020 was assessed with no adverse effects from missing two doses of the medication.

In addition, a review of the administrative records indicated that S#020 failed to administer medication as prescribed to 28 unidentified residents on 11 dates.

Issued on this 8 day of March 2016 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111) - (A1)
Inspection No. / No de l'inspection :	2016_360111_0002 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / Registre no. :	012529-15 (A1)
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Mar 08, 2016;(A1)
Licensee / Titulaire de permis :	THE CORPORATION OF THE CITY OF KAWARTHA LAKES 26 Francis Streeet, LINDSAY, ON, K9V-5R8
LTC Home / Foyer de SLD :	VICTORIA MANOR HOME FOR THE AGED 220 ANGELINE STREET SOUTH, LINDSAY, ON, K9V-4R2

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

Ministère 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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Pamela Kulas

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To THE CORPORATION OF THE CITY OF KAWARTHA LAKES, 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)

Linked to Existing Order / Lien vers ordre existant: 2015_293554_0003, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, 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 :

(A1)
The licensee shall prepare, submit and implement a plan to achieve compliance
with LTCHA, 2007, s. 19(1).

The licensee shall ensure the plan includes:
-the development and implementation of a monitoring process to ensure all residents demonstrating high risk responsive behaviours of physical aggression and or abuse, and sexually inappropriate responsive behaviours and or abuse are identified;
-those same residents identified are referred to the BSO Team to ensure the staff providing direct care to those residents, are aware of the residents demonstrating the responsive behaviours, assist in identifying the triggers, and develop and implement strategies to manage those responsive behaviours,
- all nursing staff and management will review the home's policy relating to "Zero Tolerance of Abuse and Neglect", including actions to be taken

when a
suspicion, allegation or witnessed, incident of physical or sexual abuse has been reported, and ensuring a process is in place to identify who the recipient residents are; in addition, ensuring the recipient residents are assessed, and the incident and assessment is documented, and ensuring awareness of roles and responsibility, specifically, reporting requirements and actions to be taken (notifications of POA, police and physician),
-review and revise the home s Responsive Behaviour policy to ensure clear direction is provided to all staff of the referral process to internal BSO Team and when to refer to external Psycho geriatric Resources;
-all nursing staff and management to review the home s revised Responsive Behaviour policy to ensure awareness of roles and responsibility, as it relates to the same,
- a process to be in place to ensure that immediate actions are taken to respond to
suspicions, allegations or witnessed incidents of resident to resident physical or sexual abuse, including immediately investigating as per the home s policy on Zero Tolerance of Abuse and Neglect, immediate notifications (of POA, police and the Director) and ongoing monitoring of those residents to ensure the safety of those residents at risk and any other residents who may be vulnerable, are protected from physical or sexual abuse from other residents.
- and specific measures in place when non-adherence to the home's policy and or
legislation is identified,

The plan shall be submitted in writing and emailed to LTCH Inspector-Nursing,
Lynda Brown at OttawaSAO.MOH@ontario.ca on or before March 2, 2016. The plan shall identify who will be responsible for each of the items and expected completion dates.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that resident #024 was protected from physical abuse by resident #023, pursuant to s.19 of the LTCHA.

Under O. Reg. 79/10, s.2 (1)Physical abuse means, (c) the use of physical force by a resident that causes physical injury to another resident.

Related to log #001019-16 for resident #023 & #024:

A review of the clinical records for resident #023 & #024 for a two month period indicated resident #024 was not cognitively impaired but resident #023 was. There were four documented instances where resident #024 was the recipient of either suspected or actual physical abuse from resident #023. For every documented instance, resident #023 had entered resident #024's bedroom where the incidents took place.

On a specified date and time, the first incident occurred and no injuries were noted. There was no further documentation until two days later, when staff noted injuries to specified areas. The Director, police and Substitute Decision Maker (SDM) were notified at this time of the physical abuse incident.

Approximately one month later, the second incident occurred and the SDM of resident #024 was not notified as the resident requested the SDM not be notified of the incident. There were no immediate actions identified to prevent recurrence.

Two days later, the third incident occurred and resident #024 requested the SDM be contacted the following day. The only action taken by the home to prevent a recurrence included using a locking device to resident #024 door. The Director, police and SDM were notified the following day of the incident. Actions taken to prevent a recurrence included medication changes for resident #023 and a referral to psycho-geriatric resources.

Approximately two weeks later, the fourth incident occurred. No injuries were noted at that time. The only action taken was a reminder to resident #024 to utilize a locking device. The police were not notified and the incident and it was not reported to the Director.

The home also received a verbal complaint by the SDM of resident #024 after the last incident.

During an interview with resident #024, the resident recalled all four incidents and expressed being "fearful" of resident #023, and "did not feel safe" in the home.

During interview with the acting DOC, she confirmed that the four incidents that

occurred were considered alleged or suspected physical abuse and should have been immediately reported to the Director. The acting DOC also indicated the home failed to protect resident #024 from resident #023.

Therefore, the licensee failed to protect resident #024 from ongoing physical abuse by resident #023 as identified by the following:
-when resident #023 demonstrated ongoing physical abuse and/or physical aggression towards resident #024, the behavioural triggers were not identified, and strategies and actions takes to respond to these responsive behaviours were not developed and implemented, where possible, as identified under O.Reg. 79/10, s.53(4)(a)(b)(c) under WN#9.
-The home did not immediately investigate the incidents of suspected physical abuse between resident #023 and resident #024, as identified under LTCHA, 2007, s. 23(1)(a), under WN#7.
-The home did not immediately report all the allegations of resident to resident physical abuse between resident #023 and #024, as identified under LTCHA, 2007, s.24(1) under WN#9.
-The home did not immediately report all the allegations of resident to resident physical abuse between resident #023 and #024 to the police, as identified under LTCHA, 2007, s.98 under WN#12. [s. 19. (1)](623)

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

Under O. Reg. 79/10, s.2 (1) Sexual abuse means, (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.

Related to log #000124-16 & log #036165-15 for resident #003 & #004:

Note: a critical incident report (CIR) was submitted to the Director on a specified date, for a resident to resident sexual abuse that occurred by resident #004 towards another resident. This incident was inspected by Inspector #155. This incident was not identified on the second CIR that was submitted.

The third CIR was submitted two months after the first CIR, and indicated there were 4 incidents of resident to resident sexual abuse involving resident #004 (but only 3

CIR's were received by the Director).

Review of the health care record for resident #003 indicated the resident was the recipient of previous sexual abuse by resident #001 and by resident #005.

A second CIR was submitted to the Director (two months after the first CIR), indicating on a specified date, resident #004 was witnessed by staff engaging in suspected sexual abuse towards resident #003. Both residents were cognitively impaired.

A third CIR was submitted to the Director (a week later) indicating on a specified date, resident #004 was witnessed by a staff engaging in suspected sexual abuse towards resident #003.

Review of the progress notes for resident #003 (for a three month period) indicated a week before the second CIR was submitted to the Director, the resident was found on a specified date and time, with resident #004's demonstrating inappropriate sexual responsive behaviour. There was no documented evidence to indicate the resident was assessed.

Review of the progress notes for resident #004 (for the same three month period) indicated:
-There were 3 incidents of suspected sexual abuse and/or sexually inappropriate responsive behaviours demonstrated by resident #004 towards resident #003 and other unidentified residents.
-The first incident was noted on a specified date and time and recipient resident was not identified. The second incident occurred a week later towards resident #003 and was reported to the Director.
-The third incident occurred two days later but was not reported by staff to the charge nurse until two days later, when the SDM of resident #004 reported it. The recipient resident was also not identified and this incident was not reported to the Director. The actions taken included 1:1 supervision.
-Six days later, the resident was relocated to another unit. Later the same day (after being relocated), the resident was found by staff demonstrating sexually inappropriate responsive behaviours towards an unidentified co-resident. Both SDM's were contacted and staff documented "Both SDM's and residents" were agreeable to the responsive behaviour.
-11 days later, the resident was found demonstrating sexually inappropriate

responsive behaviour towards another unidentified co-resident and the co-resident was removed.
-Three days later, the resident was witnessed demonstrating suspected sexual abuse towards another unidentified co-resident. Both residents were separated and no injuries noted. A call placed to CIATT indicated the co-resident was resident #011.

Therefore, the licensee failed to protect resident #003 (and other unidentified residents) from sexual abuse by resident #004 as identified by the following:
-When resident #004 demonstrated ongoing sexually abusive responsive behaviours towards resident #003 and other vulnerable, cognitively impaired female residents, there was no investigations completed, as indicated under LTCHA, 2007, s.23(1)(a) under WN#7.
-When resident #004 demonstrated ongoing sexually inappropriate responsive behaviours towards resident #003 and other vulnerable, cognitively impaired female residents, the plan of care did not identify triggers and strategies to manage the risk, as indicated under O.Reg. 79/10, s.53(4)(a)(b), under WN#9.
-When resident #004 demonstrated ongoing sexually inappropriate responsive behaviours towards resident #003 and other vulnerable, cognitively impaired female residents, the home did not refer to BSO Team or external Psycho geriatric resources, as identified under O.Reg. 79/10, s.55(a) under WN#10(623).

3.Related to log #025375-15 & #028518-15 for resident #005:

Review of the health record for resident #005 indicated the resident was admitted on a specified date with a diagnosis of dementia. The resident died approximately six months later. The progress notes for a three month period indicated the resident demonstrated ongoing sexually inappropriate responsive behaviours and sexual abuse towards co-resident's and staff.

Note: a follow-up inspection was also being conducted (log #036165-15) related to a previous CIR where resident #003 was the recipient of sexual abuse by resident #005. A previous CIR for a resident to resident sexual abuse incident was submitted by the home on a specified date, which occurred two weeks before the second CIR was submitted and was inspected by Inspector #155. The second CIR (submitted two weeks later) indicated suspected sexual abuse by resident #005 towards resident #007. This CIR indicated there were no previous incidents of sexual abuse involving resident #005. The third CIR (submitted approximately three weeks later),

indicated suspected sexual abuse by resident #005 towards resident #006. This CIR indicated there were 4 incidents of resident to resident sexual abuse involving resident #005 (but only three incidents were reported to the Director).Resident #003, #006 and #007 were also cognitively impaired.

In addition to the incidents reported to the Director, the progress notes of resident #005 indicated an additional incident of "suspected" resident to resident sexual abuse occurred four days before the last CIR was reported to the Director. The documentation indicated no physical or emotional distress noted by co-resident despite the co-resident "yelling" at resident #005 to get away from the resident and staff requesting additional staff assistance. The co-resident was not identified (or any documented evidence to indicate an assessment of the co-resident)and there was no documented investigation completed in order to determine who the recipient resident was, or whether there was any injury of emotional distress. This incident was also not reported to the Director.

The acting DOC was interviewed regarding the home’s investigations into "suspected" resident to resident sexual abuse and regarding identifying who the recipient residents were (of resident #005). The acting DOC indicated the registered nursing staff were directed by the previous DOC not to indicate who the recipient residents were in the progress notes of resident #005 “to protect their personal health information”. The acting DOC indicated the recipient resident’s names would be identified on the 'Risk Management' reports which should have been completed for each of the incidents. The acting DOC indicated she was unable to identify who the co-resident was as there was no documented 'Risk Management' report completed for that incident.

Therefore, the licensee failed to protect vulnerable, cognitively impaired female residents (resident #006, #007, and other unidentified female residents) on the secure unit from sexual abuse by resident #005 as identified by the following:
-When resident #005 was demonstrating sexually inappropriate responsive behaviours and/or sexual abuse, the triggers were not clearly identified and strategies to manage the behaviours were not developed or implemented, and actions were not taken to manage the risk to other vulnerable female residents, when the behaviours continued, as indicated under O.Reg. 79/10, s.53(4)(a)(b)(c), under WN#9.
-The licensee failed to ensure the home's prevention of abuse policy was complied with as there was no documentation for any of the female recipients of the sexual

abuse and/or sexually inappropriate responsive behaviours to determine if an assessment of those residents was completed. There was no indication a documented record was kept of the investigations to determine who the recipients of the suspected sexual abuse were, and no referral to Psycho geriatric Resource Consultant was completed until after the third CIR was submitted to the Director as identified under LTCHA, 2007, s. 20(1), under WN#5.
-There was no indication the SDM’s of the female recipient residents were notified regarding the incidents that were not reported to the Director, as identified under O.Reg. 79/10, s.97(1), under WN #11.
-There was no indication the police were notified of the incident of suspected resident to resident sexual abuse that occurred on October 6, 2015, as identified under O.Reg. 79/10, s.98, under WN#12.
-There was no indication the Director was notified of suspected resident to resident sexual abuse for the incident that occurred on October 6, 2015, by Resident #005, as identified under LTCHA, 2007, s.24(1), under WN#8.

The home was issued a Compliance Order for LTCHA, 2007, s.19 on February 4, 2015 during inspection #2015_293554_0003 with a compliance date of October 26, 2015. [s. 19. (1)] (111)

2. The licensee has failed to ensure that resident #024 was protected from physical abuse by resident #023, pursuant to s.19 of the LTCHA.

Under O. Reg. 79/10, s.2 (1)Physical abuse means, (c) the use of physical force by a resident that causes physical injury to another resident.

Related to log #001019-16 for resident #023 & #024:

A review of the clinical records for resident # 023 & #024 from December 1, 2015 to January 29, 2016 indicated resident #024 is not cognitively impaired but resident #023 is cognitively impaired. There were four documented instances where resident #024 was the recipient of either suspected or actual physical abuse from resident #023. For every documented instance, resident #023 had entered resident #024's bedroom where the incidents took place:
-on December 5, 2015, at approximately 22:40, resident #024 reported to the RPN that resident #023 was in her room, bit both of her hands and kicked both her

legs.The Resident was assessed and no injuries were noted at that time. There was no documentation the day after the incident to indicate whether the resident sustained any injuries until two days later (December 7, 2015), when RN assessed resident #024 and noted bruising on right hand, six small bruises on left forearm, and one that was crescent shaped (from bite).The RN indicated the resident reported that on December 5, 2015 there were three incidents that occurred with resident #023 (the first two she was scratched and the third she was bitten by resident #023). The Director (CIR #M589-000132-15), police and Substitute Decision Maker (SDM) were notified at this time of the alleged physical abuse incident.
-On January 3, 2016 at approximately 21:00, the resident reported to registered nursing staff that resident #023 entered her room and punched her in the left side of the face with a closed fist and then punched her in the left leg six times with a closed fist. The resident was assessed and no injury was noted at that time. Documentation indicated that resident #024 did not want her SDM notified of the incident. No immediate actions were identified to prevent recurrence.
-On January 5, 2016 at approximately 21:45, resident #024 reported to the RN that resident #023 was in her room and when she asked the resident to leave, resident #023 kicked her in the legs three times, then pinched and twisted the skin on her left arm above the elbow. The resident sustained "a bright red/purple bruise". Documentation indicated that resident #024 requested her SDM be contacted in the morning due to it being too late at night. This incident was not reported to the Director or police at that time. Actions taken by the home included resident #024 to use the lock on her bedroom door handle to keep resident #023 out of her room. The following day (January 6, 2016), the Director (CIR #M589-000001-16), police and SDM were notified of the incident. Actions taken to prevent recurrence included staff to remind resident #024 to utilize the lock on her bedroom door. Actions for Resident #023 included an increase in medication and a referral to Ontario Shores.
-On January 20, 2016 at approximately 21:00, the resident called staff for assistance, as resident #023 was in her room and reported resident #023 began punching her in the legs, scratched her right arm, then raised her fist to hit her in the face. No injuries noted at that time. Staff reminded resident #024 to lock her bedroom door. The SDM of resident #024 was notified of the incident. The police were not notified and the incident was not reported to the Director.
-A verbal complaint was also received from the SDM for resident #024 on January 21, 2016 regarding the incident that occurred on January 20, 2015. A meeting was held with the SDM on January 22, 2016 to discuss the concerns.

During an interview with resident #024, the resident was able to recall all the

incidents that had occurred, expressed that she was fearful of resident #023, and stated she "did not feel safe in her home".

During interview with the acting DOC, she confirmed that the documented incidents that occurred on December 5, 2015, January 3, 5 and 20, 2016, were alleged or suspected physical abuse and should have been reported to the Director. The acting DOC also indicated the home failed to protect resident #024 from resident #023.

Therefore, the licensee failed to protect resident #024 from ongoing physical abuse by resident #023 as identified by the following:
-when resident #023 demonstrated ongoing physical abuse and/or physical aggression towards resident #024, the behavioural triggers were not identified, and strategies and actions takes to respond to these responsive behaviours were not developed and implemented, where possible, as identified under O.Reg. 79/10, s.53(4)(a)(b)(c) under WN#9.
-The home did not immediately investigate the incidents of suspected physical abuse between resident #023 and resident #024, as identified under LTCHA, 2007, s. 23(1)(a), under WN#7.
-The home did not immediately report all the allegations of resident to resident physical abuse between resident #023 and #024, as identified under LTCHA, 2007, s.24(1) under WN#9.
-The home did not immediately report all the allegations of resident to resident physical abuse between resident #023 and #024 to the police, as identified under LTCHA, 2007, s.98 under WN#12. (623)

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

May 29, 2016(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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 8 day of March 2016 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : LYNDA BROWN - (A1)

Service Area Office / Bureau régional de services : Ottawa