Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Mar 13, 2018;	2018_548592_0002 (A1)	013373-17	Resident Quality Inspection

Licensee/Titulaire de permis

Bruyère Continuing Care Inc.
43 Bruyère Street OTTAWA ON K1N 5C8

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

Élisabeth-Bruyère Residence
75 Bruyère Street OTTAWA ON K1N 5C8

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

MELANIE SARRAZIN (592) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

On March 8, 2018, the home's Executive Director and Administrator requested a 30 day extension to the CO #001 LTCHA s. 6 (7) Plan of Care compliance due date. The requested extension has been granted.

Issued on this 13 day of March 2018 (A1)

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

Original report signed by the inspector.

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MELANIE SARRAZIN (592) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): January 08, 09, 10, 11, 12, 15, 16, 17, 18, 19, 22, 23, 24, 25, 26, 29 and 30, 2018

This Resident Quality Inspection also included the following:

Nine logs associated to critical incident the home submitted to the Ministry;

Log #010936-17, 022249-17, 026718-17, 028493-17 and 011084-17 related to allegation of sexual abuse and Log # 011388-17, 020665-17, 026495-17 and 016762-17 related to fall and injury.

During the course of the inspection, the inspector(s) spoke with the home's Executive Director of Long Term Care (EDLTC), the Administrator, the Director of Care (DOC), the Registered Dietician (RD), the Food Services Manager (FSM), the Recreational Therapist, the Ward Clerk, the Psychogeriatric Nurse, one Physician, several Registered Nurses (R.N.), several Registered Practical Nurses (R.P.N.), Behavioural Support of Ontario (BSO) champion, several Personal Care Attendants (PCA), housekeeping staff, the president of the family council, the president of the resident council, several family members and several residents.

During the course of the inspection, the inspector(s) conducted a tour of the resident care areas, reviewed residents' health care records, relevant licensee policies and procedures, staff work routines, posted menus, observed resident rooms, resident common areas, the Admission process and Quality Improvement system, Residents' Council and Family Council minutes, a

medication administration pass, two meal services, the delivery of resident care and services and staff to resident and resident to resident interactions.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Reporting and Complaints

Residents' Council

Responsive Behaviours

Skin and Wound Care

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

- **12 WN(s)**
- **7 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

The licensee specifically failed to ensure that there is a written plan of care for each resident that sets out,
(a) The planned care for the resident;
(c) Clear directions to staff and others who provide direct care to the resident.

Resident #011 was admitted to the home on a specified date with multiple diagnoses including a neurological disorder which is affecting the resident's mobility and the ability to be independent for the personal care.

A three month comparison between the resident's last two Minimum Data Set (MDS) assessment for continence, revealed a decline in the resident continence. The resident went from being usually continent to being occasionally incontinent. A review of the documentation in Point Click Care (PCC) within a specific two weeks period in 2018, revealed that the resident was incontinent several times during that two weeks period.

During an interview with resident #011 on January 10, 2018, the resident indicated to inspector #550 that sometimes when the call bell is used in order to have assistance for toileting, it takes staff more than twenty minutes to respond to the call which results in the resident being incontinent.

On January 18, 2018, inspector interviewed PCA #125 who was the PCA caring for the resident. PCA #125 indicated to the inspector that resident #011 uses the call bell to request staff's assistance for toileting. The resident is totally dependent of staff for toileting, performing pericare and adjusting the resident's clothes afterwards. The resident wears an incontinence product at all times.

Inspector #550 reviewed the documentation in PCC within a specific two week period in 2018 and noted documentation that resident #011 was incontinent of stools several times during that period. Inspector reviewed the resident's actual plan of care and kardex as well as the POC, all revised on a specific date in 2017, and noted they did not indicate that the resident was occasionally incontinent nor was there any information related to the care the resident requires to prevent and address such incontinence.

During an interview, the Administrator and the Director of Care (DOC) both confirmed to the inspector that resident #011's written plan of care including the kardex should indicate the resident's incontinence with the interventions in place in order to set out clear directions to staff.

2. The licensee has failed to ensure that there is a written plan of care for each resident that sets out,
(a) The planned care for the resident;
(b) The goal the care is intended to achieve; and
(c) Clear directions to staff and others who provide direct care to the resident.

Resident #011 was admitted to the home on a specified date with multiple diagnoses including a neurological disorder which is affecting the resident's mobility and the ability to be independent for the personal care.

During an interview with resident #011 on January 10, 2018, the resident indicated to inspector #550 having sore and bleeding gums, due to lack of hygiene. The resident stated that staff was only providing oral care once a day. The inspector noted brownish stains on the resident's pillow case.

On January 18, 2018, inspector interviewed PCA #125 who was the PCA caring for the resident. PCA #125 indicated to the inspector that resident #011 is totally dependent of staff for oral care as the resident is not able to do so. Oral care is to be done in the morning and evening.

Inspector #550 reviewed the resident's actual written care plan and Kardex and observed there was no provision for oral care. Both documents did not indicate the resident's need for total assistance from staff, goals or interventions related to oral care.

During an interview, the Administrator and the DOC both confirmed to the inspector that resident #011's written plan of care including the Kardex, should indicate that the resident is dependent of staff for oral care including goals and interventions to set out clear directions to staff.

3. Resident # 042 was identified with a altered skin integrity to specific body areas.

A review of the resident's health care record was done by Inspector #592 which indicates that resident #042 was identified with altered skin integrity to specific body areas upon return from the hospital on a specified date in 2017. As per the current physician orders, resident #042's still has altered skin integrity and the current treatment is to have the affected areas cleaned with a specified product and to cover the affected areas with specific dressings twice a week.

On January 18, 2018, resident #042 was observed by Inspector #592 sitting with a specific garment applied over the dressings covering the affected skin areas.

On January 18, 2018, during an interview with PCA #101, who is identified as the main caregiver for resident #042, the PCA indicated to the Inspector that resident #042 has altered skin integrity to specific body areas which are being taking care of by the registered nursing staff. PCA #101 further indicated that the PCA's are to ensure that the resident does not wear any specific garment but rather a specific article of clothing applied loosely on the dressings as the resident experiences discomfort to the affected areas. PCA #101 further indicated that there was no other specific interventions in place for resident #042 other than reporting to the nurse if the dressings were no longer intact.

On January 18, 2018, during an interview with RN #119, the RN indicated that resident #042 was hospitalized on a specified date in 2017 and that the resident

came back with the presence of altered skin integrity to specific body areas. RN #119 further indicated that a special therapeutic surface was used for the resident and that the interventions were to do the resident's dressing twice a week using specific dressings. The RN further indicated that the PCA's were to ensure that resident #042 does not have any pressure or friction to the affected areas and that resident #042 should be repositioned and turned regularly. RN #119 indicated that when resident #042 is in bed, a pillow should be put in place under a specific body location to avoid the affected areas from touching the mattress. RN #119 indicated that the specific interventions were documented and identified in the resident's plan of care, kardex and POC in order for the PCA's to provide the specified care.

A review of resident #042's current written plan of care was done by Inspector #592. The above interventions as identified by RN #119 were not in the plan of care. Furthermore, no documentation was found for the planned care for the skin alteration for resident #042, no goals and no directions were provided to the staff and others who provide direct care to resident #042.

On January 19, 2018, during an interview with the Administrator, a review of resident #042's written plan of care was done. The Administrator was unable to find any documentation related to skin integrity for resident #042. The Administrator indicated to the Inspector that it was the home's expectation that any residents at risk for skin alteration and who are identified with altered skin integrity should have a written plan of care that sets out the planned care for the resident, the goals and clear directions to the staff who provide direct care to the resident.

4. The license failed to comply with section 6.(1)(a) of the Act in that the licensee failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

Resident #013 suffered a fall on a specified date in 2017. Inspector #138 reviewed resident #013's health care record including the plan of care as defined by the home and noted that the plan of care outlined falls prevention interventions. Inspector #138 observed the resident and the resident's room and noted several potential falls prevention interventions that were not identified on the resident's plan of care. The interventions included two specific safety devices for the resident while seated in a wheelchair, and another specific safety device beside the resident's bed.

Inspector #138 spoke with staff about the interventions for falls prevention for

resident #013. PCA #116 stated that resident #013 had two specific safety devices on the resident's wheelchair to prevent the resident from falling. PCA further added that resident #013 would often fall when attempting to get out of the wheelchair after releasing one of the safety devices and so, as a result, a second safety device had been recently added to the resident's wheelchair. In addition, Inspector #138 spoke with PCA #106 about the falls prevention interventions for resident #013. PCA #106 outlined several falls prevention interventions for the resident, including the use of two specific safety devices, but also the use of another specific safety device beside the resident's bed.

Inspector #138 again reviewed resident #013's plan of care. The inspector was unable to locate the falls prevention interventions for resident #013 outlined above: the use of two specific safety devices on the resident's wheelchair to prevent the resident from rising and the use of another specific device besides the resident's bed.

As such, the license failed to ensure that the written plan of care for resident #013 set out the planned care relating to falls prevention.

5. The license failed to comply with section 6.(7) of the Act in that the licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. (this finding is a Compliance Order)

This inspection is related to Log #026495-17.

Inspector #138 reviewed a Critical Incident Report which outlined that resident #044 was diagnosed with an injury to a specific body part on a specified date in 2017, after the resident reported pain after a transfer.

Inspector #138 spoke with the home's Administrator regarding this Critical Incident Report. The Administrator reported that she conducted an internal investigation and provide the inspector with the internal investigation documents. The inspector reviewed the internal investigation documents, the resident health care record, and spoke with several staff involved in the incident. The following is a summary of the events:

Resident #044 was experiencing some decline in abilities at the time of the identified transfer. Resident #044 called a family member, reporting to the family member that when a staff member lifted a specific body area, it hurt. In turn, the

family member called the evening RPN, RPN #128, to report the concern. There had been some misunderstanding by RPN #128 regarding this report from the family member however the resident continued to complain of pain to a specific body area, specifically starting on the day that the resident had contacted a family member, continuing for two more days. Then, three days after contacting a family member, PCA #127 noted that the resident had altered skin integrity on a specific body area and reported this to RPN #128. The resident was sent for tests on the next day, as a result of the altered skin integrity and complaints of pain, and was diagnosed the same day with an injury to a specified body part. The resident's condition continued to deteriorate and the resident passed away in the home.

Inspector #138 spoke with the Administrator who stated that an internal investigation commenced, when the injury of the specific body part was diagnosed for resident #044. As part of this investigation, the Administrator spoke with staff including PCA #103 who provided care to resident #044 on the day that the transfer occurred. According to the Administrator, PCA #103 indicated that the resident was transferred as a one pivot transfer instead of a mechanical lift transfer. PCA #103 reported routinely transferring resident #044 as a one person pivot transfer because the resident would exhibit behaviours when being transferred by a mechanical lift. These behaviours by the resident included yelling, threatening to report staff, and hitting the mechanical lift.

The Administrator provided Inspector #138 with a copy of a letter of discipline that outlined that PCA #103 had received a one day suspension without pay for transferring resident #044, without a mechanical lift as per the resident's kardex and care plan.

Inspector #138 reviewed resident #044's care plan in Point Click Care at the time of the incident, and noted that it provided direction for the use of a mechanical lift when transferring the resident. Inspector #138 spoke with both PCA #101 and PCA #127 separately and both stated that the resident was to be transferred via a lift which had been in effect for resident #044 for many months.

Inspector #138 further reviewed resident #044's health care record and noted from the progress notes that, on the day of the incident, resident #044 was upset with PCA #103 over a transfer with PCA #103 and that the resident complained of being sore to a specific body area. This progress note also stated that the resident's family member called the home to report that the resident had called upset. The progress notes for the two following days, showed that the resident complained of

pain and received pain medication for the same specific body area. The resident complained of pain to the same body area three days after the incident and this time, altered skin integrity had been discovered on a specified body part upon assessment. The progress notes further show that the resident received a test on the next day, and was diagnosed with an injury of a specific body part. The progress notes show that resident #044's condition deteriorated and the resident passed away in the home. The Medical Certificate of Death dated on a specific date, listed the immediate cause of death as an injury to a specific body part and of another medical condition.

Inspector #138 further reviewed the Critical Incident Investigation Report dated on a specific date, provided by the home. This report is an internal document of the home that is the result of the home's own review of the incident. This report stated that the injury to resident #044 was most likely caused by a one person pivot transfer by a PCA staff member, that the resident deteriorated significantly after the injury, and passed away on a specified day.

A previous non compliance relating to section 6.(7) of the Act was issued September 2015, Resident Quality Inspection # 2015_285126_0035 as a voluntary plan of correction (VPC).

This incident, while isolated to one resident, represented a significant actual harm to resident #044.

6. The licensee has failed to ensure that resident #049 was reassessed and the plan of care reviewed and revised when the care set out in the plan was no longer effective to keep resident #049 away from resident #012.

Resident #049 was admitted to the home on a specified date in 2016, with several diagnoses including dementia.

This inspection is related to Inspection Log # 022249-17.

On a specified date, a Critical Incident report was submitted to the Director describing an incident of alleged sexual abuse that occurred two days before, between residents #049 and #012, whereby resident #012 was witnessed to have inappropriate sexual behaviours towards resident #049.

During review of the resident #049's health care records, Inspector #592 noted that

there was documentation of another incident of inappropriate sexual behaviour and touching dated two days after the first incident, between resident #049 and #012. The progress notes indicated that resident #012 was witnessed by a staff member doing the same inappropriate sexual behavior towards resident #049.

Upon reviewing the written plan of care for resident #049, Inspector #592 noted that interventions for suspected sexual abuse (embracing and touching) of the resident by another resident was initiated on a specific date three months prior to the reported incidents of alleged sexual abuse, as part of one of the focus problems for resident #049. It was further noted that some interventions such as to ensure that the resident is not placed beside another resident of the opposite gender in unsupervised areas and to monitor for any inappropriate behaviours were put in place.

No other interventions were noted on the written plan of care for resident #049 following the two incidents of alleged sexual abuse.

On January 25, during an interview with the ED, the Administrator and the DOC, they indicated that interventions were put in place and a plan was done following an incident of alleged sexual abuse reported three months prior to the two incidents between the two identified residents. However after a review of the written plan of care, the identified interventions that were discussed with the multidisciplinary team after the first incident, were not all added to the resident #049's written plan of care. The plan of care was not reviewed and no other interventions were implemented after the two incidents.

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

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 there is there is a written plan of care for each resident that sets out, the planned care for the resident, the goal the care is intended to achieve, clear directions to staff and others who provide direct care to the resident and that the plan of care will be reviewed and revised when the care set out in the plan is no longer effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

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 :

The licensee failed to ensure that the following are developed to meet the needs of residents with responsive behaviours:

1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required.

This inspection is related to Log #022249-17, Log #011084-17 and Log #026718-17.

Resident #012 has had eleven incidents where behaviours of a sexual nature were exhibited towards resident #008, #049 and staffs within a nine month period.

Throughout a review of resident #012's health care records, interviews with the ED, the Administrator, the DOC, several registered nursing staff, several Personal Care Attendants (PCA) and the Psychogeriatric Nurse, it was determined that the resident had a hyper sexualized personality. The resident was not assessed by the psychogeriatric team, the written plan of care was not always reviewed and revised after each incident to implement new interventions, some of the interventions were not clear, others were not implemented immediately and the resident was not referred to the Behavioural Support Ontario (BSO) Champion staff after the incidents occurred as identified in the finding O.Reg S. 53(4).

During an interview with the BSO Champion staff #101 on January 26, 2018, the BSO indicated to inspector #550 that there are two BSO Champion staff in the home; one on each floor. Each BSO Champion staff is scheduled to work 1 shift per week (7.5 hours) on each floor either on days or evenings. BSO # 101 indicated that they receive education on a yearly basis. They do not have specific residents assigned to them. In order to determine which resident they will be working with during their shift, they attend to the shift report at the beginning of the shift and any residents who are identified through the report to have exhibited responsive behaviours they will work with that day. They assist with the breakfast meal and will identify residents who are exhibiting responsive behaviours in order to know with whom they will work on that day. They also assist the PCAs to bathe residents who are difficult to bathe. They document in the "BSO Champion binder" the date, the name of the resident and the reason for working with the resident. They also document the work they have done in the respective resident's progress notes. If the BSO Champion is having difficulty managing a resident's behaviour, they can consult with the Psychogeriatric nurse from the Royal Ottawa Mental Health Centre who comes to the home on a weekly basis to visit with residents referred to the Outreach team. The BSO Champion staff #101 indicated to the inspector not knowing any formal Responsive Behaviour Program in the home. The above actions are done daily but no formalized process for the BSO.

During an interview on January 25, 2018, the Administrator indicated to the

inspector that the home did not currently have a Responsive Behaviour Program established, with written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours, resident monitoring and internal reporting protocols, and, protocols for the referral of residents to specialized resources when required. The Administrator indicated that this was identified in their strategic planning and that they had developed a program but it was currently in draft form. This program had not been introduced to their employees yet but was scheduled to be introduced soon. This was also confirmed by the ED to inspector #550 on January 30, 2018.

2. The licensee has failed to ensure that the following are developed to meet the needs of residents with responsive behaviours:

1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or others.

Resident #007 was admitted to the home on a specified date and was identified with behaviours.

During a review of resident #007's progress notes within a seven month period, for an incident of alleged sexual abuse, inspector #550 noted in the progress notes that resident #007 had exhibited behaviours of aggression on seven occasions. There were two incidents documented where resident #007 was physically aggressive towards other residents, two incidents where the resident displayed physical aggressive behaviors and three incidents where the resident was verbally aggressive towards other residents.

During an interview on January 17, 2018, the Administrator and the Director of Care indicated to inspector #550 that this resident has behaviours of physical aggression towards other residents and staff. Although they both indicated that the triggers had not been identified, they informed the inspector that when the resident is not in a good mood, the resident becomes short tempered and has to be watched closely as this may trigger an aggressive response. There are specific rules put in place for the resident to follow. The resident will react to noisy residents close by. They indicated that the resident was followed by the BSO champion in

the home and that the resident currently has a one on one sitter for specific shifts to monitor any behaviours. The resident is not eligible for a psychogeriatric assessment. There is a Duo-Tang binder at the nurses' station with instructions for the one on one sitter, titled "1:1 sitter instructions, resident #007, The RPN must review with sitter and ensure they sign". They indicated that although there is indication of the resident's aggressive behaviour and some interventions in the binder, this binder is intended for the 1:1 sitter and is not communicated to the PCAs caring for the resident.

Upon a review of resident #007's health care records, inspector #550 noted that the current written plan of care did not indicate the resident's potential physical and verbal aggression towards residents and staffs, the triggers were not documented and the approaches to care were also not documented.

On January 19, 2018, BSO staff #116 indicated to inspector #592 that resident #007 has behaviours of physical and verbal aggression towards staff and residents. The resident likes to control the unit, does not like to be told what to do and does not like new residents. When things are not done as per resident's wishes, the resident becomes agitated and aggressive. It is very difficult for the staff to manage the behaviours as the resident does not listen to them and often they have to get their supervisor to calm the resident. BSO staff #116 further indicated not being aware of all the interventions in place for the resident to manage the behaviours as the resident now has a one on one sitter and this person is taking care of the resident.

On January 30, 2018, inspector #550 interviewed PCA #118, who was the PCA caring for the resident. PCA #118 told the inspector that the resident has behaviours including physical and verbal aggression towards residents and staffs. The resident is often observed making fun of other residents and starting arguments with other residents or staffs. The resident does not like when rules are imposed. PCA #118 indicated that the resident currently has a one on one sitter on specific shifts to monitor the resident. It is important that staff knock on the bedroom door and wait for the resident to answer before entering the resident's room and to move noisy residents away from the room as this will trigger the aggressive behaviour. The PCA indicated that when resident #007 is exhibiting physical or verbal aggression towards residents, they move the other residents away from resident #007 and tell the resident to stop. These interventions are not always effective and often they have to call security to calm the resident. PCA #118 indicated this resident is difficult to manage.

As evidenced, written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, were not developed to meet the needs of resident #007.

3. The licensee failed to comply with section 53.(1)2. of the Regulation in that the licensee failed to ensure that written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviour are developed to meet the needs of residents with responsive behaviours.

Inspector #138 reviewed a Critical Incident Report which outlined that resident #044 sustained an injury to a specific body part. The home's internal investigation demonstrated that the probable cause of the injury was that the resident had been transferred by PCA #103 as a one person pivot transfer instead of a mechanical lift transfer as indicated in the plan of care for the resident.

Inspector #138 reviewed the internal investigation documents and noted that the PCA #103 had reported to the home that the resident was transferred as a one person pivot transfer instead of a mechanical lift transfer because the resident disliked the lift, would yell out and hit the lift during the transfers. Inspector #138 spoke with staff, PCA #125, PCA #127, and RPN #128, regarding resident #044's transfers and all staff reported that the resident was to transfer via a mechanical lift but that the resident had a strong dislike to the use of the mechanical lift and would yell out and strike the lift during transfers. PCA #125 further stated the resident would yell loudly, threaten to report staff, yell at the staff that they were hated, and hit the bar and the straps of the lift. PCA #125 also reported that resident #044 liked some staff better than others and for those staff that the resident did not like the resident would call them offensive names. PCA #125 stated that interventions used to deal with resident #044's behaviours when using a lift was to find a staff member that the resident liked, speak to the resident calmly prior to the transfer and explain to the resident why the mechanical lift needed to be used.

Inspector #138 reviewed resident #044's health care record including the plan of care, as defined by the home. The inspector noted that the plan of care indicated that resident #044 was planned to be a two person transfer using the mechanical lift, however, the health care record, including the plan of care did not outline the responsive behaviours above with respect to being transferred with a lift nor did the health care record including the plan of care, outline any written strategies to

address these responsive behaviours.

4. The licensee has specifically failed to ensure that, for each resident demonstrating responsive behaviours,
(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. (This is a Compliance Order)

This inspection is related to Log #022249-17, Log #011084-17 and Log #026718-17.

Resident #012 was admitted to the home on a specified date with several diagnoses including unspecified dementia.

On a specified date in 2017, an incident of inappropriate touching of sexual nature between two residents was reported through the after-hours pager notification system followed by the submission of CIR (Critical Incident Report) on the following day to the Director. It was reported that three days before, resident #012 was observed by RPN #140 having inappropriate behaviours of sexual nature towards resident #049.

Three months later, a Critical Incident report was submitted to the Director describing an incident of alleged sexual abuse between residents #049 and #012, whereby resident #012 was witnessed having inappropriate sexual behaviours towards resident #49.

Three months later following the second reported incident, an incident of allegation of sexual abuse was reported through the after-hours pager notification system followed by the submission of CIR (Critical Incident Report) on the following day to the Director. It was reported that resident #012 went into resident #008's room and asked resident #008 if the resident wanted to be more than just a friend. When resident #008 declined, resident #012 made inappropriate verbal comments while yelling and laughing at resident #008.

Inspector #550 reviewed resident #012's progress notes from within a period of 11 months and noted a total of eight other incidents of inappropriate behaviours and touching of sexual nature between resident #012 and resident #049.
There were also two other incidents of a sexual nature from resident #012 to staff members on two specific dates in 2018.

It was determined throughout the review of resident #049's health care record that resident #049 was not able to provide any consent at the time that the incidents of inappropriate behaviour and touching of sexual nature occurred.

Inspector #550 interviewed the ED, the Administrator and the DOC on January 25, 2017. They indicated that resident #012 was obsessed with resident #049. The DOC indicated that after they became aware of the first incident, a psychogeriatric consult to the Outreach team had been completed by the doctor but that the resident had not yet been assessed. Resident #012 was seen in the home by the psychogeriatric nurse and the BSO champion staff member to manage the sexual behaviours. One on one supervision was implemented after the first incident and the resident's seating was changed in the dining room so resident #12 was no longer sitting with resident #049. After the second incident, resident #012 was moved to a different floor in the home so the resident would no longer be in contact with resident #049. The Executive Director, the Administrator and the DOC indicated that since then, the resident had not exhibited any sexual behaviours.

On a specified date, the CIR submitted for the first incident was amended by the DOC to indicate that the physician had adjusted the resident's medication as the resident was still attempting sexual gestures. The resident was currently being supervised one on one, another resident who appeared to be competing with resident #012 for resident #049's attention was transferred to a different floor and the care plan was updated. A progress note dated 17 days after the first incident by the DOC indicated that the staff would ensure that the two residents would be seated at different tables for meals, staff were to monitor these residents and, if seated next to each other, they were to gently encourage one of the resident to change places. If sexual behaviours were observed staff were to use GPA approach (gentle persuasive approach) to separate the residents while supporting them emotionally. Staff were to document any behaviours observed and reaction of these residents and were to follow the above steps to minimize contact and interactions between these residents.

The same interventions were added to the first CIR 21 days later by the DOC as a "behaviour action plan". One month after the incident, a progress note by RN #143 indicated that the seating in the dining room had now been changed and resident #012 was now having meals in a different dining room. The inspector reviewed resident #012's plan of care in place at the time of the incidents until January 2018

and was not able to find that these interventions had been added on the plan of care.

It was noted that 11 days after the first reported incident, the DOC added to the written plan of care "determine what triggered/lead up to the behaviour and ensure resident is not seated next to one and another and monitor for any inappropriate behaviours" but there was no indication of which co-resident, resident #012 was not to be seated next to.

Approximately one month after the first reported incident, the Advanced Practice Nurse RN #126 reviewed the resident's interventions and added "remain calm and avoid angry reactions towards resident"

All other interventions were dated in 2016. There was no indication that the resident's plan of care was reviewed after each incident. The Executive Director, the Administrator and the DOC indicated to the inspector that the resident's plan of care had not been reviewed and revised after each incident and did not include the "behaviour action plan" that was developed 21 days after the first incident.

Documentation provided by the Administrator indicated that one on one supervision was implemented several days after a specific incident date for three days, on specific shifts. For the second reported incident, one on one supervision started on the following day, for three days on specific shifts. And, for the third reported incident, one on one supervision was started on the following day, for one specified shift for six days.

The inspector reviewed the resident's health care records. A consultation was completed by the resident's physician at the home several weeks after the first reported incident, requesting a psychogeriatric assessment of the resident for increased behaviours related to any staff interventions and new "possessive" relationship with a resident. The physician also indicated that a specific medication was increased as it was previously beneficial in managing the resident's sexual behaviours and also started another identified specific medication at the same time. There was a fax cover sheet, dated two days later, after the request for consultation was done by the resident's physician and a handwritten note by RN #119 on the "Geriatric Psychiatric Outreach Program Referral Form" indicating "was faxed".
The inspector was not able to find any documentation indicating that a psychogeriatric consult had been completed.

On January 30th, 2018, during a telephone interview, the psychogeriatric nurse indicated to the inspector that no consultation request had been received for this resident. The psychogeriatric nurse indicated that suggestions were made to the DOC that the resident be transferred to a different floor and this was eventually done. The psychogeriatric nurse was following up with the home to see if the resident had more behaviours and was told that since the resident's move to another floor, the resident did not have any other behaviours. The psychogeriatric nurse had verified with the DOC to see if the resident still needed to be assessed by the psychogeriatric team and was told that resident #012 no longer had sexual behaviours since the resident was moved to another floor.
The psychogeriatric nurse had not been informed of the two latest incidents of sexual behaviour towards staff members that had occured after the resident's move to another floor.

The DOC later confirmed to the inspector that the psychogeriatric consult had not been faxed to the psychogeriatric nurse consultant, that RN #119 had forgotten to fax it and no other follow-up was done with the psychogeriatric nurse after the last two identified incidents.

During an interview on January 26, 2018, BSO Champion PCA #101, indicated to the inspector that resident #012 has inappropriate sexual behaviours, yells out loud and can be aggressive towards other residents. The BSO Champion works one day per week on this floor and the BSO's will see the residents who were identified at the shift report to have exhibited responsive behaviours, those who are exhibiting responsive behaviours at breakfast in the dining room and assist staffs to bath difficult residents. When a resident is seen by the BSO staff, they have to write in the "BSO Champion Binder" the date, the resident visited and the reason for the visit. They also document in the progress notes. The staff member showed the inspector in the binder, a six month period time frame where resident #012 was seen by BSO. There was a total of 22 dates entered in that time frame period for resident #012. The documentation was about specific behaviours such as:

Yelling
Shouting at meal time
Trying to kiss co-resident #049
Rude to staff
Resistance to care
Loud

Fighting with another resident
Anxious and vocally inappropriate

There was no documentation to indicate that the BSO Champion staff had specific interventions that were used when working with resident #012 after each of the behaviours described above.

The BSO Champion PCA #101 confirmed that the notes completed for resident #012 were the only ones as the BSO did not work with the resident other than the 22 times that it was documented.

As evidenced, actions taken to respond to the needs of resident #012 did not include assessments, reassessments and interventions and that the resident's responses to interventions were documented.

The scope and severity of this non-compliance was reviewed by the inspector. The fact that resident #012 exhibited nine incidents of a sexual nature to resident #049 in a period of five months and even after being moved to a different floor the resident continued to exhibit incidents of a sexual nature towards an identified resident and towards staff posing a great risk of harm to those people.

Additional Required Actions:

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

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 written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other are developed to meet the needs of residents with responsive behaviours, to be implemented voluntarily.

WN #3: 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 :

The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents is complied with.

As per the LTCHA, S.O. 2007, c. 8, s. 20. (2) (e), the policy shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents.

This inspection is related to Log #028493-17, Log #022249-17, Log #011084-17 and Log #010936-17.

Inspector #592 reviewed the licensee's "Abuse and Neglect, Long Term Care" Policy, CLIN CARE 32 LTC, revised on 2016-12/2017-10, provided by the Administrator which was the home's prevention of abuse policy at the time the incidents occurred.

The policy indicated the following under Reporting Procedures:

4.1 The staff person who witnesses abuse or neglect, who believes that a resident has been or is at risk of being abused or neglected, or who is advised by a resident or visitor of abuse or neglect, immediately reports the situation to a nurse, supervisory staff, administrator, director of care, executive director, delegate or directly to the MOHLTC director.

4.3 Reporting to police: In abusive situations that may constitute a criminal offence, the
administrator, director of care or delegate (off-hours: the clinical nursing supervisor or clinical on-call) notifies the police immediately of any alleged, suspected, or witnessed incident of abuse or neglect. Decision trees for more information on whether or not the police need to be contacted are included in Section 10 of this document.

4.7 All serious cases of abuse, including all incidents of sexual abuse are considered critical incidents, and must be reported by the Administrator, director of care or executive director to the Critical Incidents Review Group as described in the policy Risk Management 02 Critical Incident Reporting and Risk Management 02 LTC Critical Incident Reporting: Residents.

The policy indicated the following under Disclosure:

5.2 If the resident is not capable the administrator, director of care or delegate immediately notifies the substitute decision-maker (as long as the substitute decision maker is not the perpetrator) of any alleged, suspected, or witnessed abuse or neglect that resulted in a physical injury or pain to the resident, or that caused distress that could be detrimental to the resident's health or well-being. In all other situations, disclosure must be within 12 hours.

The policy indicated the following under Investigation, Follow-up:

The Administrator, director of care or delegate:

6.2 Ensures that all witnessed incidents of abuse or neglect and situations where alleged or suspected abuse or neglect is being followed up and are entered into the Risk Incident Management System (RIMS).

7.1 The Clinical staff who witness an event or who it is reported to document the

nature of the incident, the time it occurred, resident status, name of persons notified, interventions, follow-up actions, and resident response in the progress notes.

Log #022249-17:

A Critical Incident report was submitted to the Director describing an incident of alleged sexual abuse that occurred on a specified date in 2017, between residents #049 and #012, whereby resident #012 was witness to have inappropriate sexual behaviours towards resident #049.

During a review of resident #012 health care records, Inspector #592 noted that there was documentation of another incident of alleged sexual abuse dated on the same day that the CIR was submitted to the Director, between resident #049 and #012. The progress notes indicated that resident #012 was witnessed by a staff member having inappropriate sexual behaviours towards resident #049.

Resident #049"s health care records were reviewed within a six week period and there was no documentation regarding the first incident of alleged sexual abuse which was sent out to the Director.

Inspector #550 found documented in resident #012's health care records eight other incidents of alleged sexual abuse between resident #049 and resident #012 which are described further on in this report under O. Reg. S. 53(4). These incidents were not documented in resident #049's progress notes.

On January 25, 2018, during an interview with the DOC, in the presence of the ED and the Administrator, the DOC indicated that all incidents of abuse or neglect should be followed up by the registered staff who witnessed or to whom the incident was reported to using the Risk Incident Management System (RIMS). Furthermore the DOC indicated that the nursing staff will also document in the resident's progress notes the nature of the incident, the time, the resident status, follow up actions and resident response. The DOC indicated to the Inspector that she was not able to find any RIM for the reported incident nor for the eight other incidents of alleged abused and no information in the progress notes related to notifying the resident SDM/POA, Police Services as needed and the Director.

Log #028493-17:

On a specified date in 2017, a critical incident report (CIR) was submitted to the Director reporting an incident of alleged sexual abuse to resident #011 by resident #007. It was documented that five days earlier, resident #011 reported that resident #007 went into the room and had sexual behaviours of inappropriate touching. The resident had to tell resident #007 "no" several times before resident #007 would stop.

Inspector #550 reviewed resident #007 and #011's health care records and was not able to find any documentation indicating that an investigation of the incident had been conducted. On the day that the incident was reported to RPN #122, the RPN documented that resident #011 reported to PCA #116 that resident #007 had entered the room, tried to touch the resident inappropriately, even when resident #011 said no and that the RN was made aware. Two days later, the DOC documented in resident #011's progress notes that she had received a call from RN #119 informing her that PCA #116 had reported the day before, the incident of alleged sexual abuse between resident #011 and resident #007 and that the RN had forgotten to report it to the Administrator or the DOC as per the home's abuse policy.

During an interview on January 18, 2018, RPN #122 indicated to the inspector that on the day that the incident was reported, RPN #122 went to see if resident #011 was alright but did not investigate further. Although the RPN documented that the incident was reported to the RN, RPN #122 had not reported it as the RN was busy and RPN #122 forgot to inform the RN later. RPN #122 did not document the resident's status, interventions and the resident's response in the progress notes as the RPN forgot. RPN #122 confirmed to the inspector that the incident was considered to be an incident of sexual abuse as resident #011 had said "no" to resident #007.

During an interview on January 15, 2018, the Administrator and the DOC indicated to the inspector that the home uses a "RIMS"report (Risk Incident Management System) to investigate incidents. As soon as the Administrator, the DOC or delegate becomes aware of an incident of abuse, they are to immediately fill out a RIMS report. The DOC indicated to the inspector she did not fill-out a RIMS report when she became aware of the incident.

Log #011084-17:

On a specified date in 2017, an incident of resident to resident alleged sexual abuse was reported to the Director through the after-hours paging system followed by the submission of a CIR report. It was reported that resident #012 was found by RPN #140 having inappropriate sexual behaviours towards resident #049. Resident #049 was observed moving away from the resident.

Inspector #550 reviewed resident #012's progress notes within a 11 month period and noted documentation of seven incidents of alleged sexual abuse between resident #012 and #049.
These seven incidents do not include the incidents as described earlier in this report by inspector #592.

It was determined throughout the review of resident #049's health care record that resident #049 was not able to provide any consent at the time that the incidents of inappropriate behaviour and touching of sexual nature occurred.

During an interview, the ED indicated that there were no RIMS report completed for the above incidents except for one of the incident.

During an interview on January 29, 2018, RN #114 indicated to inspector #550 that no RIMS report for the incident described above was completed, as it was not mandatory to complete one at the time.

Progress note by Registered staff #140, #142, #114, #139, #134, #133 and #141 did not indicate during the seven incidents of alleged sexual abuse, the follow-up actions and the name of persons notified when incidents of alleged sexual abuse were reported.

Log #010936-17

On a specified date in 2017, a Critical Incident report was submitted to the Director describing an incident of alleged sexual abuse that occurred four days prior, between residents #049 and #050, whereby resident #050 was having sexual inappropriate behaviours towards resident #049.

The incident of alleged sexual abuse was reported by a volunteer to the Recreational Therapist (RT).

On January 23, 2018, during an interview with the RT, the RT indicated that upon

becoming aware by the volunteer of the alleged sexual abuse, the RT immediately reported the incident to RN #119. The RT further indicated that instructions were received by RN #119 to write a note in the progress notes of resident #050 and to immediately notify the DOC. The RT indicated that the note was done in the resident's chart but somehow the RT forgot to notify the DOC on that day and was not scheduled to come back to the home until four days later.

On January 24, 2018, during an interview with RN #119, the RN indicated to Inspector #592 that a report was made by the RT about an incident of alleged sexual abuse between resident #049 and resident #050. RN #119 further indicated that the RT was instructed to do a note in resident #050's chart and to report immediately to the DOC. RN #119 indicated that the RT being a Manager had the same obligations has the RN's, therefore thought at that time, that it was as well the responsibility of the RT to report the incident. The RN further indicated that on the next day, the RT notified the RN that the note was not completed, as the RT had forgotten to do the progress notes, therefore the RN gave instructions to do a late entry in the resident's progress notes. RN #119 indicated that at that time, the impression was that the incident had been reported to the DOC. However RN #119 was told later by the Administrator that it had not been reported and that RN #119 should have reported the incident immediately to the DOC.

During an interview with the ED, the ED indicated to Inspector #592 that she was made aware of the alleged sexual abuse incident during the week end following the incident while working off-site. The ED further indicated that upon reviewing resident's #050's health care records she saw the documentation relating to the alleged sexual abuse between resident #049 and resident #050 completed by the RT in resident #050's progress notes. The ED further indicated that upon being made aware, she immediately contacted the Action Line to inform the Director and did a follow-up on the next day with RN #119 and the RT for not reporting immediately the incident to the Director.

During a review of both resident health care records it was also noted that the residents' SDM\POA, Police Services and the Director were not notified immediately of the Incident of alleged abuse. This was done four days later, when the Administrator became aware of the alleged incident.

Therefore the report of alleged sexual abuse between residents #049 and #050 was not reported immediately to the Director.

As evidenced by the above incidents, the home's policy to promote zero tolerance of abuse and neglect of residents was not complied with.

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

The licensee failed to comply with section 33.(3) of the Act in that the licensee failed to ensure that a personal assistive service device (PASD) is used to assist a resident with a routine activity of daily living only if the use of the PASD is included in the resident's plan of care.

1) Resident #011 was observed in bed with two quarter bed rails near the head of the bed in the up position. Inspector #138 spoke with PCA #116 regarding the use of bed rails for resident #011. PCA #116 stated that resident #011 uses the bed rails for repositioning in bed and also stated that the resident would not be able to release the bed rails. In another conversation, the Director of Care stated that bed rails are a PASD for resident #011.

Inspector #138 reviewed the plan of care as defined by the home for resident #011 and was not able to locate any information specific to the use of bed rails for the resident as a PASD.

2) Resident #020 was observed in bed with two quarter bed rails near the head of the bed in the up position. Inspector #138 spoke with PCA #107 and PCA #112 about the use of bed rails for resident #020. Both PCAs stated that the bed rails were used by the resident to assist with getting in and out of bed as well as for repositioning while in bed. PCA #112 further stated that the resident would not be able to release the bed rails. The Director of Care stated that the bed rails for resident #020 are considered a PASD for that resident.

Inspector #138 reviewed the plan of care as defined by the home for resident #020 and was not able to locate any information specific to the use of bed rails for the resident as a PASD.

As such, the licensee failed to ensure that bed rails used as a PASD for resident #011 and #020 were included in the plan of care for each of these two residents.

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 PASDs for resident #011 and #020 that can not be released by the resident is included in the resident's plan of care, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to comply with section 73.(1)8. of the Regulation in that the licensee failed to ensure course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

Inspector #138 observed the lunch meal service on a specific floor on January 16, 2018. During the meal service, it was observed that PCAs delivered desserts to all eight residents in a specific dining room while these eight residents were starting to eat the entree portion of the meal. The inspector observed that four of the eight residents stopped eating the entree portion of the meal when the desserts were delivered and did not return to their entree once their dessert was finished. It was noted that these four residents ate less than 25 per cent of the entree portion of the meal.

Inspector #138 spoke with the DOC about the desserts being delivered to residents prior to the entree portion of the meal being finished. The DOC stated that there is

a list of residents in the unit kitchen that outlines specific residents who can have all courses of their meal at once instead of course by course service. The inspector asked the DOC about the assessment process and where the assessments could be found that support the residents on the list receiving all courses of their meal at once. The DOC was not able to provide the inspector with specific direction about the assessments but did say that she had updated the plan of care for each resident on the list to indicate that the resident could have all courses of the meal at once. The DOC also stated that she too had observed that a number of residents had stopped eating their entree when the desserts were delivered and that this was a concern.

The DOC provided the inspector a copy of the list of those resident who could have all courses of the meal at once. The inspector reviewed this list and noted that there were twelve residents on list including all eight residents in the identified dining room.

The inspector reviewed the health care record for five of the residents on the list described above: resident #020, resident # 023, resident #028, resident #040, and resident #047. The inspector reviewed the health care records for each of these residents and, while the inspector noted that the care plans in Point Click Care for each of these residents had been updated on a specific date in 2017 to include a statement that the resident was able to receive all courses of the meals at the same time, the inspector was not able to locate any assessment relating to these residents being able to receive all courses of the meal at the same time.

The inspector spoke with the PCA #107 about the list of residents who are to receive all courses of their meal at the same time. PCA #107 stated that only the eight residents in the identified dining room would be provided all courses of the meal at the same time and the rationale for this was to prevent the residents from leaving the dining room before dessert was provided.

The inspector attempted to speak with the eight residents in the identified dining room and was only able to successfully communicate with two: resident #028 and resident #020. When asked about the course by course meal service, Resident #028 stated that staff put everything in front of the residents to hurry them along.

The inspector spoke with the home's Registered Dietitian regarding the list of residents on the specific floor who were to receive all courses of their meal at once. The Registered Dietitian stated that she was unaware that such list currently

existed and expressed concerns regarding both the number of residents on the list as well as concerns relating to specific residents on the list.

As such, the licensee failed to ensure course by course service of meals to residents unless otherwise indicated by the resident or the resident's assessed needs.

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 receive course by course service of meals unless otherwise assessed or requested by the resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has specifically failed to ensure that drugs are stored in an area or a medication cart,
ii. that is secure and locked.

During the resident observations done on January 9, 2018 by inspector #592 and again on January 22, 2018, by inspector #550, both inspectors observed the following medication stored in residents' rooms in unlocked areas:

-Resident #014: one jar and one tube of two different types of prescribed cream were observed on top of the resident's night table and both were labelled with the resident's name.
-Resident #015: one jar of prescribed cream half-filled, labelled with the resident's name and directions to apply twice daily in a plastic basket on the night table.
-Resident #017: two tubes of prescribed ointments labelled with the resident's name found in a plastic basket on the counter in the resident's bathroom and one inhaler also labelled with the resident's name with specific directions was found on the seat of the resident's walker in the resident's room.
-Resident #020: one jar of prescribed cream dated from several months ago, labeled with the resident's name and directions to apply daily for two weeks was observed in a plastic basket in resident's private bathroom. The jar of cream had no cap on it.
-Resident #021: five used jars with different prescribed creams were observed on a shelf in this resident's bathroom.

During an interview with PCA #112 on January 22, 2018, the PCA indicated to the inspector that the medicated creams are not supposed to be kept in the resident's room but if they are not kept at the resident's bedside, the PCAs will not know that they have to apply the cream and the directions for application.

On January 23, 2018, inspector #550 interviewed the DOC who confirmed that all drugs including medicated creams are to be stored inside the locked medication cart or the locked medication room. She further explained that last year she had the registered staff go in each resident's room to remove all medication and medicated creams but had not followed-up on this issue since.

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 topical creams are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #7: 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. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

The licensee failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

During the resident observations done on January 9, 2018 by inspector #592 and again on January 22, 2018, by inspector #550, both inspectors observed that some residents had prescribed medicated creams in their room. Throughout interviews with various PCAs and a private sitter for a resident, they indicated to inspector #550 the following:

Resident #015 had a jar of prescribed cream, labelled with the resident's name and directions to apply to a specific area in a plastic basket on the night table. During an interview on January 22, 2018, the resident's private caregiver indicated to the inspector that the resident's personal care was provided in the morning and that the medicated prescribed cream will be applied to a specific area when the skin is red. Sometimes the private caregiver applies the cream and sometimes it is done by the registered staff.

Resident #017 had two tubes of prescribed ointments labelled with the resident's name in a plastic basket on the counter in the resident's bathroom. During an interview on January 24, 2018, PCA #132 indicated to the inspector that when the resident requests it, the PCA will apply the prescribed ointment to the resident and will then inform the nurse of the application.

Resident #021 had five used jars of prescribed creams on a shelf in the bathroom; As per a physician order dated on a specified date in 2017, in resident #021's health care records, two of the prescribed creams found in the resident's room were discontinued. During an interview on January 22, 2018, PCA #112 indicated to inspector #550 that one of the creams was applied daily to a specific body area and the other cream was applied to another specific body area. Sometimes when the resident has multiple incontinence throughout the day, PCA #112 will apply another prescribed cream after each incontinence.

During an interview on January 24, 2018, the Administrator and the Director of Care indicated to the inspector that the PCAs and/or private caregivers were not authorized to apply medicated creams to the residents in the home. The registered nursing staffs are the only persons authorized to apply medicated creams to the residents.

2. The licensee failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

On January 22, 2017, inspector #550 observed that resident #017 had a prescribed inhaler on the seat of the resident's walker in the resident's bedroom. The resident explained to the inspector that the medication was kept and used when short of breath. The resident explained that respiratory illness symptoms were present and had taken the medication earlier that day.

The inspector reviewed resident #017's health care records and was not able to find an approval by the prescriber in consultation with the resident for the self-administration of the prescribed inhaler.

During an interview with the DOC on January 23, 2017, she indicated to the inspector that resident #017 is not permitted to self-administer the prescribed inhaler as the resident would not be reliable to follow the directions for administration.

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 no person administer a drug to a resident unless that person is a physician, dentist, registered nurse or a registered practical nurse and as well that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber, to be implemented voluntarily.

WN #8: 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 :

The licensee has failed to protect resident #049 from sexual abuse by resident #012.
Under O.Reg. 79/10, sexual abuse is defined as "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"

This inspection is related to Log #022249-17, Log #011084-17 and Log #026718-17.

Resident #012 was admitted to the home on a specified date, with several diagnoses including unspecified dementia.

On a specified date in 2017, an incident of inappropriate touching of sexual nature between two residents was reported through the after-hours pager notification system followed by the submission of CIR (Critical Incident Report) on the following day, to the Director. It was reported that four days prior, resident #012 was observed by RPN #140 having inappropriate sexual behaviours towards resident #049.

Three months later, a Critical Incident report was submitted to the Director describing an incident of alleged sexual abuse which had occurred two days before between residents #049 and #012, whereby resident #012 was witnessed having inappropriate sexual behaviours towards resident #049.

Three months after the second reported incident, another incident of allegation of sexual abuse was reported through the after hour's pager notification system followed by the submission of CIR (Critical Incident Report) on the following day to the Director. It was reported that resident #012 went into resident #008's room and asked the resident if the resident wanted to be more than just a friend. When resident #008 declined, resident #012 made inappropriate verbal comments while yelling and laughing at resident #008.

Inspector #550 reviewed resident #012's progress notes from within a period of 11 months and observed documented a total of eight other incidents of inappropriate behaviours and touching of sexual nature between resident #012 and resident #049.
There were also two other incidents of a sexual nature from resident #012 to staff members on two specific dates in 2018.

It was determined throughout the review of resident #049's health care record that resident #049 was not able to provide any consent at the time that the incidents of inappropriate behaviour and touching of sexual nature occurred.

Inspector #550 interviewed the ED, the Administrator and the DOC on January 25, 2017. They indicated that resident #012 was obsessed with resident #049. The DOC indicated that after they became aware of the first incident, a psychogeriatric consult to the Outreach team had been completed by the doctor but the resident had not yet been assessed. Resident #012 was seen in the home by the psychogeriatric nurse and the BSO champion staff member to manage the sexual behaviours. One on one supervision was implemented after the first incident and the resident's seating was changed in the dining room so resident #12 was no longer sitting with resident #049. After the second incident, resident #012 was moved to a different floor in the home so the resident would no longer be in contact with resident #049. The ED, the Administrator and the DOC indicated that since then, the resident had not exhibited any sexual behaviours.

On a specified date, the CIR submitted for the first incident was amended by the DOC to indicate that the physician had adjusted the resident's medication as the resident was still attempting sexual gestures. The resident was currently being supervised one on one, another resident who appeared to be competing with resident #012 for resident #049's attention was transferred to a different floor and the care plan was updated. A progress note dated 17 days after the first incident by the DOC, indicated that the staff would ensure that the two residents would be seated at different tables for meals, staff were to monitor these residents and, if seated next to each other, they were to gently encourage one of the residents to change places. If sexual behaviours were observed staff were to use GPA approach (gentle persuasive approach) to separate the residents while supporting them emotionally. Staff were to document any behaviours observed and reaction of these residents and were to follow the above steps to minimize contact and interactions between these residents.

The same interventions as documented in the progress notes were added to the first CIR 21 days later by the DOC as a "behaviour action plan". One month after the incident, a progress note by RN #143 indicated that the seating in the dining room had now been changed and resident #012 was now having meals in a different dining room. The inspector reviewed resident #012's plan of care in place at the time of the incidents until January 2018 and was not able to find that these interventions had been added on the plan of care.

It was noted that 11 days after the first reported incident, the DOC added to the written plan of care "determine what triggered/lead up to the behaviour and ensure resident is not seated next to one and another and monitor for any inappropriate behaviours" but there was no indication of which co-resident, resident #012 was not to be seated next to.

Approximately one month after the first reported incident, the Advanced Practice Nurse RN #126 reviewed intervention "remain calm and avoid angry reactions towards resident"

All other interventions were dated in 2016. There was no indication that the resident's plan of care was reviewed after each incidents. The ED, the Administrator and the DOC indicated to the inspector that the resident's plan of care had not been reviewed and revised after each incident and to include the "behaviour action plan" that was developed 21 days after the first incident.

Documentation provided by the Administrator indicated that one on one supervision was implemented after a specific incident date for three days on specific shifts. For the second reported incident, one on one supervision started on the following day for three days on specific shifts. And, for the third reported incident, one on one supervision was started on the following day for one specified shift for six days.

The inspector reviewed the resident's health care records. A consultation was completed by the resident's physician at the home several weeks after the first reported incident, requesting a psychogeriatric assessment of the resident for increased behaviours related to any staff interventions and new "possessive" relationship with a resident. The physician also indicated that a specific medication was increased as it was previously beneficial for the resident's sexual behaviours and as well started another specific medication at the same time. There was a fax cover sheet, dated two days later, after the request for consultation was done by the resident's physician and a handwritten note by RN #119 on the "Geriatric Psychiatric Outreach Program Referral Form" indicating "was faxed".
The inspector was not able to find any documentation indicating that a psychogeriatric consult had been completed.

On January 30th, 2018, during a telephone interview, the psychogeriatric nurse indicated to the inspector that no consultation request had been received for this

resident. The the psychogeriatric nurse indicated that suggestions were made to the DOC that the resident be transferred to a different floor and this was eventually done. The the psychogeriatric nurse was following up with the home to see if the resident had more behaviours and was told that since the resident's move to another floor, the resident did not have any other behaviours. The psychogeriatric nurse had verified with the Director of Care to see if the resident still needed to be assessed by the psychogeriatric team and was told that resident #012 no longer had sexual behaviours since the resident was moved to another floor.
The psychogeriatric nurse had not been informed of the two latest incidents of sexual behaviour towards staff members that had occurred after the resident's move to another floor.

The DOC later confirmed to the inspector that the psychogeriatric consult had not been faxed to the psychogeriatric nurse consultant, that RN #119 had forgotten to fax it and no other follow-up was done with the psychogeriatric nurse after the last two incidents.

During an interview on January 26, 2018, BSO Champion PCA #101, indicated to the inspector that resident #012 has sexually inappropriate behaviours, yells out loud and can be aggressive towards other residents. The BSO Champion works one day per week on this floor and she will see the residents who were identified at the shift report to have exhibited responsive behaviours, those who are exhibiting responsive behaviours at breakfast in the dining room and assist staffs to bath difficult residents. When a resident is seen by the BSO staff, they have to write in the "BSO Champion Binder" the date, the resident visited and the reason for the visit. They also document in the progress notes. The staff member showed the inspector in the binder, a 6 month period time frame where resident #012 was seen by BSO. There was a total of 22 dates entered in that time frame period for resident #012. The documentation was about specific behaviours such as:

Yelling
Shouting at meal time
Trying to kiss co-resident #049
Rude to staff
Resistance to care
Loud
Fighting with another resident
Anxious and vocally inappropriate

There was no documentation to indicate that the BSO Champion staff had specific interventions that were used when working with resident #012 after each behaviours as described above.

The BSO Champion PCA #101 confirmed that the notes completed for resident #012 were the only one as the BSO did not work with the resident other than the 22 times that it was documented.

As evidenced, actions taken to respond to the needs of resident #012 did not include assessments, reassessments and interventions and that the resident's responses to interventions were documented.

The licensee also failed to comply with the following section related to the prevention of abuse:

WN #3 -LTCHA, 2007, s.20 (1) The licensee's policy for Abuse and Neglect, Long Term Care" Policy, CLIN CARE 32 LTC was not complied with;

WN #9- As per LTCHA, 2007, s.24.(1), The Director was not immediately notified of the witnessed incidents of sexual abuse of resident #049 (Refer to WN #9)

WN #2-As per O.Reg. 79/10, r. 53.(4), The Licensee failed to ensure that resident demonstrating responsive behaviours, that 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.

A Compliance Order was issued on November 7, 2017, under inspection 2017_683126_0016 with a compliance date of February 02, 2018 under section 19(1) of the Act.

WN #9: 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 :

The licensee failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

On a specified date in 2017, a Critical Incident report was submitted to the Director describing an incident of alleged inappropriate sexual behaviour that occurred four days before, from residents #050 to resident #049.

This finding is related to Log #010936-17.

The incident of alleged sexual abuse was reported by a volunteer to the RT.

On January 23, 2018, during an interview with the RT, the RT indicated that upon becoming aware by the volunteer of the alleged sexual abuse, the RT immediately reported the incident to RN #119. The RT further indicated that instructions were provided by RN #119 to write a note in the progress notes of resident #050 and to immediately notify the DOC. The RT indicated that a note was completed in the

resident's chart but forgot to notify the DOC on that day and was not scheduled to come back to the home until four days later.

On January 24, 2018, during an interview with RN #119, the RN indicated to Inspector #592 that a report was made by the RT about an alleged sexual abuse between resident #049 and resident #050. RN #119 further indicated that the RT was instructed to do a note in resident #050's chart and to report immediately to the DOC. RN #119 indicated that the RT being a Manager had the same obligations has the RN's, therefore thought at that time, that it was as well the responsibility of the RT to report the incident. The RN further indicated that on the next day, the RT notified the RN that no note was done in the resident's chart as the RT had forgotten to do the progress notes, therefore the RN had instructed the RT to do a late entry in the resident's progress notes. Rn #119 indicated that at that time, the impression was that the incident had been reported to the DOC. However RN #119 was told later by the Administrator that it had not been reported and that RN #119 should have reported the incident immediately to the DOC.

During an interview with the ED, the ED indicated to Inspector #592 that she was made aware of the alleged sexual abuse incident during the week end following the incident while working off-site. The ED further indicated that upon reviewing resident's #050's health care records she saw the documentation relating to the alleged sexual abuse between resident #049 and resident #050 completed by the RT in resident #050's progress notes. The ED further indicated that upon being made aware, she immediately contacted the Action Line to inform the Director and did a follow-up on the next day with RN #119 and the RT for not reporting immediately the incident to the Director.

During a review of both resident health care records it was also noted that no family members, police officers, interventions and investigation were started until four days later, when the Administrator had become aware of the Incident.

Therefore the report of alleged sexual abuse between residents #049 and #050 was not reported immediately to the Director.

2. On a specified date, a Critical Incident report was submitted to the Director describing an incident of alleged sexual abuse that occurred two days before, between residents #049 and #012.

This finding is related to Log #022249-17

The incident of alleged sexual abuse was reported two days before the CIR was submitted by a family member, to PCA # 132.

On January 24, 2018, in an interview with PCA #138, the PCA indicated to the Inspector that a family member had reported an alleged sexual abuse when the family member witnessed resident #012 in an unsupervised room having inappropriate sexual behaviours towards resident #049. The PCA further indicated the incident was not witnessed by anyone else, however, the incident was reported immediately to RPN #133.

On January 24, 2018, in an interview with RPN #133, the RPN indicated to the Inspector that PCA #138 reported that a family member witnessed resident #012 having inappropriate sexual behaviors towards resident #049. RPN #133 further indicated that the staff member spoke with the family member who witnessed the incident and there was no touching involved, however due to the seriousness of the incident, RPN #133 reported the incident immediately to RN #134 who was the RN in charge on that day.

On January 25, 2018, in an interview with RN #134, the RN indicated to Inspector #592 that there was no recollection of the incident between resident #012 and #049. RN #134 further indicated that if the incident would have been reported, the RN would immediately report the incident to the on call Clinical Manager and do a progress notes in both resident's health care records.

Inspector #592 did not find any progress notes from RN #134, however the ED provided to the Inspector the documentation report from the on call Clinical Supervisor which indicated that the registered staff had contacted the Clinical Supervisor on the day of the incident to report the incident of alleged sexual abuse.

On January 29, 2018, in an interview with RN #136 who was identified as the clinical on call Supervisor working on the day of the incident, indicated that the incident was reported about the incident of alleged sexual abuse, however the RN was unsure of the accuracy of the reported incident and instead of reporting to the Director, RN #136 had requested for the manager to conduct a follow-up the next day.

On January 24, 2018, during an interview with the DOC, she indicated that she was

made aware of the incident of alleged sexual abuse between resident # 012 and #049 on the following day by RN #134. She further indicated that the on Call Clinical Supervisors were registered staff members working in their sister health care organization that is not a long term care home. The DOC further indicated that she has contacted the after hour pager to report the incident immediately after becoming aware of the incident to inform the Director.

3. On a specified date, a Critical Incident report was submitted to the Director describing an incident of alleged sexual abuse that occurred two days before, between residents #049 and #012.

It was determined through interviews with the ED, the Administrator, the DOC, several staff members and a review of resident #049's health care records that the resident was not capable of giving consent for any of the incidents discussed in this report.

During a review of the resident #012 health care records, Inspector #592 noted that there was documentation of another incident of alleged sexual dated on the same day that the CIR was submitted to the Director, between resident #049 and #012. The progress notes indicated that resident #012 was witnessed by a staff member having inappropriate sexual behaviours towards resident #049.

When Inspector #592 inquired with the DOC and the ED about the reporting of the incident, they both indicated that it was reported through the CIR used for another incident of alleged abused which occurred 48 hours before, referring to Log # 022249-17 above. They both further indicated that while amending the CIR for the previous incident, the information related to the second incident had been added to the same CIR report. The Administrator and the DOC told the Inspector that they thought that due to the similarity of the incidents between the same residents, they did not need to complete a new CIR and to notify the Director. Furthermore, the ED provided to the Inspector the documentation report from the on call Clinical Supervisor which indicated that the registered staff had contacted the on Call Clinical Supervisor on the day of the incident to report the incident of alleged sexual abuse, however the incident of alleged sexual abuse was not immediately reported to the Director.

4. This inspection is related to Log #011084-17.

On a specified date, an incident of inappropriate touching of sexual nature between two residents was reported through the after-hours pager notification system followed by the submission of a CIR (Critical Incident Report) on the following day, to the Director. It was reported that three days before the CIR report was submitted, resident #012 was observed by RPN #140 to have inappropriate behaviours of sexual nature.

It was determined through interviews with the ED, the Administrator, the DOC, several staff members and a review of resident #049's health care records that the resident was not capable of giving a consent for any of the incidents discussed in this report.

During an interview, the ED indicated to inspectors #592 and #550 that she became aware of the incident, while she was working off-site reviewing the progress notes for resident #049 regarding a different incident. Because RPN #140 had not reported the incident the day it occurred, she immediately called the after-hours pager to report the incident and submitted a CIR the next day when she returned to work.

Inspector #550 reviewed resident #012's progress notes within an 11 month period and observed documented, eight other incidents of alleged sexual abuse between resident #012 and #049. Two out of these eight incidents are addressed earlier in this report by inspector #592. There was six other incidents of inappropriate behaviours of sexual nature documented in the resident's progress notes.

There was no documentation that these incidents had been reported to the Director.

On January 29, 2018, RN #114 indicated to inspector #550 that the incident was not reported to the Director or the on-call manager and that incidents like these were not reported to the on-call managers; they only reported serious incidents. If they would report each time resident #012 was touching inappropriately resident #049, they would be constantly reporting as this was an on-going behaviour. RN #119 indicated to the inspector that there was no recollection of someone reporting this specific incident and if so, no recollection if the incident was reported then to the on-call Manager.

The Administrator and the Director of care indicated that these incidents had not been reported to the Director.

As evidenced, the above incidents of alleged sexual abuse were not immediately reported to the Director.

5. A Critical Incident Report was submitted to the Director on a specified date in 2017, reporting an incident of resident to resident alleged sexual abuse. It was reported that six day before, resident #011 reported that resident #007 had inappropriate sexual behaviours when attempting inappropriate touching of sexual nature towards resident #011 which had occurred four days earlier. The resident had to tell resident #007 "no" several times before the resident stop.

During an interview on January 11, 2018, resident #011 indicated to inspector #550 that resident #007 had gone in the room a few weeks earlier and that resident #007 had inappropriate behaviours of sexual nature. The resident indicated not liking that.

Inspector #550 reviewed the resident health care records and observed documented in the progress notes by RPN #122 on the day that the resident had reported the incident, that resident #011 had reported to PCA that resident #007 had entered the room and had inappropriate sexual behaviours towards resident #011, even if the resident #011 said no and that the RN was made aware of the incident.

During an interview on January 18, 2018, RPN #122 indicated to inspector #550 that although the documentation indicated that the incident was reported to the RN, RPN #122 indicated that it was not. When the RPN went to report the incident, RN #119 was busy with the Doctor and RPN #122 forgot to tell the RN later of the incident.

During an interview, RN #119 indicated to the inspector that the incident of abuse had been reported by PCA #116 on the following day, and that RN #119 did not report the incident to anyone or document it. Two days after the incident, the RN called the DOC from home to inform the DOC of the incident as RN #119 was not working that day. The Administrator was made aware of the incident two days after the incident by the DOC and a CIR report was completed. The Administrator indicated she was not able to submit the CIR until three days later, due to difficulties with the CI reporting system.

The Administrator indicated to the inspector that this incident of alleged sexual

abuse was not immediately reported to the Director. As per their policy, the nurse should have immediately notified the Administrator or Director of Care who in turn would have immediately informed the Director of the incident.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

The licensee has failed to keep a written record relating to each evaluation under paragraph 3 that includes; the date of the evaluation, the name of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Resident # 042 was identified with altered skin integrity to specific body areas.

A review of the resident's health care record was done by Inspector #592 which indicates that resident #042 was identified with altered skin integrity to specific body areas upon the return from the hospital on a specific date in 2017. As per the current physician orders, resident #042's still has altered skin integrity and the current treatment is to have the affected areas cleansed with a specified product and to cover with specific dressings twice a week.

On January 18, 2018, in an interview with RN #119, the RN indicated to the Inspector that the actual skin status for resident #042 was unknown as the weekly wound skin assessment were not always performed.

On January 22, 2018, during a phone interview with RN # 126 who is identified as the skin resource person for the home, noticed that the weekly wound skin assessments were not always performed for the residents and that it was something that the home had identified in their skin and wound care program. RN #126 further indicated that the home's program and policy were reviewed during the summer of 2017 with the presence of several multidisciplinary team members and that documentation proposed actions in wound care changes.

On January 22, 2018, in an interview, the Administrator indicated to the Inspector that the home had just completed work on their skin policy and that she was not aware if the program had been evaluated, however would touch base with the skin resource person.

Later on, the Administrator provided the Inspector with some documentation relating to one of the skin and wound care committee meeting, however the Inspector was not able to find any written record relating to the evaluation of the skin program, specifically to the summary of changes and the date that those changes were implemented.

In a discussion with the ED, she indicated that the home had just completed work on their skin and wound care policy therefore the program had not been evaluated as it was newly implemented.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was not reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident # 042 was identified with altered skin integrity to specific body areas.

A review of the resident's health care record was done by Inspector #592 which indicates that resident #042 was identified with altered skin integrity to specific body areas upon the return from the hospital on a specific date in 2017. As per the current physician orders, resident #042's still has altered skin integrity and the current treatment is to have the affected areas cleansed with a specified product and to cover with specific dressings twice a week.

Inspector #592 reviewed the resident health care record of resident #042 and noted that there was weekly documentation in the resident's progress notes on the resident's skin integrity. The documentation indicated when the dressings were changed, however, Inspector #592 was not able to find the description of the skin status, such as the stage, measurements and the current status of the wounds.

On January 18, 2018, in an interview with RN #119, full time RN, the RN indicated to the Inspector that the PCA's would report any redness or any changes in the skin status of a resident to the registered staff. RN #119 further indicated that upon being made aware of a skin alteration, the RN will complete a Wound Care Assessment which will then be completed weekly for any identified altered skin integrity issues. The RN indicated that resident #042 had to receive a weekly Wound Care Assessment due to the presence of altered skin integrity, however the RN indicated that the Wound Care assessments for this resident were not always completed. RN #119 further indicated that the resource person for the skin care program was also completing the weekly skin assessments for the resident, however the RN was unsure if resident #042 had been regularly seen by the resource person, resulting that the staging and measurements of the wounds were not completed. The RN indicated that the status of the resident's skin integrity was unknown at this current time.

On January 22, 2018, during an interview with RN #126, who is the skin care resource person, the RN indicated that the home's expectation was that a weekly skin assessment are done to all residents exhibiting a skin breakdown. RN #126 further indicated that it was identified during the progress notes review process that the weekly Wound Care Assessments were not always completed when residents were exhibiting skin breakdown, issues specifically for resident #042. RN #126 received a notification about the resident's altered skin integrity, however the resident had not been assessed yet. RN #126 further indicated that resident #042 skin status was unknown as the weekly assessments were not completed which

were to include the staging and measurement of the wounds.

The Administrator indicated to the Inspector that resident #042 should have had a weekly wound assessment completed as part of the home's wound care program.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

The licensee failed to comply with section 107.(3)4. of the Regulation in that the licensee failed to ensure that the Director (Ministry of Health and Long Term Care) is informed of an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health status no later than one business day after the occurrence of the incident.

This finding is related to Log # 020665-17.

Inspector #138 reviewed a Critical Incident Report outlining that resident #042 suffered a fall on a specified date. The resident complained of pain after the fall and, as a result, was sent for tests on the following day. The physician reviewed the test results that diagnosed that resident #042 had a specific injury and immediately sent the resident to the hospital.

The Director was not notified of this incident involving resident #042 via a Critical Incident Report, until eight business days after the resident was sent to hospital with a known injury.

As such the licensee failed to inform the Director within one business day of the fall involving resident #042 that led to a diagnosis of a specific injury.

Issued on this 13 day of March 2018 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St, Suite 420
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston, bureau 420
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Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : MELANIE SARRAZIN (592) - (A1)

Inspection No. / No de l'inspection : 2018_548592_0002 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 013373-17 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Mar 13, 2018;(A1)

Licensee / Titulaire de permis : Bruyère Continuing Care Inc.
43 Bruyère Street, OTTAWA, ON, K1N-5C8

LTC Home / Foyer de SLD : Élisabeth-Bruyère Residence
75 Bruyère Street, OTTAWA, ON, K1N-5C8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Chantale Cameron

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To Bruyère Continuing Care Inc., 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) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

1.The licensee is required to ensure that any staff who participates in a resident transfer is aware of that resident's plan of care as it relates to the resident's transfer and shall provide the transfer according to the plan of care unless otherwise indicated by a written assessment included in the health care record.

2.The licensee is required to ensure that any staff who participates in a resident transfer receives education on lifts and transfers which includes the home's policy on lifts and transfers

Grounds / Motifs :

1. The license failed to comply with section 6.(7) of the Act in that the licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. (this finding is a Compliance Order)

This inspection is related to Log #026495-17.

Inspector #138 reviewed a Critical Incident Report which outlined that resident #044 was diagnosed with an injury to a specific body part on a specified date in 2017, after the resident reported pain after a transfer.

Inspector #138 spoke with the home's Administrator regarding this Critical Incident

Report. The Administrator reported that she conducted an internal investigation and provide the inspector with the internal investigation documents. The inspector reviewed the internal investigation documents, the resident health care record, and spoke with several staff involved in the incident. The following is a summary of the events:

Resident #044 was experiencing some decline in abilities at the time of the identified transfer. Resident #044 called a family member, reporting to the family member that when a staff member lifted a specific body area, it hurt. In turn, the family member called the evening RPN, RPN #128, to report the concern. There had been some misunderstanding by RPN #128 regarding this report from the family member however the resident continued to complain of pain to a specific body area, specifically starting on the day that the resident had contacted a family member, continuing for two more days. Then, three days after contacting a family member, PCA #127 noted that the resident had altered skin integrity on a specific body area and reported this to RPN #128. The resident was sent for tests on the next day, as a result of the altered skin integrity and complaints of pain, and was diagnosed the same day with an injury to a specified body part. The resident's condition continued to deteriorate and the resident passed away in the home.

Inspector #138 spoke with the Administrator who stated that an internal investigation commenced, when the injury of the specific body part was diagnosed for resident #044. As part of this investigation, the Administrator spoke with staff including PCA #103 who provided care to resident #044 on the day that the transfer occurred. According to the Administrator, PCA #103 indicated that the resident was transferred as a one pivot transfer instead of a mechanical lift transfer. PCA #103 reported routinely transferring resident #044 as a one person pivot transfer because the resident would exhibit behaviours when being transferred by a mechanical lift. These behaviours by the resident included yelling, threatening to report staff, and hitting the mechanical lift.

The Administrator provided Inspector #138 with a copy of a letter of discipline that outlined that PCA #103 had received a one day suspension without pay for transferring resident #044, without a mechanical lift as per the resident's kardex and care plan.

Inspector #138 reviewed resident #044's care plan in Point Click Care at the time of the incident, and noted that it provided direction for the use of a mechanical lift when

transferring the resident. Inspector #138 spoke with both PCA #101 and PCA #127 separately and both stated that the resident was to be transferred via a lift which had been in effect for resident #044 for many months.

Inspector #138 further reviewed resident #044's health care record and noted from the progress notes that, on the day of the incident, resident #044 was upset with PCA #103 over a transfer with PCA #103 and that the resident complained of being sore to a specific body area. This progress note also stated that the resident's family member called the home to report that the resident had called upset. The progress notes for the two following days, showed that the resident complained of pain and received pain medication for the same specific body area. The resident complained of pain to the same body area three days after the incident and this time, altered skin integrity had been discovered on a specified body part upon assessment. The progress notes further show that the resident received a test on the next day, and was diagnosed with an injury of a specific body part. The progress notes show that resident #044's condition deteriorated and the resident passed away in the home. The Medical Certificate of Death dated on a specific date, listed the immediate cause of death as an injury to a specific body part and of another medical condition.

Inspector #138 further reviewed the Critical Incident Investigation Report dated on a specific date, provided by the home. This report is an internal document of the home that is the result of the home's own review of the incident. This report stated that the injury to resident #044 was most likely caused by a one person pivot transfer by a PCA staff member, that the resident deteriorated significantly after the injury, and passed away on a specified day.

A previous non compliance relating to section 6.(7) of the Act was issued September 2015, Resident Quality Inspection # 2015_285126_0035 as a voluntary plan of correction (VPC).

This incident, while isolated to one resident, represented a significant actual harm to resident #044. (138)

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

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

May 04, 2018(A1)

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(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).

Order / Ordre :

The licensee is required to have a process in place to ensure that actions are taken to respond to resident #012's responsive behaviours.

1. This process shall include assessments, referral to internal and external specialized resources and identification of specific interventions including the BSO champion interventions, to respond to the resident's needs.

2. If interventions are found to be ineffective, the resident's plan of care should be revised to include new interventions and strategies to prevent, minimize or respond to the responsive behaviours

Grounds / Motifs :

1. The licensee has specifically failed to ensure that, for each resident demonstrating responsive behaviours,
(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. (This is a Compliance Order)

This inspection is related to Log #022249-17, Log #011084-17 and Log #026718-17.

Resident #012 was admitted to the home on a specified date with several diagnoses including unspecified dementia.

On a specified date in 2017, an incident of inappropriate touching of sexual nature between two residents was reported through the after-hours pager notification system followed by the submission of CIR (Critical Incident Report) on the following day to the Director. It was reported that three days before, resident #012 was observed by RPN #140 having inappropriate behaviours of sexual nature towards resident #049.

Three months later, a Critical Incident report was submitted to the Director describing an incident of alleged sexual abuse between residents #049 and #012, whereby resident #012 was witnessed having inappropriate sexual behaviours towards resident #49.

Three months later following the second reported incident, an incident of allegation of sexual abuse was reported through the after-hours pager notification system followed by the submission of CIR (Critical Incident Report) on the following day to the Director. It was reported that resident #012 went into resident #008's room and asked resident #008 if the resident wanted to be more than just a friend. When resident #008 declined, resident #012 made inappropriate verbal comments while yelling and laughing at resident #008.

Inspector #550 reviewed resident #012's progress notes from within a period of 11 months and noted a total of eight other incidents of inappropriate behaviours and touching of sexual nature between resident #012 and resident #049.
There were also two other incidents of a sexual nature from resident #012 to staff members on two specific dates in 2018.

It was determined throughout the review of resident #049's health care record that resident #049 was not able to provide any consent at the time that the incidents of inappropriate behaviour and touching of sexual nature occurred.

Inspector #550 interviewed the ED, the Administrator and the DOC on January 25, 2017. They indicated that resident #012 was obsessed with resident #049. The DOC indicated that after they became aware of the first incident, a psychogeriatric consult to the Outreach team had been completed by the doctor but that the resident had not yet been assessed. Resident #012 was seen in the home by the psychogeriatric nurse and the BSO champion staff member to manage the sexual behaviours. One on one supervision was implemented after the first incident and the resident's seating was changed in the dining room so resident #12 was no longer sitting with resident #049. After the second incident, resident #012 was moved to a different floor in the home so the resident would no longer be in contact with resident #049. The Executive Director, the Administrator and the DOC indicated that since then, the resident had not exhibited any sexual behaviours.

On a specified date, the CIR submitted for the first incident was amended by the DOC to indicate that the physician had adjusted the resident's medication as the resident was still attempting sexual gestures. The resident was currently being supervised one on one, another resident who appeared to be competing with resident #012 for resident #049's attention was transferred to a different floor and the care plan was updated. A progress note dated 17 days after the first incident by the DOC indicated that the staff would ensure that the two residents would be seated at different tables for meals, staff were to monitor these residents and, if seated next to each other, they were to gently encourage one of the resident to change places. If sexual behaviours were observed staff were to use GPA approach (gentle persuasive approach) to separate the residents while supporting them emotionally. Staff were to document any behaviours observed and reaction of these residents and were to follow the above steps to minimize contact and interactions between these residents.

The same interventions were added to the first CIR 21 days later by the DOC as a "behaviour action plan". One month after the incident, a progress note by RN #143 indicated that the seating in the dining room had now been changed and resident #012 was now having meals in a different dining room. The inspector reviewed resident #012's plan of care in place at the time of the incidents until January 2018 and was not able to find that these interventions had been added on the plan of care.

It was noted that 11 days after the first reported incident, the DOC added to the written plan of care "determine what triggered/lead up to the behaviour and ensure resident is not seated next to one and another and monitor for any inappropriate behaviours" but there was no indication of which co-resident, resident #012 was not to be seated next to.

Approximately one month after the first reported incident, the Advanced Practice Nurse RN #126 reviewed the resident's interventions and added "remain calm and avoid angry reactions towards resident"

All other interventions were dated in 2016. There was no indication that the resident's plan of care was reviewed after each incident. The Executive Director, the Administrator and the DOC indicated to the inspector that the resident's plan of care had not been reviewed and revised after each incident and did not include the "behaviour action plan" that was developed 21 days after the first incident.

Documentation provided by the Administrator indicated that one on one supervision was implemented several days after a specific incident date for three days, on specific shifts. For the second reported incident, one on one supervision started on the following day, for three days on specific shifts. And, for the third reported incident, one on one supervision was started on the following day, for one specified shift for six days.

The inspector reviewed the resident's health care records. A consultation was completed by the resident's physician at the home several weeks after the first reported incident, requesting a psychogeriatric assessment of the resident for increased behaviours related to any staff interventions and new "possessive" relationship with a resident. The physician also indicated that a specific medication was increased as it was previously beneficial in managing the resident's sexual behaviours and also started another identified specific medication at the same time. There was a fax cover sheet, dated two days later, after the request for consultation was done by the resident's physician and a handwritten note by RN #119 on the "Geriatric Psychiatric Outreach Program Referral Form" indicating "was faxed". The inspector was not able to find any documentation indicating that a psychogeriatric consult had been completed.

On January 30th, 2018, during a telephone interview, the psychogeriatric nurse

indicated to the inspector that no consultation request had been received for this resident. The psychogeriatric nurse indicated that suggestions were made to the DOC that the resident be transferred to a different floor and this was eventually done. The psychogeriatric nurse was following up with the home to see if the resident had more behaviours and was told that since the resident's move to another floor, the resident did not have any other behaviours. The psychogeriatric nurse had verified with the DOC to see if the resident still needed to be assessed by the psychogeriatric team and was told that resident #012 no longer had sexual behaviours since the resident was moved to another floor.
The psychogeriatric nurse had not been informed of the two latest incidents of sexual behaviour towards staff members that had occured after the resident's move to another floor.

The DOC later confirmed to the inspector that the psychogeriatric consult had not been faxed to the psychogeriatric nurse consultant, that RN #119 had forgotten to fax it and no other follow-up was done with the psychogeriatric nurse after the last two identified incidents.

During an interview on January 26, 2018, BSO Champion PCA #101, indicated to the inspector that resident #012 has inappropriate sexual behaviours, yells out loud and can be aggressive towards other residents. The BSO Champion works one day per week on this floor and the BSO's will see the residents who were identified at the shift report to have exhibited responsive behaviours, those who are exhibiting responsive behaviours at breakfast in the dining room and assist staffs to bath difficult residents. When a resident is seen by the BSO staff, they have to write in the "BSO Champion Binder" the date, the resident visited and the reason for the visit. They also document in the progress notes. The staff member showed the inspector in the binder, a six month period time frame where resident #012 was seen by BSO. There was a total of 22 dates entered in that time frame period for resident #012. The documentation was about specific behaviours such as:

Yelling
Shouting at meal time
Trying to kiss co-resident #049
Rude to staff
Resistance to care
Loud
Fighting with another resident

Anxious and vocally inappropriate

There was no documentation to indicate that the BSO Champion staff had specific interventions that were used when working with resident #012 after each of the behaviours described above.

The BSO Champion PCA #101 confirmed that the notes completed for resident #012 were the only ones as the BSO did not work with the resident other than the 22 times that it was documented.

As evidenced, actions taken to respond to the needs of resident #012 did not include assessments, reassessments and interventions and that the resident's responses to interventions were documented.

The scope and severity of this non-compliance was reviewed by the inspector. The fact that resident #012 exhibited nine incidents of a sexual nature to resident #049 in a period of five months and even after being moved to a different floor the resident continued to exhibit incidents of a sexual nature towards an identified resident and towards staff posing a great risk of harm to those people.

(550)

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

Apr 03, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 13 day of March 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MELANIE SARRAZIN - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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Service Area Office / Bureau régional de services : Ottawa