Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 9, 2019	2019_650565_0013	000242-18, 027122-18, 003372-19, 004498-19, 008425-19, 008850-19, 012651-19, 014531-19	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Peel
10 Peel Centre Drive Suite B, 3rd Floor BRAMPTON ON L6T 4B9

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

Malton Village Long Term Care Centre
7075 Rexwood Road MISSISSAUGA ON L4T 4M1

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

MATTHEW CHIU (565), NICOLE RANGER (189)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 13, 14, 15, 16, 19, 20, 21, 22, 23, 26, 27, and 28, 2019.

Inspector #763 shadowed during this inspection.

During the course of the inspection, the following Critical Incident System (CIS) intake logs were inspected:
- 000242-18, 004498-19, 008425-19, 012651-19, 014531-19 related to resident injury resulting in significant change in health status, and
- 003372-19, 008850-19, 027122-18 related to resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Supervisors of Care (SOC), Activation Therapist (AT), Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Assistants (PCA), Dietary Aide (DA), Summer Student (SS), Residents, and Family Members.

The inspectors conducted observations of resident to resident interactions, staff to resident interactions and provision of care, record review of resident and home records, staff training records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #006, #007, #008, and #009 were protected from abuse.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" means, (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

a. On an identified date, the home submitted a Critical Incident System (CIS) report to the Ministry of Long Term Care (MLTC) related to an incident of resident to resident sexual abuse. According to the CIS report, at an identified time the day before, PCA #125 informed RPN #109 that they found resident #005 touching resident #008 inappropriately. A specified action was taken by staff.

Record review and staff interviews revealed the following:
- A review of clinical record revealed resident #005's cognition at the time of the incident was borderline intact.
- On the identified date and time, PCA #126 informed RPN #109 that they found resident #005 inside resident #008's room, touching resident #008 inappropriately. A specified action was taken by staff. RPN #109 reported resident #008 was asleep, and they informed the RN on duty and the SOC #110 regarding the incident.
- SOC #110 reported that they were alerted of the incident via the shift report the next day. The SOC reported that they initiated a specified care for resident #005 during the identified days.

b. On an identified date, the MLTC received an after hours pager notifying of a second incident of resident to resident abuse. A CIS report was submitted two days later. According to the CIS report, on the identified date and time, staff observed an interaction between residents #005 and #006. Resident #006 further stated that resident #005 had demonstrated an identified action and touched them. About an hour later, resident #005 was found demonstrating an identified action in resident #010's room when resident #010 was asleep.

Record review and staff interviews revealed the following:
- On the identified date and time, RPN #114 reported that the PCA had informed them that they observed an interaction between residents #005 and #006. Resident #006

further stated that resident #005 had demonstrated an identified action and touched them. A specified action was taken towards resident #005, and the incident was reported to the upcoming shift and the DOC.
- RPN #116, who worked on the upcoming shift, reported that at an identified time, they were informed by PCA #115 that they observed resident #005 had demonstrated a specified action towards resident #010 in their room. PCA #115 reported that they were unsure what resident #005 was doing. RPN #116 reported that they informed the DOC about the incident, and a specified care was started for resident #005.
- The DOC reported that after the incidents on the identified date, resident #005 received the specified assessments and care until approximately two months later.

c. On an identified date, the MLTC received an after hours pager notifying of a third incident of resident to resident sexual abuse. A CIS report was submitted the next day. According to the CIS report, at an identified time two days prior, DA #113 observed resident #005 touching resident #009 in an identified home area.

Record review and staff interviews revealed the following:
- On the identified date and time, DA #113 reported that they observed residents #005 touching resident #009 in an identified home area. A specified action was taken by DA #113 and a PCA.
- SOC #108 reported that they initiated a specified care for resident #005 following the incident on the identified date. The SOC stated that at the time of the incident, resident #005's cognitive status was borderline intact.
- From the identified date to approximately a month later, resident #005 received the specified care. On an identified date, a specified arrangement was given to resident #005, and the DOC stated the reason for the arrangement.
- Record review revealed that on an identified date and time, it was reported that residents #005 and #007 were in an identified home area. Resident #005 performed a specified action and made inappropriate comments to an identified staff member. Interview with PCA #111, who worked on the identified date, reported that they witnessed the incident between resident #005 and the identified staff member, and that resident #005 was attempting to initiate a specified action towards resident #007. PCA #111 reported resident #005's awareness of what they were doing.
- Record review and interview with PCA #111 revealed that on an identified date, the PCA noticed resident #005 attempting to initiate a specified action in front of resident #012. PCA #111 reported a specified interaction between the PCA and resident #005, and stated a subsequent identified action were taken. PCA #111 reported resident #005's awareness of what they were doing.

- SOC #106 reported that resident #005 had the specified care in place until the identified date. The SOC reported after the above mentioned incident with resident #012, the specified care was not implemented, however the resident had received the specified assessments.

d. On an identified date, the home submitted a CIS report notifying of a fourth incident of resident to resident sexual abuse. According to the CIS report, on the day before it was submitted, RPN #124 heard resident #007 screaming and observed resident #005 touching resident #007.

Record review and staff interviews revealed the following:
- PCA #111 reported that they were working when the incident happened. The PCA further reported that they heard resident #007 yelling and observed resident #005 touching resident #007. An identified action was taken by staff, however SOC #106 reported that the specified care for resident #005 was not implemented until an identified date.

Interview with the DOC indicated that resident #005 received the specified care and assessments. The inspector reviewed the above mentioned incidents with the DOC and the specified care being implemented and revised for resident #005, during the identified six-month period, that led to the final incident occurred on the identified date.

Given the evidence of what the staff told the inspector what they saw when they witnessed the incidents, the identified care for resident #005 between incidents, and resident #005's cognitive status, the home had failed to take appropriate actions to ensure the safety and to protect residents #006, #007, #008, and #009 from abuse. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for resident #002 that sets out the planned care for the resident.

Review of a CIS report revealed that on an identified date, resident #002 was found on the floor at a specified home area. As a result, the resident sustained an identified injury.

Record review revealed that resident #002 had both cognitive and physical impairments. The resident was at a specified risk for falls and had interventions implemented for falls prevention. The plan did not set out the specified care for resident #002.

Review of the Physiotherapy Referral indicated resident #002 fell on an identified date. The PT assessed resident #002 seven days later, and one of the PT's recommendations was to consider the specified care.

Review of the Initial Post Fall Assessment indicated the resident experienced another fall approximately four months later. One of the strategies stated staff will ask for a specified device for resident #002.

On two identified dates, the inspector observed that resident #002 was in an identified home area, and the specified device was applied for the resident.

Interviews with PCAs #122, #123, RPNs #124 and #125 indicated that resident #002 was at risk for falls and had a specified contributing factor for their risk. The specified device for resident #002 was used as a falls prevention strategy. PCA #122, RPNs #124, and #125 said the specified device was first given to the resident approximately two to four months ago, and later as resident #002 had a specified change in their care needs, the specified device was provided to meet that change.

Interview with SOC #106 indicated that the specified device should be applied for resident #002. SOC #106 confirmed that resident #002's falls prevention plan of care did not set out the specified device for the resident until after staff interviews that it was brought this concern to staff attention. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the plan of care for resident #003 was revised at any other time when care set out in the plan had not been effective.

Review of a CIS report revealed that on an identified date, resident #003 had a fall and sustained a significant injury.

Record review revealed that resident #003 had cognitive and physical impairments, and they were at specified risk for falls. The resident's fall prevention plan stated the specified goals and interventions which were last revised approximately nine months prior to the fall incident.

Review of resident #003's progress notes and post-fall assessments revealed they had two specified falls in the last three months prior to the above-mentioned fall.

Interviews with PCAs #100, #101, and #102 indicated they did not recall resident #003's risk for falls and the above mentioned two falls. The PCAs further stated they did not recollect what falls prevention interventions were put in place for resident #003 at that time.

Interviews with RN #103, PT #104, and SOC #106 indicated that resident #003 was at risk for falls and had the above mentioned falls. The staff further stated the falls prevention plan of care had not been effective as it was unable to meet its goal, and the resident continued to fall. SOC #106 stated that after a resident's fall, staff should reassess the resident and implement new strategies when the care was ineffective. SOC #106 confirmed that resident #003's falls prevention plan of care was not revised when

the care set out in the plan had not been effective. [s. 6. (10) (c)]

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:
- there is a written plan of care for each resident that sets out the planned care for the resident, and
- the resident's plan of care is revised at any other time when care set out in the plan has not been effective, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On an identified date and time in the afternoon, the home submitted a CIS report to the MLTC related to an incident of resident to resident sexual abuse. According to the CIS report, at an identified time the night before, PCA #125 informed RPN #109 that they found resident #005 touching resident #008 inappropriately. A specified action was taken by staff.

On an identified date, the MLTC received an after hours pager notifying of an incident of resident to resident sexual abuse. A CIS report was submitted on the next day. According to the CIS report, at an identified time two days prior, DA #113 observed resident #005 touching resident #009 inappropriately.

On the identified date and time, the home submitted a CIS report to the MLTC, notifying of an incident of resident to resident sexual abuse. According to the CIS report, the day before, RPN #124 heard resident #007 screaming, and the RPN observed resident #005 touching resident #007 inappropriately.

A review of the home's policy titled, Mandatory and Critical Incident System Reporting, Policy Number LTC1-04.114 indicated that a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm to the resident has occurred or may occur to immediately report the suspicion and the information which is based to the MLTC Director.

During an interview with SOC #110 who submitted the CIS report for the above mentioned first incident, they acknowledged that they did not immediately report the incident of abuse to the Director that occurred on the identified date, as they were notified of the incident the next day. The SOC reported that the nurse who discovered the incident on the day it happened is required to report all incidents to the management and follow the licensee reporting requirements.

During an interview with SOC #106, they acknowledged that the CIS report submitted for the above mention third incident was not immediately reported as they were informed about the incident on the day after it happened. The CIS report was completed after they received the report the next day.

During an interview with the DOC, they acknowledged that the CIS report submitted for the above mentioned second incident was not immediately reported as they were informed about the incident the next day, and an after hour pager notification was placed at that time. The DOC acknowledged that the staff did not follow the home's policy for mandatory reporting for all the above mentioned incidents. [s. 20. (1)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 301. Protection of privacy in reports

Specifically failed to comply with the following:

s. 301. (2) Where an inspection report mentioned in clause (1) (a), (c) or (d) contains personal information or personal health information, only the following shall be posted, given or published, as the case may be:
1. Where there is a finding of non-compliance, a version of the report that has been edited by an inspector so as to provide only the finding and a summary of the evidence supporting the finding. O. Reg. 79/10, s. 301 (2).
2. Where there is no finding of non-compliance, a version of the report that has been edited by an inspector so as to provide only a summary of the report. O. Reg. 79/10, s. 301 (2).

s. 301. (3) Where an order mentioned in clause (1) (b) or (e) contains personal information or personal health information, only a version of the order that has been edited by an inspector to provide a summary of the content of the order shall be posted or published, as the case may be. O. Reg. 79/10, s. 301 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that where an inspection report mentioned in clause (1) (a), (c) or (d) contains personal information or personal health information, only a version of the report that has been edited by an inspector so as to provide only the finding and a summary of the evidence supporting the finding was posted.

On an identified date and time, the inspector was passing the main floor hallway and observed the Resident and Family Information board containing the following MLTC

inspection licensee reports posted on the board that contains personal information or personal health information:
- 2017_440210_0001, licensee report dated February 7, 2017,
- 2018_420643_0011, licensee report dated July 18, 2018,
- 2019_780699_0002, licensee report dated February 25, 2019,
- 2019_769646_0002, licensee report dated February 26, 2019,
- 2019_631210_0009, licensee report dated June 7, 2019, and
- 2018_420643_0010, licensee report dated July 18, 2019.

The inspector spoke with the Administrator to determine which reports should be posted in the home, and the Administrator reported only edited public reports should be posted. The Administrator observed the inspection licensee reports on the board and proceeded to take the reports down. The Administrator stated that they had directed the receptionist to review the MLTC inspection reports to ensure they are up to date, and the receptionist had delegated that task to the Summer student.

Inspector #565 interviewed the Summer student #123 who reported that on an identified date, they were directed by the receptionist to print out all reports that was emailed to them via a link. The Summer student reported that they printed out all the reports and posted the reports on the Resident and Family Information board on the identified date, and they were not aware of whether they were licensee or public copies.

Interview with the Administrator confirmed that the above six inspection licensee reports were posted in the home during an identified seven-day period, and that the personal information or personal health information in the reports were not protected. [s. 301. (2)]

2. The licensee has failed to ensure that where an order mentioned in clause (1) (b) or (e) contains personal information or personal health information, only a version of the order that has been edited by an inspector to provide a summary of the content of the order was posted.

On an identified date and time, the inspector was passing the main floor hallway and observed the Resident and Family Information board containing the following MLTC orders were posted on the board that contains personal information or personal health information:
- 2017_642606_0008, order dated June 2, 2017, and
- 2018_420643_0010, order dated July 18, 2019.

The inspector spoke with the Administrator to determine which reports should be posted in the home, and the Administrator reported only edited public copy of an order should be posted. The Administrator observed the licensee orders on the board and proceeded to take the reports down. The Administrator stated that they had directed the receptionist to review the MLTC inspection reports to ensure they are up to date, and the receptionist had delegated that task to the Summer student.

Inspector #565 interviewed the Summer student #123 who reported that on an identified date, they were directed by the receptionist to print out all reports that was emailed to them via a link. The Summer student reported that they printed out all the reports and posted the reports on the Resident and Family Information board on the identified date, and they were not aware of whether they were licensee or public copies.

Interview with the Administrator confirmed that the above two licensee orders were posted in the home during an identified seven-day period, and that the personal information or personal health information in the orders were not protected. [s. 301. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that
- where an inspection report mentioned in clause (1) (a), (c) or (d) contains personal information or personal health information, only a version of the report that has been edited by an inspector so as to provide only the finding and a summary of the evidence supporting the finding shall be posted
- where an order mentioned in clause (1) (b) or (e) contains personal information or personal health information, only a version of the order that has been edited by an inspector to provide a summary of the content of the order shall be posted, to be implemented voluntarily.

Issued on this 30th day of September, 2019

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MATTHEW CHIU (565), NICOLE RANGER (189)
Inspection No. / No de l'inspection :	2019_650565_0013
Log No. / No de registre :	000242-18, 027122-18, 003372-19, 004498-19, 008425-19, 008850-19, 012651-19, 014531-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 9, 2019
Licensee / Titulaire de permis :	The Regional Municipality of Peel 10 Peel Centre Drive, Suite B, 3rd Floor, BRAMPTON, ON, L6T-4B9
LTC Home / Foyer de SLD :	Malton Village Long Term Care Centre 7075 Rexwood Road, MISSISSAUGA, ON, L4T-4M1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jessica Altenor

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 The Regional Municipality of Peel, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCHA, 2007.

Specifically, the licensee shall ensure that residents #006, #007, #008, #009, and all residents are protected from sexual abuse by resident #005.

Grounds / Motifs :

1. The licensee has failed to ensure that residents #006, #007, #008, and #009 were protected from abuse.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" means, (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

a. On an identified date, the home submitted a Critical Incident System (CIS) report to the Ministry of Long Term Care (MLTC) related to an incident of resident to resident sexual abuse. According to the CIS report, at an identified time the day before, Personal Care Assistant (PCA) #125 informed Registered Practical Nurse (RPN) #109 that they found resident #005 touching resident #008 inappropriately. A specified action was taken by staff.

Record review and staff interviews revealed the following:
- A review of clinical record revealed resident #005's cognition at the time of the incident was borderline intact.
- On the identified date and time, PCA #126 informed RPN #109 that they found resident #005 inside resident #008's room, touching resident #008 inappropriately. A specified action was taken by staff. RPN #109 reported

resident #008 was asleep, and they informed the Registered Nurse (RN) on duty and the Supervisor of Care (SOC) #110 regarding the incident.
- SOC #110 reported that they were alerted of the incident via the shift report the next day. The SOC reported that they initiated a specified care for resident #005 during the identified days.

b. On an identified date, the MLTC received an after hours pager notifying of a second incident of resident to resident abuse. A CIS report was submitted two days later. According to the CIS report, on the identified date and time, staff observed an interaction between residents #005 and #006. Resident #006 further stated that resident #005 had demonstrated an identified action and touched them. About an hour later, resident #005 was found demonstrating an identified action in resident #010's room when resident #010 was asleep.

Record review and staff interviews revealed the following:
- On the identified date and time, RPN #114 reported that the PCA had informed them that they observed an interaction between residents #005 and #006. Resident #006 further stated that resident #005 had demonstrated an identified action and touched them. A specified action was taken towards resident #005, and the incident was reported to the upcoming shift and the Director of Care (DOC).
- RPN #116, who worked on the upcoming shift, reported that at an identified time, they were informed by PCA #115 that they observed resident #005 had demonstrated a specified action towards resident #010 in their room. PCA #115 reported that they were unsure what resident #005 was doing. RPN #116 reported that they informed the DOC about the incident, and a specified care was started for resident #005.
- The DOC reported that after the incidents on the identified date, resident #005 received the specified assessments and care until approximately two months later.

c. On an identified date, the MLTC received an after hours pager notifying of a third incident of resident to resident sexual abuse. A CIS report was submitted the next day. According to the CIS report, at an identified time two days prior, Dietary Aide (DA) #113 observed resident #005 touching resident #009 in an identified home area.

Record review and staff interviews revealed the following:
- On the identified date and time, DA #113 reported that they observed residents #005 touching resident #009 in an identified home area. A specified action was taken by DA #113 and a PCA.
- SOC #108 reported that they initiated a specified care for resident #005 following the incident on the identified date. The SOC stated that at the time of the incident, resident #005's cognitive status was borderline intact.
- From the identified date to approximately a month later, resident #005 received the specified care. On an identified date, a specified arrangement was given to resident #005, and the DOC stated the reason for the arrangement.
- Record review revealed that on an identified date and time, it was reported that residents #005 and #007 were in an identified home area. Resident #005 performed a specified action and made inappropriate comments to an identified staff member. Interview with PCA #111, who worked on the identified date, reported that they witnessed the incident between resident #005 and the identified staff member, and that resident #005 was attempting to initiate a specified action towards resident #007. PCA #111 reported resident #005's awareness of what they were doing.
- Record review and interview with PCA #111 revealed that on an identified date, the PCA noticed resident #005 attempting to initiate a specified action in front of resident #012. PCA #111 reported a specified interaction between the PCA and resident #005, and stated a subsequent identified action were taken. PCA #111 reported resident #005's awareness of what they were doing.
- SOC #106 reported that resident #005 had the specified care in place until the identified date. The SOC reported after the above mentioned incident with resident #012, the specified care was not implemented, however the resident had received the specified assessments.

d. On an identified date, the home submitted a CIS report notifying of a fourth incident of resident to resident sexual abuse. According to the CIS report, on the day before it was submitted, RPN #124 heard resident #007 screaming and observed resident #005 touching resident #007.

Record review and staff interviews revealed the following:
- PCA #111 reported that they were working when the incident happened. The PCA further reported that they heard resident #007 yelling and observed resident #005 touching resident #007. An identified action was taken by staff,

however SOC #106 reported that the specified care for resident #005 was not implemented until an identified date.

Interview with the DOC indicated that resident #005 received the specified care and assessments. The inspector reviewed the above mentioned incidents with the DOC and the specified care being implemented and revised for resident #005, during the identified six-month period, that led to the final incident occurred on the identified date.

Given the evidence of what the staff told the inspector what they saw when they witnessed the incidents, the identified care for resident #005 between incidents, and resident #005's cognitive status, the home had failed to take appropriate actions to ensure the safety and to protect residents #006, #007, #008, and #009 from abuse.

The severity of this non-compliance was identified as potential for actual harm, the scope was identified as level two as it related to four out of six residents reviewed. Review of the home's compliance history revealed a previous non-compliance to the same subsection was issued on February 2, 2018, under inspection report #2017_547591_0015 for the non-compliance with the LTCHA, 2007 s. 19 (1). Due to the scope being pattern and previous non-compliance, a compliance order is warranted. (189)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2019

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

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

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère 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 9th day of September, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Matthew Chiu

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