Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 27, 2017	2016_356618_0024	031397-16	Resident Quality Inspection

Licensee/Titulaire de permis

DRS PAUL AND JOHN REKAI CENTRE
345 SHERBOURNE STREET TORONTO ON M5A 2S3

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

WELLESLEY CENTRAL PLACE
160 WELLESLEY STREET EAST TORONTO ON M4Y 1J2

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

CECILIA FULTON (618), SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 31, November 1, 2, 3, 4, 7, 8, 9, 10, 14, 15, 16, 2016

**The following Critical Incidents were inspected:
Related to Plan of Care: Log # 007424-14**

**The following complaint intakes were inspected:
Related to Plan of Care: Log #'s 005768-14, 024952-16, 029686-16, 020211-15.
Related to Medication Administration: Log # 001924-16
Related to Housekeeping: Log # 025662-15.
Related to Prevention of Abuse: Log # 012688-16**

The following follow up intake was inspected: Log # 015655-15

During the course of the inspection, the inspector(s) spoke with The Executive Director (ED), Director of Resident Services (DORS), Resident/Family Relations Co-ordinator, Registered staff, Registered Dietitian (RD), Dietary Manager, Personal Support Workers (PSW's), House Keepers (HKG), Environmental Services Manager (ESM), Family Council chair, Resident Council chair, Resident(s) and Substitute Decision Maker(s) (SDM).

During the course of the inspection, the inspectors conducted observations of residents and home areas, staff and resident interactions, provision of care, medication administration, infection prevention and control practices, snack service delivery, reviewed clinical health records, minutes of Residents' Council and Family Council meetings, minutes of relevant committee meetings, and relevant policy and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours

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

10 WN(s)
6 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 44. (7)	CO #001	2015_377502_0005	210

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from abuse by anyone.

Record review of the Critical Incident Report (CIR) revealed that in April, 2016, resident #017 was observed by registered staff #105 inappropriately touching resident #018. Staff #105 separated the residents and redirected resident #017 back to their room.

Interview with PSW #117 revealed that resident #017 was known to make verbal remarks, but PSW #117 had never observed resident #017 making inappropriate advances towards staff or other residents.

Interview with staff #105 revealed that resident #017 exhibited behaviours of inappropriate verbal remarks, and at times would attempt to touch staff members inappropriately. Staff #105 revealed that prior to that morning, they had never observed resident #017 touching a co-resident.

Interview with staff #105 further revealed that on that same morning, they had become aware that resident #017 had made inappropriate advances towards other co-residents. Staff #105 had sent an e-mail to the DORS and the Executive Director (ED) that morning informing them that resident's #023 and #025 had reported to them that morning that resident #017 had tried to touch them. This e-mail further revealed that staff #105 had found resident #017 in resident #024's room and that resident #024 reported that resident #017 had touched them inappropriately.

Review of these three resident's progress notes revealed that staff #105 had documented the incident they had observed with resident #024 in their progress notes and that the physician had seen resident #024 in follow up to this and that resident #024 recalled the incident and stated it was the first time it had ever happened.

There was no documentation in resident's #023 or #025's progress notes about this reported incident.

Interview with DORS #102 revealed that they had not received this communication from staff #105 and that this is not the expected way that staff would communicate issues to the DORS.

Interview with the DOC #102 confirmed that resident #018 had not been protected from abuse.

The severity of the non-compliance and the severity of the harm were actual. The scope of the non-compliance was patterned. A review of the Compliance History revealed that

there was a Written Notification (WN) and a Voluntary Plan of Correction (VPC) issued in inspection 2015_398605_0008 dated April 9, 2015. As a result of the severity, scope, and the licensee's previous compliance history, a compliance order is warranted. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rules are complied with: 1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2)

During the course of the inspection several observations were made of doors leading to enclosed balconies on the second, third and fourth floors. All of these observations revealed that the doors to these balconies were unlocked and there was no supervision of a resident's access to these balconies.

Interview with the Environmental Services Manager (ESM) confirmed that these doors are unlocked from 1000 hrs to 2000 hrs from May through October so that residents may use them. The ESM provided a Door Schedule confirming this.

Interview with staff revealed that supervision of these areas is maintained by a staff member often seated at the nurses station who would be able to see the door and by the staff's awareness of residents' whereabouts. Staff interviews confirmed that there was no formal process for supervising residents' access to these balconies.

Observation by the inspector revealed that there is often no one seated at those nursing stations and no staff with in the vicinity of these doors who could supervise access to the balconies. Residents were observed walking or wheeling unsupervised in the vicinity of these doors.

Review of the homes policy; Building Safety/Secure doors and outside areas, Index I.D. J-60, dated April 9, 2013 states that residents can have access to these areas under the supervision of the staff.

Interview with the Director of Resident Care Services (DORS) #102 confirmed that there is no formal system in place to ensure that access to these balconies is supervised and that residents are able to access the balconies without supervision. [s. 9. (1) 1.1.]

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 prevent unsupervised access to balconies by residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone immediately reported the suspicion and the information upon which this was based to the Director.

Record review of the CIR revealed that in April, 2016, resident #017 was observed by registered staff #105 inappropriately touching resident #018. Staff #105 separated the residents and redirected resident #017 back to their room.

Record review and interview with staff #105 revealed that they did not inform the Director of the incident.

Interview with DORS, #102 revealed that they became aware of this incident when they received a call from the police that evening informing them that this incident had occurred and suggesting that the home increase supervision of resident #017. DORS #102 revealed that a family member of resident #017 had notified the police of this incident. The DORS revealed that no staff from the home had notified them regarding this incident.

Review of the CIR revealed that it was not submitted to the Ministry until two days after the incident was reported to have occurred.

Review of the home's policy "Abuse or Neglect Policy", Index I.D. P-10, dated December 19, 2000, indicates that on becoming aware of abuse or neglect the person first having knowledge of this shall immediately inform the Director at the Ministry of Health and Long Term Care (MOHLTC).

Interview with DORS #102 revealed that staff should be aware of the reporting requirements, and any staff member is expected to make the report to the Director at the MOHLTC. DORS #102 confirmed that staff #105 should have called the Director themselves to immediately report this incident. [s. 24. (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 a person who had reasonable grounds to suspect abuse of a resident by anyone immediately reported the suspicion and the information upon which this was based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of potentially harmful interactions between residents by identifying and implementing interventions.

This was an Inspector initiated inspection based on the finding under Section 19.

Record review revealed that resident #017 had identified behaviours.

Record review revealed that in April, 2016, registered staff #105 became aware that resident #017 had been demonstrating inappropriate behaviour towards three co-residents. At 0855 hrs on that day staff #105 sent an e-mail to the DORS and the ED informing them that residents #023 and #025 had reported that resident #017 had been trying to touch them. The e-mail further revealed that staff #105 had observed resident #017 in resident #024's room and resident #024 stated they had been touched on the by resident #017.

Interview with DORS #102 revealed they did not receive this communication and this is not the expected method of contacting them.

Record review and interview with staff #105 revealed that on that same day they had observed resident #017 inappropriately touching of resident #018.

Interview with staff #105 revealed that after becoming aware of the incidents of inappropriate touching of resident #018 by resident #017, they had informed unit staff to keep a close eye on resident #017. Record review and interview with staff #105 revealed that no other interventions were initiated to manage or monitor resident #017's behaviours.

Interview with DORS #102 confirmed that changes to resident #017's care plan had not been initiated when staff became aware of resident #017's change in behaviours. [s. 54. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to minimize the risk of potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were offered a minimum of a snack in the afternoon and evening.

Resident #002, triggered during stage one of this inspection due to a documented weight change.

Record review revealed that resident #002 had identified nutritional risk and was ordered a diet specific to their requirements.

Review of the Nutritional look back reports and the Point of Care (POC) report for nutrition/snack monitoring revealed that for the 30 days between October and November 2016, the resident had only received 21 snacks out of a possible 87 times.

Interview with PSW #107 revealed that resident #002 had not been offered snacks on a regular basis for the past several months because the kitchen had not been providing the prescribed snack for the resident. PSW #107 revealed that they had notified a registered staff about this.

Interview with PSW #108 revealed that resident #002 is often not offered a snack because this resident's prescribed snack was not provided.

Interview with the Registered Dietitian (RD) confirmed this resident's nutritional risks and interventions and confirmed that the resident should be offered between meal snacks.

Interview with the Manager of Dietary services confirmed that there has been communication problems with the kitchen staff and that they were aware that snacks have not been provided as ordered for this resident. [s. 71. (3) (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 ensure that residents are offered a minimum of a snack in the afternoon and evening, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of CIR and a corresponding complaint revealed that resident #009 was administered the wrong dose of medication on four days in January 2016.

A review of the physician's order in January 2016 revealed a new order for this resident's identified medication and that the previous order was discontinued.

A review of the electronic medication administration record (EMAR) revealed an order entry for the order was incorrect. The EMAR was signed by registered staff indicating administration of the medication as it appeared on the EMAR on the identified dates in January 2016.

Interview with resident #009's Substitute Decision Maker (SDM), revealed that on an identified date in January 2016, they interrupted the administration of the medication when they observed the wrong dose was about to be administered.

Record review revealed that resident #009 had received the incorrect dose of this medication on three identified dates in January 2016. The home initiated an investigation.

Interview with registered staff #111 revealed the practice at the time of this incident for medication order transcription was for the physician's order to be transmitted to pharmacy using the digi-pen as well, the registered nurse was to fax a drug record book sheet to pharmacy where they will have written the order again. When the order was received in the pharmacy, the pharmacist was responsible to transcribe the order from the physician's digi-pen order into the computer/EMAR. Once the order was transcribed into the EMAR another registered nurse would check the accuracy of the EMAR with the original physician's order. Interviews revealed that the practice was being followed as required.

After the incident, changes were made to the transcription process including the pharmacy discontinuing the use of the digi-pen for transmitting orders to pharmacy and implemented a scanner/fax method of transmission. Additional safety measures that were implemented included, having two pharmacists process new orders when there is an identified change from the current dose on file for this type of medication. [s. 131. (2)]

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 ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the infection prevention and control program.

Stage one observation of lingering odour led the inspector to make further observations and inquiries about the housekeeping practices.

Interview with staff #115 revealed that they initiate cleaning of a resident's room in the resident's bathroom. Staff #115 revealed that unless that area was "nasty", they would use the same rag to clean the remainder of the resident's room.

Review of the homes policy; Staff Daily Cleaning Routines, Light Duty Cleaner, Index I.D. Es B-15-65, dated January 21, 2015, states that a separate cleaning cloth is to be used for each resident room and a separate cleaning cloth is to be used for each resident washroom.

Interview with the Environmental Services manager (ESM), staff #114 confirmed that the use of a separate cloth to clean the resident's washroom and bedroom is expected as part of the infection prevention and control program. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On October 26, 2016, a complaint was submitted to MOHLTC that on June 21, 2016, resident #006 was transferred improperly which resulted in the resident having to be lowered to the floor in the middle of the transfer.

A review of resident #006's written plan of care revealed the resident's transfer requirements.

Interview with registered staff #111 confirmed that PSW #112 had not followed the resident's plan of care regarding transfers and this resulted in the PSW not being able to successfully complete the transfer and having to lower the resident to the floor. [s. 6. (7)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee sought the advice of the Family council in developing the satisfaction survey.

Information provided by the current Family Council chair person revealed that advice was not sought by the Family Council in the development of the satisfaction survey.

Interview with the ED confirmed that the licensee had not sought the input of the Family Council in developing the 2015 satisfaction survey. [s. 85. (3)]

2. The licensee has failed to ensure that the advice of the Resident's Council was sought when developing and carrying out the 2015 satisfaction survey.

Interview with the Resident's Council chairperson revealed that the resident's council had not been consulted to provide advice when the 2015 satisfaction survey was being developed.

Interview with staff #116 revealed that the licensee had not sought the advice of the Resident's council when developing and carrying out the satisfaction survey.

Review of the 2015 meeting minutes for the Resident's Council did not provide any documentation to the council's involvement in the development of the satisfaction survey. [s. 85. (3)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents received annual training in responsive behaviours.

Review of the education attendance records revealed that 9 per cent of staff did not participate in the Behaviour Management education offered in 2015.

Interview with the ED confirmed that all of the staff should have attended this training, but had not. [s. 221. (2)]

2. The licensee has failed to ensure that all staff who provide direct care to residents participate in the abuse and neglect training that is offered.

Review of the education attendance for records revealed that 10 per cent of staff did not participate in the Resident abuse and neglect training offered in 2015.

Interview with the ED confirmed that all of the staff should have attended this training, but had not. [s. 221. (2)]

Issued on this 1st day of February, 2017

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

Original report signed by the inspector.

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) :	CECILIA FULTON (618), SLAVICA VUCKO (210)
Inspection No. / No de l'inspection :	2016_356618_0024
Log No. / Registre no:	031397-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 27, 2017
Licensee / Titulaire de permis :	DRS PAUL AND JOHN REKAI CENTRE 345 SHERBOURNE STREET, TORONTO, ON, M5A-2S3
LTC Home / Foyer de SLD :	WELLESLEY CENTRAL PLACE 160 WELLESLEY STREET EAST, TORONTO, ON, M4Y-1J2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sue Graham-Nutter

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To DRS PAUL AND JOHN REKAI CENTRE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with s. 19. (1). to ensure that residents are protected from abuse by anyone and are not neglected by the licensee or staff.

Please submit compliance plan to cecilia.fulton@ontario.ca on or before February 24, 2017.

The plan will include but not be limited to the following elements:

1. Develop and implement steps to ensure that all staff receive training and/or retraining on the home's policy to promote zero tolerance of abuse and neglect of residents, including strategies that foster a culture of respect for residents, and the prevention of abuse and neglect.

2. Staff are educated to recognize forms of abuse and neglect and comply with the home's policy on the prevention of abuse and neglect.

3. Staff are educated to recognize responsive behaviours which may result in resident to resident abuse and how to implement strategies to monitor and re-direct these behaviours.

4. Staff are educated to understand each staff person's responsibility toward the safety of the residents who have been abused or neglected and reporting incidents of abuse and neglect to the home and MOHLTC

5. Develop and implement a schedule to test and monitor staff compliance with the home's abuse policies.

Grounds / Motifs :

1. The licensee has failed to ensure that residents are protected from abuse by anyone.

Record review of the Critical Incident Report (CIR) revealed that in April, 2016, resident #017 was observed by registered staff #105 inappropriately touching resident #018. Staff #105 separated the residents and redirected resident #017 back to their room.

Interview with PSW #117 revealed that resident #017 was known to make verbal remarks, but PSW #117 had never observed resident #017 making inappropriate

advances towards staff or other residents.

Interview with staff #105 revealed that resident #017 exhibited behaviours of inappropriate verbal remarks, and that resident #017 had on occasion been observed masturbating in their room, and at times would attempt to touch staff members inappropriately. Staff #105 revealed that prior to that morning, they had never observed resident #017 touching a co-resident.

Interview with staff #105 further revealed that on that same morning, they had become aware that resident #017 had made inappropriate advances towards other co-residents. Staff #105 had sent an e-mail to the DORS and the Executive Director (ED) at 0855 hrs that morning informing them that resident's #023 and #025 had reported to them that morning that resident #017 had tried to touch them. This e-mail further revealed that staff #105 had found resident #017 in resident #024's room and that resident #024 reported that resident #017 had touched them inappropriately.

Review of these three resident's progress notes revealed that staff #105 had documented the incident they had observed with resident #024 in their progress notes and that the physician had seen resident #024 in follow up to this and that resident #024 recalled the incident and stated it was the first time it had ever happened.

There was no documentation in resident's #023 or #025's progress notes about this reported incident.

Interview with DORS #102 revealed that they had not received this communication from staff #105 and that this is not the expected way that staff would communicate issues to the DORS.

Interview with the DOC #102 confirmed that resident #018 had not been protected from abuse.

The severity of the non-compliance and the severity of the harm were actual. The scope of the non-compliance was patterned. A review of the Compliance History revealed that there was a Written Notification (WN) and a Voluntary Plan of Correction (VPC) issued in inspection 2015_398605_0008 dated April 9, 2015. As a result of the severity, scope, and the licensee's previous compliance history, a compliance order is warranted. [s. 19. (1)] (618)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 17, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 27th day of January, 2017

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Cecilia Fulton

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