Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 26, 2016	2016_200148_0011	011658-16	Resident Quality Inspection

Licensee/Titulaire de permis

CITY OF OTTAWA
Long Term Care Branch 275 Perrier Avenue OTTAWA ON K1L 5C6

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

GARRY J. ARMSTRONG HOME
200 ISLAND LODGE ROAD OTTAWA ON K1N 5M2

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

AMANDA NIXON (148), LINDA HARKINS (126), RUZICA SUBOTIC-HOWELL (548)

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): April 25-29 and May 2-6, 2016.

During this inspection the following logs were completed: one complaint related to the provision of resident equipment and one critical incident related to alleged sexual abuse.

During the course of the inspection, the inspector(s) spoke with The home's Administrator, Special Advisor to City of Ottawa's Manger Office (Special Advisor), Program Manager of Resident Care, Program Manager of Personal Care, Manager of Recreation/Leisure, Staffing Coordinator, Manger of Environmental Services, Social Worker, Administration Assistant, Project Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers, (PSW), Food Service Workers, Housekeeping aides, a Rehabilitation Assistant, volunteers, family members and residents.
The inspectors reviewed resident health care records, the home's planned menu, nursing staffing plan, investigation notes related to alleged abuse and bed system assessments. Inspectors also reviewed home policies including the home's policy to promote zero tolerance of abuse. In addition, inspectors observed meal service, medication pass and resident/staff interactions.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
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
Reporting and Complaints
Residents' Council
Skin and Wound Care
Sufficient Staffing

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

- **7 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.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 had failed to ensure that resident #041 was protected from sexual abuse by resident #033.

In accordance with O. Regs 2. (1) (b), sexual abuse is define 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.

On April 28, 2016, Inspector # 126 reviewed the health care record of resident #033 including progress notes for the period of approximately four months, as it related to a triggered Quality of Care and Quality of Life Indicators (QCLI) identified in the Resident Quality Inspection (RQI). In a progress note on a specified date, the Manager of Resident Care (MRC) documented that she spoke to resident #033 to reinforce co-resident #041's message that resident #041 no longer wished for resident #033 to touch him/her. Resident #033 indicated understanding. As the progress notes were reviewed for resident #033 and resident #041, it was noted that several incidents of a sexual nature occurred involving resident #033 touching resident #041.

On April 28, 2016, Inspector #126 discussed the above incidents with the Acting Administrator who indicated that he was aware of these incidents between resident #033 and resident #041. He indicated that the two residents had a relationship and that they consented to the touching. He indicated that the management team provided support to resident #041 and resident #041's Power of Attorney to ensure the relationship between the two residents was acceptable. Inspector #126 inquired why resident #041's POA was involved and he indicated that resident #041 made the POA aware of everything that was going on.

On April 29, 2016, Inspector #126 interviewed the MRC, who indicated that she discussed the relationship with both residents and to her interpretation they both had capacity to make these personal decisions and that this relationship was consensual. She also indicated that resident #041 was not always that clear; sometimes resident #041 would say one thing and then the next time resident #041 would denied that something happened. Earlier in 2016, the MRC documented in the Unit Daily Record that both resident's were consenting to the touching. The MRC indicated that a meeting was held with resident #041 and POA. She indicated that post meeting, a Critical Incident was be submitted and that the police force were notified.

On April 29, 2016, Inspector #126 interviewed resident #041 and his/her POA. The Power Of Attorney (POA) in this case is for care and finance and was visiting because there was a meeting with Management that afternoon to discuss the incidents between resident #041 and resident #033. Resident #041 indicated that he/she no longer wanted

to be touched by resident #033. The POA indicated that he/she did not think that resident #041 had any previous sexual relationships. The POA also indicated that at some unknown date, resident #041 had called him/her to get a new type of pyjama that would not allow resident #033 to touch resident #041. Inspector #126 discussed with resident #041 that residents are allowed to have a relationship in the home but where there is sexual activity, each resident needs to give consent to each activity, each time. Resident #041 repeated again, that he/she no longer wanted to be touched by resident #033. Inspector # 126 asked resident #041 if he/she enjoyed sitting at the same table of resident #033 for meals and resident #041 stated that it is ok because they like to talk.

Resident #033 is alert and oriented and mobilizes independently with a wheelchair. Resident # 033 is able to make decisions related to personal care and finance.

Resident # 041 is alert and oriented and ambulates independently. Resident #041's POA is involved in the decisions related to personal care and finances. In a consultation in 2015, a physician described the clinical picture of resident #041 as being a person who was very quiet and polite, who kept a kind smile on his/her face and was difficult to read how he/she felt. The physician noted that the resident never spoke spontaneously during the interview, answering the questions with simple conventional phrases/sentences. The physician also noted that the resident's POA was very involved and was the person who speaks for the resident.

On a specified date, just before supper, Resident #041 approached RPN #114 and informed her that resident #033 continued to touch him/her even if he/she said no. Resident #041, also told her that he/she may have to change pyjama style because it was easy for resident #033 to put his/her hands inside while he/she is laying down.

RPN #114 did not report that discussion until three days later, when she sent an email to the Manager of Resident Care.
In response to a call from the MRC, RN #135 came to the unit to discuss the report with the RPN and resident #041. As per the progress notes, RN #135 went to resident #041's room and resident #041 told her that three days ago, resident #033 touched him/her from his/her chest to his/her genital area and when resident #041 told resident #033 to stop, resident #033 did not listen. Resident #041 did not want to give more details but stated he/she did not want to be touched by resident #033 anymore. RN #135 documented that resident #041 did not want to call the police and that she notified the Ministry of Health and Long Term Care.

Two days later, the Acting Administrator and the MRC met with resident #041 to discuss the above reports. The MRC documented that resident #041 stated that when resident #041 told resident #033 to stop, he/she did . Resident #041 stated he/she told resident #033 that he/she no longer wanted to have intimate relations. Resident #033 had not touch him/her since.

Nineteen days after the Acting Administrator and MRC spoke with resident #041, PSW #137 reported to RPN #114 that resident #033 was touching resident #041 on his/her stomach. Resident #041 was approached by RPN #114 and RN #131, resident #041 denied that he/she had been touched by the resident #033.

Sixteen days after the above witnessed incident by PSW #137, resident #041 approached RPN #114 to report that resident #033 continues to touch him/her, that he/she does not want the touching and he/she does not know how to tell resident #033 to stop. Resident #041 added that his/her POA was aware. RPN #114 notified RN #131who came to the unit. RN #131 discussed with resident #041 who stated that resident #033 was touching him/her and that he/she wanted resident #033 to stop. Resident #041 reported that he/she was lying on the couch, when resident # 033 came to touch him/her as usual. Resident #041 stated that resident #033 does not know when to quit. Resident #041 stated that he/she has never felt ok with being touched. Resident #041 also stated that he/she did not ask resident #033 to stop when resident #33 started to touch him/her and that resident #033 did not stop when he/she told resident #033 to stop. Resident #041 stated he/she did not want to be touched anymore and that he/she did not want to have resident #033 come to his/her room anymore.

Interviews were held with RNs, RPNs and PSWs between May 2 and May 6, 2016, by Inspector #126. Staff indicated to the Inspector, that they had concerns of the relationship between the two residents. They felt the level of cognition was different between the two, as resident #033 was aware of what was going on and that they didn't think that resident #041 really understood. They indicated that they were directed by the Manager of Resident Care to treat both residents has capable, that the residents had a consensual relationship and that touching was consensual.

In the current plan of care for resident #041, it was indicated that resident #041 has personal and intimate relations with resident #033. Resident #041 has expressed consent and that he/she will let resident #033 know if it bothers him/her. Resident #041 is now in the process of breaking up this relationship with resident #033, previously had intimate relationship. Resident #041 does not want to be touched by resident #033

anymore.

In the current plan of care for resident #033, it was indicated that resident #033 has personal and intimate relations with resident #041. Resident had expressed consent that he/she feels that it calms his/her friend.

As of a specified date, resident #041 clearly indicated to staff that he/she no longer wanted to be touched by resident #033. No interventions were developed, implemented or documented in the plan of care to ensure protection of resident #041 from resident #033. Staff indicated that they were just observing the situation and no documentation was required.

The inspection demonstrates that resident #041 expressed to Registered Staff that he/she no longer wanted to be touched by resident #033. Resident #041 was not protected from sexual abuse from resident #033. Consent was not provided by resident #041, therefore legislative requirements (s.24, r.98) and abuse policy were not complied with (s.20). [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:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

Garry J. Armstrong is long term care home consisting of seven floors. Floors two through seven are primarily resident home areas, whereas the first floor of the home is primarily administrative space and common areas for resident activities. On each of the floors, with the exception of the first floor, there is a nursing station accessed by a door that is equipped with swipe key access, whereby the door is locked when the door is closed. Each nursing station faces two elevator doors which are utilized by staff, family, volunteers and residents.

On April 29, 2016, Inspector #548 observed the third floor nursing station door to be left open with no staff members present. It was observed that two residents were in the vicinity of the nursing station approximately four feet away.

On May 2, 2016, Inspector #548 observed the fourth floor nursing station door was open with no staff member present. At 1030hours, RN #101 entered the nursing station and indicated the door was closed when she left and she was not certain who had left it open. RN #101 indicated the door is to be kept closed at all times. On May 2, 2016, at 1100 hours, the Inspector observed the fifth floor nursing station door to be left open with no staff member present. During an interview, RN #121 indicated that only staff are to access the nursing station and it is not an area to be accessed by residents.

On May 03, 2016, at approximately 1100 hours Inspector #548 observed the fourth floor nursing station door to be left open with no staff member present. This was subsequently observed on the fifth and seventh floor. At the time of the observations residents were in the vicinity of the nursing station on the fourth, fifth and seventh floor.

On May 3, 2016, during an interview the Manager of Personal Care indicated that the nursing station was a non-residential area. [s. 9. (1) 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 to ensure that doors leading to non-residential areas are closed and locked when not supervised by staff, 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 failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with.

In accordance with O.Reg. 79/10, s.2(1), emotional abuse is defined as follows: any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences. Verbal abuse is defined as any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences. 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.

The home's policy to promote zero tolerance of abuse, was identified as policy #750.65, titled Abuse. The policy indicates to report immediately any suspicion or allegation of resident abuse to the Charge Nurse, immediately report the allegation to the Administrator and Manager of Resident Care.

Resident #047 is dependent on staff for assistance with activities of daily living. Although behaviours of yelling out have improved recently, it was noted by staff and the plan of care that yelling out was a common behaviour and was found to be disruptive to some residents.

Resident #034 uses a wheelchair as primary mode of locomotion through the home, it was noted by staff and the most recent Minimum Data Set (MDS) Assessment, that the resident makes daily decisions and is able to understand the consequences of his/her actions.

On a specified date, during the evening shift, PSW #126 witnessed resident #034 in the hallway, at the bedroom door of resident #047. Resident #047 was yelling out and resident #034 had a water gun and was shooting water at resident #047 while verbalizing, I want to shoot you, shut up. When asked by Inspector #148, PSW #126 indicated that the resident was angry and aggressive, she immediately spoke with resident #034 and told him/her that this behaviour was not right, redirected the resident and then proceeded to assist resident #047 as the resident was quite wet from the water. PSW #126 reported to Inspector #148 that she thought the actions of resident #034 were abusive as the actions were threatening and resident #047 could not defend him/herself.

PSW #126 immediately reported her observations to RPN #132. The RPN wrote a progress note on the same date indicating the observations of PSW #126. In the note the RPN indicates she spoke with the resident and explained that the actions were not acceptable and not to do it again. During an interview with Inspector #148, RPN #132 indicated that she did not report the incident to anyone, indicating that resident #034 thought the incident was funny and did not seem aggressive.

Inspector #148 spoke with the Administrator of the home at the time of the incident. He reported that it would have been expected that the RPN report to the Administrator or Manager of Resident Care, at minimum to the Charge Nurse so that the information could be assessed in relation to alleged abuse. [s. 20. (1)]

2. On a specified date just before supper, resident #041 approached RPN #114 and informed her that resident #033 continued to touch him/her even when he/she said no. RPN #114 did not report that discussion until three days later at 0927hours, when she sent an email to the Manager of Resident Care. [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 policy to promote zero tolerance of abuse is complied with specifically as it relates to the procedure for staff members to report alleged abuse to supervisors and/or members of management as identified by the policy, to be implemented voluntarily.

WN #4: 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 failed to ensure that a person who has reasonable grounds to suspect that abuse has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

In accordance with O.Reg. 79/10, s.2(1), emotional abuse is defined as follows: any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences. Verbal

abuse is defined as any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences. 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.

A Critical Incident Report (CIR) was submitted to the Director during the course of this inspection, which described an incident of suspected verbal abuse from a staff member to resident #017 as described by the Manager of Personal Care. Resident #017 indicated that the PSW had yelled and screamed at him/her while helping the resident to bed, to the point the resident requested the PSW to remove herself from the resident's room.

The health record, the home's investigation notes and relevant policy were reviewed. A progress note entry on the date of the incident, indicated the PSW informed the Charge Registered Nurse that she had not screamed or raised her voice towards the resident and a student was present at the time. The RN writes that she went to speak with the resident, however, the resident was asleep.

On May 3, 2016, resident #017 described the incident to Inspector #548 as follows: the PSW was rude, held the resident's arm and had placed the resident in bed using force and yelling. The resident indicated a student PSW was present at the time. The resident goes on to say that he/she made three requests to the PSW to get the registered nurse and the request was denied. The resident indicated that he/she spoke with the nurse regarding the situation.

On May 3, 2015, during an interview with Inspector #548, the Manager of Personal Care indicated that he completed the CIR once informed of the alleged verbal abuse by the Inspector. He indicated the PSW was placed on administrative leave pending the home's investigation. The Manager indicated that the Manger of Resident Care spoke with the RN, who had reported that she had forgotten to report the incident.

On May 5, 2016, during an interview with Inspector #548 Manager of Resident Care indicated there is an RN scheduled and delegated to act on behalf of the Licensee for all matters after hours. She further indicated she is in the midst of the investigation of the alleged staff to resident verbal abuse. She indicated the registered nurse became aware of the allegation by the PSW who provided the RN with details of the incident. She indicated the RN was in charge at the time of the incident and had made a note of the

incident however, did not report directly to the on-call manager, as procedural requirements. [s. 24. (1)]

2. Resident #047 is dependent on staff for assistance with activities of daily living. Although behaviours of yelling out have improved recently, it was noted by staff and the plan of care that yelling out was a common behaviour and was found to be disruptive to some residents.

Resident #034 uses a wheelchair as primary mode of locomotion through the home, it was noted by staff and the most recent Minimum Data Set (MDS) Assessment, that the resident makes daily decisions and is able to understand the consequences of his/her actions.

On a specified date, volunteer #118 reported an incident to the home's Social Worker (SW) involving resident #034 and #047. The SW reported, by email to the home's Administrator at the time, the Program Manger of Resident Care and the Program Manager of Personal Care (in position at the time), that the volunteer had observed resident #034 in his/her wheelchair outside of resident #047's room and said you're going to die and took out a plastic water gun and held it up towards resident #047.

A progress note dated November 26, 2015, written by the home's current Administrator, indicated that he and the Program Manager of Resident Care met with resident #034 to discuss the reported incident. The note indicated that the Administrator explained to resident #034 that the behaviors and remarks made to resident #047 were unacceptable and threatening, that resident #034 is of sound mind and that the behaviours could be seen as criminal. Resident #034 then relinquished to water gun and promised he/she would not do anything to threaten or harm resident #047.

Inspector #148 reviewed the Critical Incident System, which is used by the long term care home to make mandatory reports to the Director. No report of the November 26, 2015 incident was made to the Director.

Inspector #148 discussed the email notification and progress note with the home's Administrator, at the time of the incident. He indicated that in review of the progress note, it would appear to be alleged abuse and further indicated that the incident should have been reported to the Director. [s. 24. (1)]

3. On a specified date, resident #041 approached RPN #114 to report that resident #033

continues to touch him/her, and that resident #041 does not want that the touching and is not sure how to tell resident #033 to stop. RPN #114 notified RN #131 who came to the unit. RN #131 discussed the matter with resident #041.

On May 6, 2016, Inspector #126 interviewed RN #131. RN #131 indicated that on the date of resident #041's report, she came to the unit to talk to resident #041 after being notified of the incident. She indicated that on that evening, she was in contact with the Manager of Resident Care. A Critical Incident was not submitted immediately and was submitted to the Director 13 days after the 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 has reasonable grounds to suspect abuse of a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (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 plan of care based on an assessment of the resident and the resident's needs and preferences.

Resident #011 is care planned to require one staff for all aspects of personal hygiene,

specifically indicating that the resident can brush teeth if toothbrush prepared and handed to the resident and is able to rinse mouth if glass prepared. Staff have the resident remove the partial upper plate and clean it for the resident.

Inspector #148 spoke with PSWs #104, #105 and #106, who are familiar with the resident's care. Each indicated that the resident is not able and/or not willing to participate in oral care. Each stated that the staff provide the resident with extensive to total assist and that the resident has not worn dentures in some time.

Inspector #148 spoke with RN #107, who indicated that the resident no longer sees the dentist due to behaviours and that this decision was made with the resident and substituted decision maker.

A review of the health care record demonstrated that the last dental visit was in 2013. The most recent Minimum Data Set (MDS) assessment indicates that the resident requires set up to brush teeth and staff to complete brushing in hard to reach areas and that the resident is followed routinely by the dentist. The previous MDS assessment indicates that daily cleaning of the residents teeth is completed by staff. A recent progress note indicates the resident has few of their own teeth and no dentures. A 2014 MDS assessment indicates the resident does not have dentures.

The current plan of care is not based on the assessment of the resident or the needs of the resident as it relates to the need for assistance and provision of dentures. [s. 6. (2)]

2. 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.

Resident #015 is identified as a risk for falls and had a recent fall in April 2016. The resident mobilizes with the use of a wheelchair and requires the use of a Maxilift with two persons for transferring between surfaces.

The health record was reviewed, the care plan for fall intervention specifies that the call bell is to be within reach when in the chair or in bed.

On May 2, 2016, at approximately 1100 hours, Inspector #548 observed the resident to be in bed, the call bell resting on top of the bedside table behind the resident approximately two-three feet away and not within reach. The resident informed the Inspector that he/she was on the bed pan for approximately 15 minutes. The resident

was not aware of where the call bell was and indicated that he/she was waiting for someone to come and assist him/her off the bedpan.

Inspector #548 observed the resident to be in the same state from approximately 1100 to 1109 hours, in bed with the call bell resting on the table top, at which time two PSWs entered the room. During an interview, PSW #105 indicated that the resident was placed on the bed pan approximately 15 minutes ago by another PSW. PSW #105 indicated that all residents are to have the call bell beside them. In the presence of the Inspector the PSW observed the call bell to be resting on the bedside table top. PSW #105 indicated that the resident is to have the call bell within reach at all times while in the bed.

On May 4,2016, RN #101 indicated the resident is to have the call bell within reach while he/she is in bed. [s. 6. (7)]

WN #6: 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 advice of the Residents' Council was sought in the development and carrying out of the satisfaction survey, and in acting on its results.

During an interview with the Resident Council President, resident #42 could not recall if the Council had been given an opportunity to provide advice regarding the most recent satisfaction survey.

Inspector #148 spoke with the home's Manager of Recreation and Volunteer Services, who assists the Residents' Council. She indicated that she was not aware that the licensee was required to seek the advice of the Council in developing and carrying out of the satisfaction survey. To her knowledge this has not been completed in the last year.

Inspector #148, spoke with the Project Coordinator who has responsibilities including the development and management of the satisfaction survey, she demonstrated that the last known review of the satisfaction survey by the Residents' Council was in late 2013. The Administrator of the home (Special Advisor), in place in 2015, was able to confirm that the Residents' Council did not have an opportunity to give advice on the development and carrying out of the survey in 2015. [s. 85. (3)]

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. (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 :

1. The licensee has 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 May 4, 2016, Inspector #126 visited resident #032 in the resident's room. An empty bottle of pain medication was on the resident's bed and a new bottle of another pain medication was observed to be on the resident's walker.

Resident #032 indicated that he/she goes shopping and purchased the other pain medication by error instead of usual pain medication. The resident indicated that he/she takes the medication as needed. Discussion held with RN #113 who indicated that she was not aware that resident #032 had a pain medication in his/her bedroom nor was she aware the resident was taking that medication.

Resident #032s' health care record was reviewed and no physician order was found for the medication. RN #113 indicated that she will have a discussion with resident #032 and notify the physician. [s. 131. (5)]

Issued on this 1st day of June, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMANDA NIXON (148), LINDA HARKINS (126), RUZICA SUBOTIC-HOWELL (548)
Inspection No. / No de l'inspection :	2016_200148_0011
Log No. / Registre no:	011658-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 26, 2016
Licensee / Titulaire de permis :	CITY OF OTTAWA Long Term Care Branch, 275 Perrier Avenue, OTTAWA, ON, K1L-5C6
LTC Home / Foyer de SLD :	GARRY J. ARMSTRONG HOME 200 ISLAND LODGE ROAD, OTTAWA, ON, K1N-5M2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Dean Lett

To CITY OF OTTAWA, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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 LTCHA, 2007, S.19 (1) to ensure resident # 041 is protected from sexual abuse.

The licensee shall ensure the plan includes:
1) Interventions that will protect resident # 041 from sexual abuse from resident # 033 by updating the plan care of care of both residents to ensure clear directions are provided to staff.
2) Development and the implementation of a monitoring process to ensure:
a) The person who had reasonable ground to suspect abuse of a resident that resulted in harm or risk of harm immediately reports the suspicion to the Director,
b) That the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence,
c) That every alleged, suspected or witnessed incident of abuse that the licensee is aware of is immediately investigated
3) The licensee shall ensure that staff are educated and understand the definition of resident abuse particularly sexual abuse.
4) The licensee shall ensure that the management/staff understand the meaning of consent (whether the complainant had the capacity to provide consent and whether consent was actually provided), regardless of the relationship status of the residents involved and develop a process to ensure concerns related to consent are brought forward and discussed with the health care team.
5) Develop and implement measures to ensure protection of resident as per the home abuse policy(Abuse 750.65)
6) The plan should also identify who is responsible for ensuring completion of each item above and to monitor compliance with abuse.

This plan must be submitted in writing by June 2, 2016, to Amanda Nixon, LTCH Inspector Nursing at 347 Preston St., 4th floor, Ottawa ON K1S 3J4 OR by fax at 1-613-569-9670.

Grounds / Motifs :

1. The licensee had failed to ensure that resident #041 was protected from sexual abuse by resident #033.

In accordance with O. Regs 2. (1) (b), sexual abuse is define 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.

On April 28, 2016, Inspector # 126 reviewed the health care record of resident #033 including progress notes for the period of approximately four months, as it related to a triggered Quality of Care and Quality of Life Indicators (QCLI) identified in the Resident Quality Inspection (RQI). In a progress note on a specified date, the Manager of Resident Care (MRC) documented that she spoke to resident #033 to reinforce co-resident #041's message that resident #041 no longer wished for resident #033 to touch him/her. Resident #033 indicated understanding. As the progress notes were reviewed for resident #033 and resident #041, it was noted that several incidents of a sexual nature occurred involving resident #033 touching resident #041.

On April 28, 2016, Inspector #126 discussed the above incidents with the Acting Administrator who indicated that he was aware of these incidents between resident #033 and resident #041. He indicated that the two residents had a relationship and that they consented to the touching. He indicated that the management team provided support to resident #041 and resident #041's Power of Attorney to ensure the relationship between the two residents was acceptable. Inspector #126 inquired why resident #041's POA was involved and he indicated that resident #041 made the POA aware of everything that was going on.

On April 29, 2016, Inspector #126 interviewed the MRC, who indicated that she discussed the relationship with both residents and to her interpretation they both had capacity to make these personal decisions and that this relationship was consensual. She also indicated that resident #041 was not always that clear; sometimes resident #041 would say one thing and then the next time resident #041 would denied that something happened. Earlier in 2016, the MRC documented in the Unit Daily Record that both resident's were consenting to the touching. The MRC indicated that a meeting was held with resident #041 and POA. She indicated that post meeting, a Critical Incident was be submitted and that the police force were notified.

On April 29, 2016, Inspector #126 interviewed resident #041 and his/her POA. The Power Of Attorney (POA) in this case is for care and finance and was visiting because there was a meeting with Management that afternoon to discuss the incidents between resident #041 and resident #033. Resident #041

indicated that he/she no longer wanted to be touched by resident #033. The POA indicated that he/she did not think that resident #041 had any previous sexual relationships. The POA also indicated that at some unknown date, resident #041 had called him/her to get a new type of pyjama that would not allow resident #033 to touch resident #041. Inspector #126 discussed with resident #041 that residents are allowed to have a relationship in the home but where there is sexual activity, each resident needs to give consent to each activity, each time. Resident #041 repeated again, that he/she no longer wanted to be touched by resident #033. Inspector # 126 asked resident #041 if he/she enjoyed sitting at the same table of resident #033 for meals and resident #041 stated that it is ok because they like to talk.

Resident #033 is alert and oriented and mobilizes independently with a wheelchair. Resident # 033 is able to make decisions related to personal care and finance.

Resident # 041 is alert and oriented and ambulates independently. Resident #041's POA is involved in the decisions related to personal care and finances. In a consultation in 2015, a physician described the clinical picture of resident #041 as being a person who was very quiet and polite, who kept a kind smile on his/her face and was difficult to read how he/she felt. The physician noted that the resident never spoke spontaneously during the interview, answering the questions with simple conventional phrases/sentences. The physician also noted that the resident's POA was very involved and was the person who speaks for the resident.

On a specified date, just before supper, Resident #041 approached RPN #114 and informed her that resident #033 continued to touch him/her even if he/she said no. Resident #041, also told her that he/she may have to change pyjama style because it was easy for resident #033 to put his/her hands inside while he/she is laying down.

RPN #114 did not report that discussion until three days later, when she sent an email to the Manager of Resident Care.
In response to a call from the MRC, RN #135 came to the unit to discuss the report with the RPN and resident #041. As per the progress notes, RN #135 went to resident #041's room and resident #041 told her that three days ago, resident #033 touched him/her from his/her chest to his/her genital area and when resident #041 told resident #033 to stop, resident #033 did not listen.

Resident #041 did not want to give more details but stated he/she did not want to be touched by resident #033 anymore. RN #135 documented that resident #041 did not want to call the police and that she notified the Ministry of Health and Long Term Care.

Two days later, the Acting Administrator and the MRC met with resident #041 to discuss the above reports. The MRC documented that resident #041 stated that when resident #041 told resident #033 to stop, he/she did . Resident #041 stated he/she told resident #033 that he/she no longer wanted to have intimate relations. Resident #033 had not touch him/her since.

Nineteen days after the Acting Administrator and MRC spoke with resident #041, PSW #137 reported to RPN #114 that resident #033 was touching resident #041 on his/her stomach. Resident #041 was approached by RPN #114 and RN #131, resident #041 denied that he/she had been touched by the resident #033.

Sixteen days after the above witnessed incident by PSW #137, resident #041 approached RPN #114 to report that resident #033 continues to touch him/her, that he/she does not want the touching and he/she does not know how to tell resident #033 to stop. Resident #041 added that his/her POA was aware. RPN #114 notified RN #131who came to the unit. RN #131 discussed with resident #041 who stated that resident #033 was touching him/her and that he/she wanted resident #033 to stop. Resident #041 reported that he/she was lying on the couch, when resident # 033 came to touch him/her as usual. Resident #041 stated that resident #033 does not know when to quit. Resident #041 stated that he/she has never felt ok with being touched. Resident #041 also stated that he/she did not ask resident #033 to stop when resident #33 started to touch him/her and that resident #033 did not stop when he/she told resident #033 to stop. Resident #041 stated he/she did not want to be touched anymore and that he/she did not want to have resident #033 come to his/her room anymore.

Interviews were held with RNs, RPNs and PSWs between May 2 and May 6, 2016, by Inspector #126. Staff indicated to the Inspector, that they had concerns of the relationship between the two residents. They felt the level of cognition was different between the two, as resident #033 was aware of what was going on and that they didn't think that resident #041 really understood. They indicated that they were directed by the Manager of Resident Care to treat both residents has capable, that the residents had a consensual relationship and that touching

was consensual.

In the current plan of care for resident #041, it was indicated that resident #041 has personal and intimate relations with resident #033. Resident #041 has expressed consent and that he/she will let resident #033 know if it bothers him/her. Resident #041 is now in the process of breaking up this relationship with resident #033, previously had intimate relationship. Resident #041 does not want to be touched by resident #033 anymore.

In the current plan of care for resident #033, it was indicated that resident #033 has personal and intimate relations with resident #041. Resident had expressed consent that he/she feels that it calms his/her friend.

As of a specified date, resident #041 clearly indicated to staff that he/she no longer wanted to be touched by resident #033. No interventions were developed, implemented or documented in the plan of care to ensure protection of resident #041 from resident #033. Staff indicated that they were just observing the situation and no documentation was required.

The inspection demonstrates that resident #041 expressed to Registered Staff that he/she no longer wanted to be touched by resident #033. Resident #041 was not protected from sexual abuse from resident #033. Consent was not provided by resident #041, therefore legislative requirements (s.24, r.98) and abuse policy were not complied with (s.20). [s. 19. (1)] (126)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 11, 2016

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 26th day of May, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : AMANDA NIXON

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