Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Aug 25, 2016;	2016_280541_0014 (A1)	011701-16	Resident Quality Inspection

Licensee/Titulaire de permis

2109577 ONTARIO LIMITED
195 Forum Drive Unit 617 MISSISSAUGA ON L4Z 3M5

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

2109577 ONTARIO LIMITED O/A ARBOUR HEIGHTS
564 Tanner Drive KINGSTON ON K7M 0C3

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

AMBER LAM (541) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance date for Compliance Order #003 has been extended to October 31, 2016.

Issued on this 25 day of August 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

AMBER LAM (541) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): May 3-13, 2016

Three critical incident, seven complaint and three follow-up inspections were conducted concurrently with this RQI. The critical incidents were identified as follows: #2982-000036-15 (a complaint regarding resident care), #2982-000035-15 (a medication incident) and #2982-000013-16 (an alleged staff to resident abuse). The complaint inspections are identified as follows: Log #035580-15 (concerns regarding resident care), log #000026-16 (alleged resident to resident abuse), log #001448-16 (concerns re: resident rights), log #004816-16 (concerns re: availability of bathing supplies), log #009803-16 (concerns re: POA notification), log #011246-16 (concerns regarding resident care). In addition, three compliance orders were followed up: CO#001 related to infection control, CO #002 related to safe transferring, and CO #001 related to duty to protect.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Clinical Nurse Manager (CNM), Registered Nurses, Registered Practical Nurses, Personal Care Providers (PCPs), Dietary Aides, Family and Resident Council President's and Residents. In addition, the inspectors reviewed resident health care records, conducted a tour of the home, observed resident meal service and reviewed relevant policies.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Sufficient Staffing

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

- **4 WN(s)**
- **0 VPC(s)**
- **3 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
O.Reg 79/10 s. 229. (4)	CO #001	2015_280541_0041	622
O.Reg 79/10 s. 36.	CO #002	2015_280541_0041	197

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, has the resident been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

During the stage one observations, the inspectors noted the majority of residents utilized two quarter bed rails at all times. Residents #013, #022 and #026 health care records were reviewed and observations were made. The quarter bed rails for these three residents were observed to be used daily.

Inspector #541 asked for the home's policy for bed rails and inspector was provided with policy # RCSM-E-05 "Bed Rails". The policy indicated all residents are assessed for the need of raised quarter bed rails on admission and the assessment is to be documented in the resident electronic chart. The policy further indicated the care plan would reflect the need for bed rails.

Inspector interviewed the home's DOC who indicated an assessment for use of quarter rails for could be found in the resident's progress notes or in the care plan.

Resident #013, #022 and #026's progress notes were reviewed and there were no assessments for the use of bed rails. Resident #013, #022 and #026's current care plans were reviewed and there was no documentation indicating the use of bed rails.

Inspector #541 requested the home's assessment of the resident bed system including any steps to prevent bed entrapment. The home's DOC informed Inspector #541 that the home has not completed bed safety assessments. [s. 15. (1) (a)]

Additional Required Actions:

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

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

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Resident #007 was identified as requiring assistance to maintain continence and has significant cognitive impairment.

Resident #007's most recent continence Resident Assessment Protocol (RAP) completed on a specified date indicates resident requires extensive assistance from two + persons for toilet use and personal hygiene. The RAP further indicates resident #007 is frequently incontinent and is totally dependent on staff for toileting needs.

Resident #007's plan of care effective on a specified date was reviewed on May 5, 2016. Under the focus for Toileting, the plan of care states the following:
- SELF PERFORMANCE: Resident requires LIMITED ASSISTANCE. Provide supervision and physical assistance.
- SUPPORT PROVIDED: one person physical assist.

PCP #115 indicated in an interview with Inspector #541 that resident #007 often requires two staff persons for assistance with care, especially if the resident is agitated or upset. PCP #136 indicated that resident #007 responds better to caregivers of a specific gender therefore the PCP #115 can typically get the care provided alone however indicates the other staff have more difficulty and more often than not resident #007's care requires two PCPs.

Resident #007's point of care (POC) documentation was reviewed on May 5, 2016 for the previous 14 days. On most days, resident #007 required total assistance by two staff members for toileting.

Resident #007's plan of care does not provide clear direction to staff related to the assistance required for toileting. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

On a specified date, resident #016 fell. RPN # 126 documented in the post-fall assessment that the resident was found beside the toilet sitting by the wall, moaning in pain.

When interviewed, RPN #126 indicated she was called over from another unit because the regular RPN on this unit was on break at the time of the fall. She said that one of the PCPs working was asking why the resident had been left unattended on the toilet. The PCP who left the resident on the toilet unattended never informed RPN #126 why the resident had been left. The resident sustained an injury as a result of the fall.

The care plan in place at the time of the resident's fall indicates the following related to toileting:
- requires extensive assistance for entire process, one person physical assist

The regular RPN on the unit, #109, was interviewed on May 6, 2016 and stated that Resident #016 should not have been left unattended due to the resident's risk for falls.

An interview with the DOC on May 10, 2016 confirmed that the expectation would have been for the PCP to remain with the resident throughout the toileting process.

Therefore, care was not provided to resident as specified in the plan of care.

Resident #024 had a fall on a specified date. RPN #027 was informed that someone was on the floor and a post-fall assessment was completed by the same RPN. Resident #024 stated to the RPN that he/she fell, hit his/her head. The RPN noted redness and a small bump on the back of the resident's head.

The current care plan in effect at the time of the fall for resident #024 includes the following related to falls:
- high risk for falls characterized by history of falls/ injury, multiple risk factors related to the resident's diagnosis
- fall prevention alarm in place in resident's bathroom for safety

On specified dates the resident's fall prevention alarm was observed and the following was found:
- On a specified date and time the resident's alarm was noted not to be working and appeared to be turned off. RPN #112 was called to the resident's room and switched a button on the side of the alarm. A green light started to flash periodically and when tested the alarm did sound.
- On another specified date and time the resident's fall prevention alarm was noted to be turned off.
- On a specified date and time the resident's fall prevention alarm was noted to be turned off. At this time RPN #027 was called to the resident's room and turned the fall prevention alarm on. The RPN indicated to the inspector that this alarm should remain on at all times since the resident has been known to toilet him/herself and is at high risk of falls.

Therefore, the care set out in resident #024's plan of care related to falls was not provided to the resident as specified in the plan.

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

A Compliance Order #001 was issued in March 15, 2016 (Inspection # 2016_28054_0006) under LTCHA 2007 s. 19 Duty to Protect. The licensee failed to comply with the order to "educate all staff on how to identify and report resident to resident sexual abuse."

The licensee's plan to comply with CO #001 included the following related to staff education on how to identify resident to resident sexual abuse:
- Development of Intimacy and Sexuality policy – to include algorithm for determining consent
- Education to all staff on Intimacy and Sexuality policy
- Discussion on sexuality and intimacy with Resident's Council and Family Council

The licensee developed policy #RCSM-G-15 titled "Sexuality and Intimacy" effective April 2016. This policy provides direction to staff to determine if a resident is capable to consent to sexual activity.

O. Reg 79/10 s. 2(1)b defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a person other than a licensee or staff member.
Policy #RCSM-G-15 is not referenced in the home's policy to promote zero tolerance of abuse (#ADM-VI-06).

On page 5, the "Sexuality and Intimacy" policy states the following:
"Consent to sexual expression between two residents is implied and therefore presumed to be professionally acceptable when neither resident protests, even if cognitively impaired. This applies to residents who are able to object by either words or behaviors for other things they do not want such as personal care".

The policy further states: "it is important that staff observe, monitor situations and assess levels of sexual behavior to determine if interventions are necessary for the resident's well-being."

On page 5, under the heading "Capacity to Consent", the "Sexuality and Intimacy" policy states:
"Residents who have a CPS score of 0-2 are considered to be cognitively capable of giving consent to sexual activity as long as the resident is able to demonstrate their understanding of basic information regarding the sexual relationship or interaction, is able to appreciate consequences of the decision, is able to communicate and express a choice and is able to withdraw consent at any time".

Resident #008 was identified by the home as having sexual behaviors towards co-residents. Resident #008's progress notes were reviewed.

On a specified date it was documented that resident #008 was kissing three co-residents' on the cheek (residents #007, #045 and #057). Resident #045 was noted to say "don't do that", staff intervened and the residents' were easily re-directed. The registered staff member assessed the situation as "resident seeking friendship", and no further interventions or actions were taken.

On a specified date resident #008 was observed kissing resident #058 in the hallway. Both residents were engaged and not easily redirected. PCP #134 had to physically intervene before residents would stop with verbal redirection. No distress noted by either resident.

On a specified date, resident #008 was being redirected out of the tv room by staff when the resident walked up to resident #007 and kissed the resident on the mouth. Both residents assessed as smiling and not distressed.

On a specified date, resident #008 was noted to stop a resident (not identified) in the hallway and kiss the resident on the lips, staff redirected resident and was effective. Progress note indicates no distress by either resident.

On May 11, 2016 PCP #135 was interviewed by Inspector #541. When asked what action is taken when residents are witnessed kissing, she stated that the residents would be separated. When asked if residents noted above could consent to this type of behavior, PCP #135 stated she did not think any of the residents noted above could consent to any behavior that is sexual in nature.

RPN #116 was interviewed by Inspector #541 on May 11, 2016. When asked by inspector how she determines if a resident can consent to sexual activity, RPN #116 stated "if the resident has a CPS above 3 they cannot consent". RPN #116 further stated that none of the residents noted above would be capable of consenting to sexual activity. When asked what action is taken if sexual behavior is witnessed between two residents, RPN #116 stated it would depend on the activity and that if it was assessed as being a "greeting" then it would not be sexual in nature.

The home has failed to educate staff how to appropriately identify resident sexual abuse in manner that is compliant with O. Reg 79/10 s. 2(1) b. There were 4 documented incidents where resident #008 was noted to kiss co-residents. PCP #135 and RPN #116 both informed Inspector #541 during interviews that no resident on this unit was capable of consenting to any sexual activity. Each time resident #008 was witnessed to kiss co-residents, the situation was deemed to be consensual and no further action was taken.

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 003

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

O. Reg 79/10 s. 2(1)b defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a person other than a licensee or staff member.

Resident #008 was identified by the home as having sexual behaviors towards co-residents. Resident #008's progress notes were reviewed and the following was noted:

On May 6, 2016 it was documented that resident #008 was kissing three co-residents' on the cheek (residents #007, #045 and #057). Resident #045 was noted to say "don't do that", staff intervened and the residents' were easily re-directed. The registered staff member assessed the situation as "resident seeking friendship", and no further interventions or actions were taken.

Resident #008 non-consensually kissed resident #045 who demonstrated this action was unwanted by stating "no don't do that."

The Critical Incident System was reviewed and the licensee did not submit a Critical Incident to notify the Ministry of Health and Long-Term Care for the alleged abuse that occurred between resident #008 and resident #045 on May 6, 2016. [s. 24. (1)]

Issued on this 25 day of August 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : AMBER LAM (541) - (A1)

Inspection No. / No de l'inspection : 2016_280541_0014 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 011701-16 (A1)

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

Report Date(s) / Date(s) du Rapport : Aug 25, 2016;(A1)

Licensee / Titulaire de permis :
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195 Forum Drive, Unit 617, MISSISSAUGA, ON, L4Z-3M5

LTC Home / Foyer de SLD :
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564 Tanner Drive, KINGSTON, ON, K7M-0C3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Christine Sellery

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To 2109577 ONTARIO LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee is hereby ordered to complete a documented assessment for each resident that utilizes bed rails and evaluate his or her bed system in accordance with evidence-based practices to minimize risk to the residents by:

-taking steps to prevent resident entrapment, taking into consideration all potential zones of entrapment, and
-other safety issues related to the use of bed rails are addressed, including height and latch reliability.

Ontario

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used, has the resident been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

During the stage one observations, the inspectors noted the majority of residents utilized two quarter bed rails at all times. Residents #013, #022 and #026 health care records were reviewed and observations were made. The quarter bed rails for these three residents were observed to be used daily.

Inspector #541 asked for the home's policy for bed rails and inspector was provided with policy # RCSM-E-05 "Bed Rails". The policy indicated all residents are assessed for the need of raised quarter bed rails on admission and the assessment is to be documented in the resident electronic chart. The policy further indicated the care plan would reflect the need for bed rails.

Inspector interviewed the home's DOC who indicated an assessment for use of quarter rails for could be found in the resident's progress notes or in the care plan.

Resident #013, #022 and #026's progress notes were reviewed and there were no assessments for the use of bed rails. Resident #013, #022 and #026's current care plans were reviewed and there was no documentation indicating the use of bed rails.

Inspector #541 requested the home's assessment of the resident bed system including any steps to prevent bed entrapment. The home's DOC informed Inspector #541 that the home has not completed bed safety assessments.

The scope of the non-compliance was determined to be widespread as the majority of the residents in the home use quarter bed rails. The risk of the non-compliance was determined to be a potential for risk. It is noted the home was issued a voluntary plan of correction (VPC) January 2016 (Inspection #2015_280541_0041). (541)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Sep 30, 2016

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that interventions and care related to falls prevention are provided to residents #016 and #024 as specified in their plans of care.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

On a specified date, resident #016 fell. RPN # 126 documented in the post-fall assessment that the resident was found beside the toilet sitting by the wall, moaning in pain.

When interviewed, RPN #126 indicated she was called over from another unit because the regular RPN on this unit was on break at the time of the fall. She said that one of the PCPs working was asking why the resident had been left unattended on the toilet. The PCP who left the resident on the toilet unattended never informed RPN #126 why the resident had been left. The resident sustained an injury as a result of the fall.

The care plan in place at the time of the resident's fall indicates the following related to toileting:
- requires extensive assistance for entire process, one person physical assist

The regular RPN on the unit, #109, was interviewed on May 6, 2016 and stated that Resident #016 should not have been left unattended due to the resident's risk for falls.

An interview with the DOC on May 10, 2016 confirmed that the expectation would have been for the PCP to remain with the resident throughout the toileting process.

Therefore, care was not provided to resident as specified in the plan of care.

Resident #024 had a fall on a specified date. RPN #027 was informed that someone was on the floor and a post-fall assessment was completed by the same RPN. Resident #024 stated to the RPN that he/she fell, hit his/her head. The RPN noted redness and a small bump on the back of the resident's head.

The current care plan in effect at the time of the fall for resident #024 includes the following related to falls:
- high risk for falls characterized by history of falls/ injury, multiple risk factors related to the resident's diagnosis
- fall prevention alarm in place for safety

On specified dates the resident's fall prevention alarm was observed and the following was found:
- On a specified date and time the resident's alarm was noted not to be working and appeared to be turned off. RPN #112 was called to the resident's room and switched a button on the side of the alarm. A green light started to flash periodically and when tested the alarm did sound.
- On another specified date and time the resident's alarm was noted to be turned off.

- On a specified date and time the resident's alarm was noted to be turned off. At this time RPN #027 was called to the resident's room and turned the fall prevention alarm on. The RPN indicated to the inspector that this fall prevention alarm should remain on at all times since the resident has been known to toilet him/herself and is at high risk of falls.

Therefore, the care set out in resident #024's plan of care related to falls was not provided to the resident as specified in the plan.

A compliance order is warranted as although the scope of this non-compliance was determined as isolated, the severity level was determined to be actual harm as both residents were injured as a result of the fall. In addition, the home was issued Written Notification (WN) under LTCHA s.6(7) for not following a residents plan of care related to falls in February 2015. (541)

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

Jul 04, 2016

Order # /
Ordre no : 003

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

Linked to Existing Order /
Lien vers ordre existant: 2016_280541_0006, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all staff are educated on how to identify resident to resident sexual abuse in a manner that ensures compliance with the definition of sexual abuse as per O. Reg 79/10 s. 2(1)b.

The plan shall be submitted by June 27, 2016 to Amber Moase via fax at 613-
569-9670.

Grounds / Motifs :

1. A Compliance Order #001 was issued in March 15, 2016 (Inspection # 2016_28054_0006) under LTCHA 2007 s. 19 Duty to Protect. The licensee failed to comply with the order to "educate all staff on how to identify and report resident to resident sexual abuse."

The licensee's plan to comply with CO #001 included the following related to staff education on how to identify resident to resident sexual abuse:
- Development of Intimacy and Sexuality policy – to include algorithm for determining consent
- Education to all staff on Intimacy and Sexuality policy
- Discussion on sexuality and intimacy with Resident's Council and Family Council

The licensee developed policy #RCSM-G-15 titled "Sexuality and Intimacy" effective April 2016. This policy provides direction to staff to determine if a resident is capable to consent to sexual activity.

O. Reg 79/10 s. 2(1)b defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a person other than a licensee or staff member.
Policy #RCSM-G-15 is not referenced in the home's policy to promote zero tolerance of abuse (#ADM-VI-06).

On page 5, the "Sexuality and Intimacy" policy states the following:
"Consent to sexual expression between two residents is implied and therefore presumed to be professionally acceptable when neither resident protests, even if cognitively impaired. This applies to residents who are able to object by either words or behaviors for other things they do not want such as personal care".

The policy further states: "it is important that staff observe, monitor situations and assess levels of sexual behavior to determine if interventions are necessary for the resident's well-being."

On page 5, under the heading "Capacity to Consent", the "Sexuality and Intimacy" policy states:
"Residents who have a CPS score of 0-2 are considered to be cognitively capable of giving consent to sexual activity as long as the resident is able to demonstrate their understanding of basic information regarding the sexual relationship or interaction, is able to appreciate consequences of the decision, is able to communicate and express a choice and is able to withdraw consent at any time".

Resident #008 was identified by the home as having sexual behaviors towards co-residents. Resident #008's progress notes were reviewed.

On a specified date it was documented that resident #008 was kissing three co-residents' on the cheek (residents #007, #045 and #057). Resident #045 was noted to say "don't do that", staff intervened and the residents' were easily re-directed. The registered staff member assessed the situation as "resident seeking friendship", and no further interventions or actions were taken.

On a specified date resident #008 was observed kissing resident #058 in the hallway. Both residents were engaged and not easily redirected. PCP #134 had to physically intervene before residents would stop with verbal redirection. No distress noted by either resident.

On a specified date, resident #008 was being redirected out of the tv room by staff when the resident walked up to resident #007 and kissed the resident on the mouth. Both residents assessed as smiling and not distressed.

On a specified date, resident #008 was noted to stop a resident (not identified) in the

hallway and kiss the resident on the lips, staff redirected resident and was effective. Progress note indicates no distress by either resident.

On May 11, 2016 PCP #135 was interviewed by Inspector #541. When asked what action is taken when residents are witnessed kissing, she stated that the residents would be separated. When asked if residents noted above could consent to this type of behavior, PCP #135 stated she did not think any of the residents could consent to any behavior that is sexual in nature.

RPN #116 was interviewed by Inspector #541 on May 11, 2016. When asked by inspector how she determines if a resident can consent to sexual activity, RPN #116 stated "if the resident has a CPS above 3 they cannot consent". RPN #116 further stated the residents noted above, would not be able to consent. When asked what action is taken if sexual behavior is witnessed between two residents, RPN #116 stated it would depend on the activity and that if it was assessed as being a "greeting" then it would not be sexual in nature.

The home has failed to educate staff how to appropriately identify resident sexual abuse in manner that is compliant with O. Reg 79/10 s. 2(1) b. There were 4 documented incidents where resident #008 was noted to kiss co-residents. PCP #135 and RPN #116 both informed Inspector #541 during interviews that no resident on this unit was capable of consenting to any sexual activity. Each time resident #008 was witnessed to kiss co-residents, the situation was deemed to be consensual and no further action was taken.

In addition the licensee failed to comply with LTCHA 2007 s. 24(1) by not reporting an incident of alleged resident to resident sexual abuse to the Director. (As per WN #004)

As a result of the education provided to front line staff, residents are at risk of being sexually abused.
(541)

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

Oct 31, 2016(A1)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l’inspecteur

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 25 day of August 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : AMBER LAM - (A1)

Service Area Office /
Bureau régional de services : Ottawa