Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 24, 2022	2022_595110_0006	000986-22, 001036-22	Critical Incident System

Licensee/Titulaire de permis

Mon Sheong Foundation
36 D'Arcy Street Toronto ON M5T 1J7

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

Mon Sheong Stouffville Long-Term Care Centre
162 Sandiford Drive Stouffville ON L4A 0V6

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

DIANE BROWN (110)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 4, 7, 8, 9, 2022.

The following intake was completed in this Critical Incident System (CIS) inspection:
Log #000986-22 - Follow-up to Order from Inspection 2021_947752_0008 related to Infection Prevention and Control practices in the home.
Log # 001036-22 - Related to allegations of resident to resident sexual abuse.

During the course of the inspection, the inspector(s) spoke with Administrator, Resident Care Team Leads, Registered Dietitian, Social Services Coordinator, Registered Practical Nurse, Personal Support Workers, residents.

During the course of the inspection, the inspector toured the home, observed infection prevention and control practices, meal and nourishment service, education records, audits, staff to resident interactions, health records and relevant plocies

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 VPC(s)**
- **0 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	2021_947752_0008	110

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

A Critical Incident Systems (CIS) report inspection was completed related to resident #001 and incidents of non consensual sexual behavior towards co-residents.

The resident had a psychiatrist consultation and the consultation report directed staff to encourage identified behavioral strategies. A review of the resident's plan of care, food and fluid intake records along with interviews with the Registered Dietitian and Resident Care Team Lead (RCTL) confirmed the lack of collaboration between the psychiatrist recommendations and the dietary department. The resident had two further incidents of inappropriate sexual behavior.

The resident had a follow-up psychiatrist consultation that acknowledged the resident's recent inappropriate sexual behaviors. The report plan included directing registered staff, if the sexual behaviors continued, despite behavioural interventions, to inform the psychiatrist for reassessment as medications can be used to manage sexual behaviors. A record review and interview with RCTL confirmed that the psychiatrist had not been contacted after a further incident of inappropriate sexual behavior.

Sources: psychiatrist consultation reports, Progress notes and written plan of care. Point click care food and fluid intake records, interview with Registered Dietitian #107 and

Resident Care Team Lead #106. [s. 6. (4) (a)]

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

A Critical Incident Systems (CIS) report inspection was completed related to resident #001 and incidents of non consensual sexual behavior towards residents including resident #004.

Resident #001 had an incident of a non consensual sexual behavior towards resident #004, then a few days later towards residents #002 and #003. Interventions were implemented.

A few weeks later a record review and an interview with resident #004 revealed another incident where resident #001 displayed non consensual sexual behavior towards them. The resident disclosed to the Inspector they felt assaulted by resident #001. Resident Care Team Lead (RCTL) revealed an identified intervention was not in place, at the time of incident, as required by the resident's plan of care.

Sources: Resident interview, progress notes, interviews with PSW #102, #101, RPN #105 and RCTL #108. [s. 6. (7)]

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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other and the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 failed to ensure that resident #004 was protected from sexual abuse by resident #001.

Section 2 (1) of the Ontario Regulation 79/10 defines sexual abuse as any non-consensual touching, behavior or remark of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

During a Critical Incident Systems (CIS) report inspection related to resident #001's sexual abuse towards residents #002 and #003 two sexual incidents were also discovered by resident #001 towards resident #004.

Following resident #001's sexual behaviors towards resident #004, staff described resident #004 in a manner that revealed a significant negative impact.. An interview with resident #004 confirmed they felt assaulted by resident #001 and described their associated distress.

The resident #004's cognitive performance scale was one, or no cognitive impairment.

Failure to protect resident #004 from sexual abuse resulted in them being emotionally harmed and frightened by resident #001.

Sources: Resident #001s progress notes psychiatrist assessment ; Interviews with resident #004, Resident Care Team Leads #106, #108, PSWs #100, #101, #102, #104, RPN #105. [s. 19. (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 residents are protected from sexual abuse, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that an alleged abuse of a resident by anyone that resulted in harm or a risk of harm to the resident was immediately reported to the Director.

During a Critical Incident Systems (CIS) report inspection related to resident #001 two incidents of unreported sexual abuse were identified towards resident #004. During an interview with resident #004 they disclosed they felt assaulted by resident #001 and continued to feel afraid. A record review and staff interviews also identified the residents family expressed concerns over the incidents and the negative emotional impact to the resident.

An interview with RCTL #106 confirmed that a CIS report had not been submitted to the Director alleging sexual abuse of resident #001 towards resident #004.

Sources: Resident #001s progress notes psychiatrist assessment. Interviews with resident #004, Resident Care Team Leads #106, #108, PSWs #100, #101, #102, #104, RPN #105. [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 an alleged abuse of a resident by anyone that resulted in harm or a risk of harm to the resident was immediately reported to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
6. Psychological well-being. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure there was a plan of care based on an interdisciplinary assessment of the resident that includes psychological well-being.

During a Critical Incident Systems (CIS) report inspection related to resident #001, two incidents of a non consensual sexual nature were identified towards resident #004.

After the first incident staff described examples of how resident #004 was feeling afraid and scared of resident #001.

An interview with resident #004 revealed they felt assaulted by resident #001 and continued to feel afraid. The resident stated since the incidents they have not been able to sleep well and even now felt unsafe.

The resident's cognitive performance scale was one, or no cognitive impairment.

A review of the resident's plan of care failed to include an assessment of the residents psychological well-being.

Sources: written plan of care, interview with PSWs #104, #100, #101, RPN #105. Resident interview. [s. 26. (3) 6.]

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 there was a plan of care based on an interdisciplinary assessment of the resident that includes psychological well-being, to be implemented voluntarily.

Issued on this 20th day of May, 2022

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

Original report signed by the inspector.