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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 16, 2015	2015_270531_0028	O-002880-15	Critical Incident System

Licensee/Titulaire de permis

BELCREST NURSING HOMES LIMITED
250 Bridge Street West BELLEVILLE ON K8P 5N3

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

Belmont Long Term Care Facility
250 Bridge Street West BELLEVILLE ON K8P 5N3

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

SUSAN DONNAN (531)

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): October 9 and Oct 13, 2015

During the course of the inspection, the inspector(s) spoke with the resident, Personal Support Workers, Registered Practical Nurses, Registered nurses, the Assistant Director of Care, the Director of Care and the Administrator. The inspector(s) also toured the home, observed residents' care and services, reviewed resident health care records and reviewed relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **1 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 has failed to comply with the LTCH Act 2007, c. 8, s. 19(1) whereby a resident was not protected from sexual abuse.

Under O. Reg. 79/10, sexual abuse is defined as "any non-consensual touching, behaviours or remarks of a sexual nature or sexual exploitation directed towards a resident by a person.

On a specified date, a critical incident report was submitted to the Ministry of Health and Long Term Care by the licensee reporting a staff to resident alleged sexual abuse.

A review of the resident's health care record and Critical Incident #901-000035-15 for resident #001 indicated that the resident has multiple comorbidities.

The critical incident was described as follows:
On a specified date, a complaint was received from resident #001 that PSW #101 was "rough". The Director was notified by RPN #102 via pager #10264 and she contacted the Director of Care for further instructions.
A subsequent investigation by the Assistant Director of Care (ADOC) and the Director of Care (DOC) was commenced the following day, during which resident #001 made allegations of sexual assault against PSW #101 who was suspended that same day. The police were notified two days later. PSW #101 was arrested and charged with sexual assault following their interview with resident #001.

Resident #001 was interviewed by inspector #531 on a specified date; although the resident was initially hesitant he/she confirmed that PSW #101 was "rough" with him/her when providing care. Resident #001 told the inspector that PSW #101 should not be allowed to be alone in the tub room or bathroom with residents when providing care. The resident further shared that PSW #101 was rough and in a hurry to take off his/her clothes, when washing his/her outer body and that he/she inserted his/her hand inside of his/her a particular body part. Resident #001 indicated that this happened on more than one occasion and that when he/she asked PSW #101 to stop, he/she swore at him/her and told resident #001 that he/she wanted to ensure that resident #001 was clean on the inside and out. Resident #001 explained that although he/she reported his/her concern to his/her spouse he/she was afraid to tell anyone else as he/she was fearful PSW #101 would become upset and the "rough care" would increase. Resident #001 indicated that PSW #101 came to him/her one evening and ask resident #001 not to report him/her as he/she may lose his/her job. Resident #001 told inspector #531 that PSW #101 always bathed him/her and that it got so he/she hated bath days. Resident #001 indicated that he/she had reported the rough treatment to the "head nurse" and the police.

Inspector #531 interviewed PSW #100 on a particular date, and was told that on the day of the incident while settling resident #001 for his/her afternoon rest, resident #001 asked if PSW #101 was working that afternoon, adding that PSW #101 was rough. PSW #100 indicated that he/she immediately reported the incident to RPN #102 as resident #001 appeared "concerned" and had identified the PSW by name. PSW #100 told inspector #531 that he/she told resident #001 that he/she would "tell the nurse in charge". PSW #100 advised the inspector that PSW #101 was scheduled to work that evening.

RPN #102 confirmed that the information was reported by PSW #100. The RPN advised that he/she contacted the Director of Care (DOC) immediately to ask if the incident "needed to be reported to the "Director"; the Director of Care (DOC) provided the following instructions:
-examine resident #001 for injuries
-request PSW #100 document her communication with resident #001
-notify the "Director"
-if there were no injuries upon examination of resident #001 the Director of Care would investigate the next day.
-if there were no injuries upon examination of resident #001 then PSW #101 would be allowed to work his/her scheduled shift and regular assignment which included resident #001.
RPN #102 told the inspector that the DOC also instructed that staff provide care to residents in pairs.
RPN #102 told the inspector that he/she did report the allegation to RPN #108 (the RPN in charge that evening) and that the DOC had been contacted for instructions and was to commence an investigation the next morning.

In an interview on a particular date, the Assistant Director of Care (ADOC) acknowledged that she was made aware of the incident on the following morning when she received a hand written note from PSW #100 documenting his/her conversation with resident #001 regarding PSW #101 being rough. The ADOC stated that she immediately followed up with resident #001 who acknowledged his/her communication with PSW #100 and confirmed that PSW #101 was rough with him/her. The ADOC told inspector #531 that resident #001 was asked "how is he/she rough", does he/she hurt you?" to which resident #001 hesitantly responded that PSW #101" is always in a hurry to get your clothes off, all your clothes ; he/she is rough washing his/her private areas, he/she washes him/her then goes up inside of a particular body part with his/her hand and he/she is rough about it. Resident #001 advised the ADOC that this occurred more than once and when resident #001 asked him/her to stop he/she swore at her. Resident #001

advised the ADOC that he/she had told his/her spouse and he/she was going to speak to PSW #101. The ADOC indicated resident #001 told her that this had happened more than once and that it got so he/she hated his/her bath days but was afraid if he/she mentioned it that PSW #101's rough handling of him/her would increase. The ADOC confirmed that resident #001's spouse was not notified until later that day when he/she came into visit.

On a specified date RPN #108 was interviewed and indicated he/she was informed by RPN #102 that resident #001 reported that PSW #101 was rough and that the DOC would investigate the next day. RPN #108 indicated that he/she did not receive any further instructions with respect to care of resident #001 or monitoring of the staff.

During an interview on the same day, with PSW #109 he/she confirmed that he/she worked evenings with PSW #101 on the evening of the incident and cared for their regularly assigned residents. He/she indicated that they were not advised that resident care was to be delivered in pairs.

On a particular date PSW #100, 103, 109, 110, 111, 112, RPN # 104, 108, 102 and RN #106, and #107 confirmed with inspector #531 that they had been contacted by the DOC to inform them that there had been an allegation of sexual abuse and PSW #101 had been charged with sexual assualt; not to discuss the information outside of the home and if they had any information to please bring it forward to management or the police. The name of the resident (s) was not provided.

On the same day, the DOC confirmed :
-instructions provided to RPN #102
-investigation commenced the following day
-police were notified on two days later
-resident #001's care plan was not revised to include support of the resident
-staff had not been provided with the name of the resident(s)

The DOC confirmed that the Employee Assistance Program was contacted and was on site to assist staff involved in the alleged abuse, but the home had not provided any support of that nature to resident #001. The DOC confirms the name of the resident has not been released to staff and that she randomly monitors resident #001 for emotional support.

The licensee failed to protect resident #001 from abuse as evidenced by the following:

a)The licensee's Abuse Policy (ADM-VI-06) was not complied with (as identified in WN #2).
b)The licensee did not ensure that every alleged, suspected or witnessed incident of abuse by a resident was immediately investigated (as identified in WN#3)
c)The SDM of Resident #001 was not immediately notified of every alleged, suspected or witnessed incidents of abuse (as identified in WN #4).
d) The appropriate police force was not immediately notified of every alleged, suspected or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence (as identified in WN #6). [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 s. 20 (1) whereby the licensee did not ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A review of the resident's health care record and Critical Incident report #901-000035-15 for resident #001 indicated that the resident has multiple comorbidities. On a specified date a complaint was received from resident #001 that PSW #101 was "rough". The Director was notified by RPN #102 via pager #10264 and the home's Director of Care for further instructions.

A subsequent investigation by the Assistant Director of Care (ADOC) and the Director of Care (DOC) was the following day, during which resident #001 made allegations of

sexual assault against PSW #101.

A review of the home's abuse policy (ADM-VI-06 RCSM-L-10) indicates:
Procedure C: Detection and Protection:
#4. The nurse in charge, along with witness will question the alleged victim, the alleged assailant and document the information on the "initial abuse investigation form."
If after an initial investigation, abuse is suspected notification to the police is required immediately, as a delay could interfere with the initiation of a criminal investigation and prosecution.
•If abuse is caused by a staff member,the staff member will be suspended from duties immediately until an investigation is completed.

#10. The DOC/administrator must conduct an interview with the staff person suspected of abusing a resident. The appropriate form must be completed. If the suspected abuser is a staff person he or she must sign there written response to the allegation. (Suspect Statement in Abuse form) The witness must sign this form.

Page 11 Outcomes:
#2. All reports of alleged or actual abuse will be reported to the home and an investigation will be commenced immediately.

The incident of sexual abuse was not immediately investigated,(as in WN#3), the police (as in WN#6) and the SDM of the resident (as in WN#4) were not immediately notified.. The home's abuse procedures were not documented as per policy.

On a specified date during an interview with the Administrator and review of the home's abuse policy she indicated that the issue had been identified and there is a plan to develop an abuse process map. [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 the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCH 2007, s. 23 (1)(a)(i) whereby the licensee did not ensure that every alleged, suspected or witnessed incident of abuse was immediately investigated.

A review of the resident's health care record and Critical Incident report #901-000035-15 for resident #001 indicated that the resident has multiple comorbidities. On a specified date a complaint was received from resident #001 that PSW #101 was "rough". The Director was notified by RPN #102 via pager #10264 and the home's Director of Care for further instructions.

A subsequent investigation by the Assistant Director of Care (ADOC) and the Director of Care (DOC) was commenced the following day, during which resident #001 made allegations of sexual assault against PSW #101.

On particular date during an interview with PSW #100 she told the inspector that on the date of the incident while settling resident #001 for his/her afternoon rest, resident #001 inquired if PSW #101 was working that afternoon, and communicated to him/her that PSW #101 was rough. PSW #100 indicated that he/she immediately reported the incident to RPN #102 as resident #001 appeared "concern" and identified the PSW by name. PSW #100 confirmed that PSW #101 was schedule to be on duty that evening and he/she needed to inform RPN #102 of the incident before shift change.

During an interview with RPN #102 he/she confirmed that the information was reported to him/her by PSW #100. RPN #102 confirmed that he/she contacted the Director of Care to confirm if the incident "needed to be reported to the Director". RPN #102 confirmed that the Director of Care provided the following instructions:
-examine resident #001 for injuries
-request that PSW #100 document her communication with resident #001
-notify the director
-if there were no injuries that the DOC would investigate on the following day.
-if there were no injuries upon examination of resident #001 then there was no reason that PSW #101 should not be allowed to work his/her scheduled shift and regular assignment which included resident #001.

On a specified date, during and interview with the Administrator and the Director of Care they acknowledged the instructions provided to RPN #102 on the day of the incident and that the investigation was completed the following day. [s. 23. (1) (a)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10 s. 97. (1)(a) whereby resident #001's SDM was not immediately notified upon becoming aware of the alleged abuse.

A review of the resident's health care record and Critical Incident report #901-000035-15 for resident #001 indicated that the resident has multiple comorbidities. On a specified date, a complaint was received from resident #001 that PSW #101 was "rough". The Director was notified by RPN #102 via pager #10264 and the home's Director of Care for further instructions.

A subsequent investigation by the Assistant Director of Care (ADOC) and the Director of Care (DOC) was commenced on the following day, during which resident #001 made allegations of sexual assault against PSW #101.

Review of resident #001's health care record and critical incident report #901-000035-15 indicate that on a specified date resident #001 reported to PSW #100 that PSW #101 was rough with him/her. RPN #102 confirmed that she reported the incident to the Director after hours page and the home's Director of Care. RPN #102 indicated that she did not notify the SDM.

During an interview with the ADOC and the DOC they both confirmed that the SDM was notified on the following day . [s. 97. (1) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure 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. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s. 98 whereby the licensee did not ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence.

On a specified date, a Critical Incident Report was submitted to the Ministry of Health and Long Term Care by the home reporting a staff to resident alleged sexual abuse.

The incident was described as follows:
Received a complaint on a specified date from resident #001 that PSW #101 was "rough". Director notified via pager # 10264.
Upon investigation on the following date, resident #001 made allegations of sexual assault. PSW #101 was suspended pending investigation. Police were notified two days following the incident.

On a specified date during an interview with the Administrator and the Director of Care they confirmed that the police were notified two days following the incident. [s. 98.]

Issued on this 16th day of December, 2015

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN DONNAN (531)
Inspection No. / No de l'inspection :	2015_270531_0028
Log No. / Registre no:	O-002880-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 16, 2015
Licensee / Titulaire de permis :	BELCREST NURSING HOMES LIMITED 250 Bridge Street West, BELLEVILLE, ON, K8P-5N3
LTC Home / Foyer de SLD :	Belmont Long Term Care Facility 250 Bridge Street West, BELLEVILLE, ON, K8P-5N3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Denise Mackey

To BELCREST NURSING HOMES 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) (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 to include the development of strategies, interventions and protocols to ensure:

Every incident of alleged, suspected and or witnessed incident of abuse is immediately investigated in accordance with LTCHA 2007 s. 23.

The resident's SDM is immediately notified of every incident of alleged, suspected or witnessed incident of abuse as per O. Reg. 79/10 s. 97.

Every incident of alleged, suspected or witnessed incident of abuse is immediately reported to the police as per O.Reg 79/10 s. 98.

Strategies and interventions to provide emotional support to Resident #001.

The planned interventions, strategies and protocols are effective in protecting residents from abuse and that these are regularly reviewed and evaluated.

The plan is to be submitted to the Ottawa Service Area Office of the Ministry of Health and Long Term Care at:
347 Preston St., Suite 420, 4th Floor,
Ottawa ON K1S 3J4 or by:
Fax.: 613-569-9670 on or before December 31, 2015.

Grounds / Motifs :

1. The licensee has failed to comply with the LTCH Act 2007, c. 8, s. 19(1) whereby a resident was not protected from sexual abuse.

Under O. Reg. 79/10, sexual abuse is defined as "any non-consensual touching, behaviours or remarks of a sexual nature or sexual exploitation directed towards a resident by a person.

On a specified date a critical incident report was submitted to the Ministry of Health and Long Term Care by the licensee reporting a staff to resident alleged sexual abuse.

A review of the resident's health care record and Critical Incident #901-000035-15 for Resident #001 indicated that the resident has multiple comorbidities.

The critical incident was described as follows:
On a specified date a complaint was received from resident #001 that PSW #101 was "rough". The Director was notified by RPN #102 via pager #10264 and the home's Director of Care for further instructions.

A subsequent investigation by the Assistant Director of Care(ADOC) and the Director of Care(DOC) was commenced on the following date during which resident #001 made allegations of sexual assault against PSW #101 who was suspended that same day. The police were notified two dates later. PSW #101 was arrested and charged with sexual assault following their interview with resident #001.

Resident #001 was interviewed by inspector #531 on a specified date; although the resident was initially hesitant he/she confirmed that PSW #101 was "rough" with him/her when providing care. Resident #001 told the inspector that PSW #101 should not be allowed to be alone in the tub room or bathroom with residents when providing care. The resident further shared that PSW #101 was rough and in a hurry to take off his/her clothes, when washing his/her outer body and that he/she inserted his/her hand inside a particular body part. Resident #001 indicated that this happened on more than one occasion and that when he/she asked PSW #101 to stop, he/she swore at him/her and told resident #001 he/she wanted to ensure that the resident was clean on the inside and out. Resident #001 explained that although he/she reported his/her concern to his/her spouse he/she was afraid to tell anyone else as he/she was fearful PSW #101 would become upset and the "rough care" would increase. Resident #001 indicated that PSW #101 came to him/her one evening and asked he/she not report him/her as he/she may lose his/her job. Resident #001 told inspector #531 that PSW #101 always bathed him/her and that it got so he/she hated bath

days. Resident #001 indicated that he/she had reported the rough treatment to the "head nurse" and the police.

Inspector #531 interviewed PSW #100 on a particular date, and was told that on the day of the incident while settling resident #001 for his/her afternoon rest, resident #001 asked if PSW #101 was working that afternoon, adding that PSW #101 was rough. PSW #100 indicated that he/she immediately reported the incident to RPN #102 as resident #001 appeared "concerned" and had identified the PSW by name. PSW #100 told inspector #531 that he/she told resident #001 that he/she would "tell the nurse in charge". PSW #100 advised the inspector that PSW #101 was scheduled to work that evening.

RPN #102 confirmed that the information was reported by PSW #100. The RPN advised that he/she contacted the Director of Care (DOC) immediately to ask if the incident "needed to be reported to the "Director"; the Director of Care (DOC) provided the following instructions:
-examine resident #001 for injuries
-request PSW #100 document her communication with resident #001
-notify the "Director"
-if there were no injuries upon examination of resident #001 the Director of Care would investigate on the next day.
-if there were no injuries upon examination of resident #001 then PSW #101 would be allowed to work his/her scheduled shift and regular assignment which included resident #001.
-RPN #102 told the inspector that the DOC also instructed that staff provide care to residents in pairs.
RPN #102 told the inspector that he/she did report the allegation to RPN #108 (the RPN in charge that evening) and that the DOC had been contacted for instructions and was to commence an investigation the next morning.

In an interview on particular date the Assistant Director of Care (ADOC) acknowledged that she was made aware of the incident on the following morning when she received a hand written note from PSW #100 documenting his/her conversation with resident #001 regarding PSW #101 being rough. The ADOC stated that she immediately followed up with resident #001 who acknowledged his/her communication with PSW #100 and confirmed that PSW #101 was rough with him/her. The ADOC told inspector #531 that resident #001 was asked "how is he/she rough", does he/she hurt you?" to which resident #001 hesitantly responded that PSW #101" is always in a hurry to get your clothes off, all your

clothes ; he/she is rough washing his/her private areas, he/she washes him/her then goes up inside a particular body part with his/her hand and he/she is rough about it. Resident #001 advised the ADOC that this occurred more than once and when resident #001 asked him/her to stop he/she swore at him/her. Resident #001 advised the ADOC that he/she had told his/her spouse and he/she was going to speak to PSW #101. The ADOC indicated resident #001 told her that this had happened more than once and that it got so he/she hated her bath days but was afraid if he/she mentioned it that PSW #101's rough handling of him/her would increase. The ADOC confirmed that resident #001's spouse was not notified until later that day when he/she came into visit.

On specified date, RPN #108 was interviewed and indicated he/she was informed by RPN #102 that resident #001 reported that PSW #101 was rough and that the DOC would investigate the next day. RPN #108 indicated that he/she did not receive any further instructions with respect to care of resident #001 or monitoring of the staff.

During an interview on the same day, with PSW #109 he/she confirmed that he/she worked evenings with PSW #101 on the evening of the incident and cared for their regularly assigned residents. He/she indicated that they were not advised that resident care was to be delivered in pairs.

On a particular date, PSW #100, 103, 109, 110, 111, 112, RPN # 104, 108, 102 and RN #106, and #107 confirmed with inspector # 531 that they had been contacted by the DOC to inform them that there had been an allegation of sexual abuse and PSW #101 had been charged with sexual assault; not to discuss the information outside of the home and if they had any information to please bring it forward to management or the police. The name of the resident (s) was not provided.

On the same day, the DOC confirmed :
-instructions provided to RPN #102
-investigation commenced the following day.
-police were notified two days following the incident
-resident #001's care plan was not revised to include support of the resident
-staff had not been provided with the name of the resident(s)

The DOC confirmed that the Employee Assistance Program was contacted and was on site to assist staff involved in the alleged abuse, but the home had not

provided any support of that nature to resident #001. The DOC confirms the name of the resident has not been released to staff and that she randomly monitors resident #001 for emotional support.

The licensee failed to protect resident #001 from abuse as evidenced by the following:
a)The licensee's Abuse Policy (ADM-VI-06) was not complied with (as identified in WN #2).
b)The licensee did not ensure that every alleged, suspected or witnessed incident of abuse by a resident was immediately investigated (as identified in WN#3)
c)The SDM of Resident #1 was not immediately notified of every alleged, suspected or witnessed incidents of abuse (as identified in WN #4).
d) The appropriate police force was not immediately notified of every alleged, suspected or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence (as identified in WN #6). (531)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2015

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
Performance Improvement and Compliance 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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
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
Direction de l'amélioration de la performance et de la conformité
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 16th day of December, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Susan Donnan

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