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 #/ No de registre	Type of Inspection / Genre d'inspection
Jan 08, 2018;	2017_621547_0011 (A1)	013393-17	Resident Quality Inspection

Licensee/Titulaire de permis

CENTRE D'ACCUEIL ROGER SEGUIN
435 Lemay Street Clarence Creek ON K0A 1N0

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

CENTRE D'ACCUEIL ROGER SEGUIN
435 Lemay Street Clarence Creek ON K0A 1N0

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

LISA KLUKE (547) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The Licensee requested an extension to comply order CO #001 s.19(1) from January 15, 2018 to February 14, 2018. Extension request reasons reviewed and granted.

Issued on this 8 day of January 2018 (A1)

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

Original report signed by the inspector.

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LISA KLUKE (547) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): August 29, 30, 31, September 1, 5, 6 and 7, 2017

The following critical incident inspections were conducted during this resident quality inspection:

log's #011530-17 and #012700-17 related to alleged resident to resident sexual abuse incidents.

During the course of the inspection, the inspector(s) spoke with several residents, families, President of Resident's Council, a member of the Family Council, Registered and non-Registered nursing staff, the Activity Manager, the Chef d'Installation Materielle (CIM), Housekeeping staff, Assistant Director of Care (ADOC), the Director of Care (DOC) and the Administrator.

In addition the inspection team, reviewed resident health care records, Resident and Family Council minutes, policy and procedures related to: Self medication, Medication Incident Reports, Physical restraints, Infection, Prevention and Control and Prevention of Abuse and Neglect. The inspection team observed resident interactions, aspects of resident care and interactions with staff, along with medication administration services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Continence Care and Bowel Management

Dignity, Choice and Privacy

Falls Prevention

Infection Prevention and Control

Medication

Minimizing of Restraining

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Skin and Wound Care

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

- **16 WN(s)**
- **5 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. 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 :

The Licensee has failed to protect residents in the home from alleged resident to resident sexual abuse by resident #022.

Sexual abuse is defined by the LTCH, 2007 s.2 as:

- any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than the Licensee or staff member;("mauvais traitement d'ordre sexuel")

Two Critical Incidents (CI) related to alleged resident to resident sexual abuse incidents involving resident #022 were submitted by the Licensee to the Director in June 2017:

On June 9, 2017 the home submitted information regarding four separate alleged resident to resident non-consensual touching of a sexual nature incidents that occurred during a specified five month period in 2017.

On June 21, 2017 the home submitted information regarding two separate alleged resident to resident non-consensual touching of a sexual nature incidents that occurred on a specified date.

On August 31, 2017 Inspector #547 interviewed RN #102 regarding the documented incident of non-consensual touching of a sexual nature that occurred to resident #026 a specified date. RN #102 indicated that she immediately spoke to resident #022, who indicated to her that he/she had touched resident #026 on a specified body part. RN #102 further interviewed resident #026 who was upset that resident #022 had been touched on a specified body part and indicated that he/she did not want this to happen again. From this information, the incident that occurred on a specified date can be defined as non-consensual. RN #102 indicated that she did not report this incident to the Director of the Ministry of Health (MOH), but that she thought she had left a voice mail for the Director of Care (DOC) that day about this incident as the DOC is responsible to make this report to the Director of the MOH.

On September 1, 2017 Inspector #547 interviewed RN #104 who observed the non-consensual touching of a sexual nature of resident #029 on a specified date. RN #104 also observed the non-consensual touching of a sexual nature of resident #027 on a separate specified date. RN #104 indicated that she did not report these incidents to the Director of the MOH, as she was shocked and not sure what she was required to do. She indicated that she received training regarding abuse in another Long Term Care Home, after these incidents occurred and recognized that these incidents were abusive in nature and reported them to the DOC on her next

shift she worked. She did not recall the date she reported this to the DOC, however it was sometime during a specified month.

On September 7, 2017 the DOC indicated to Inspector #547 that resident #027, #028 and #029 all had dementia and would not be able to consent to the inappropriate touching by resident #022 in a sexual nature. Nursing staff were aware of the above incidents and normalized this is a responsive behaviour for resident #022, and did not recognize this as sexual abuse of residents #027, #028 and #029 that were not able to vocalize their sentiments related to their cognitive impairment. She realized that training was required for all nursing staff to be aware to recognize sexual abuse with non-consenting residents. The DOC further confirmed that education had not been completed on an annual basis regarding abuse prevention as required.

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The Licensee of a Long Term Care home has failed to ensure that the home is equipped with a resident-staff communication and response system specifically related to r.17(1)a and d:

a) can be easily seen, accessed and used by residents, staff and visitors at all times;
d) is available at each bed, toilet, bath and shower location used by residents.

For the purpose of this report, the resident-staff communication and response system is referred to as a call bell system.

On August 29, 2017 Inspector #550 noted the shared bathroom #122-b had a call bell system and cord that could not be easily accessed by any resident seated on this toilet.

On September 7, 2017 Inspector #547 interviewed housekeeper #114 who was cleaning bathroom #122-b if anyone could reach the call bell system in this room while seated on the toilet. Housekeeper #114 indicated that the call bell cord is too small, and cannot be reached when seated on the toilet, and that she had noticed

this before, and wondered why it was like that. Inspector #547 interviewed the "Chef d'Installation Materielle (CIM)" who indicated upon entry to this bathroom that this call system was not accessible to residents that would use this toilet and that the call bell cord would need to be longer and connected somehow to the arm rail next to the toilet for ease of access for residents. The CIM further indicated that he was not aware of this missing call system until Inspector #547 brought this to his attention during this inspection.

On August 29, 2017 Inspector #550 noted the tub room on the 1C Dementia unit was made up of a bath tub and separate shower space. Inspector #550 observed no call bell system located in the section where the bathtub is located in this room. On September 7, 2017 Inspector #547 interviewed the CIM regarding the call system set up in the tub room on the 1C Dementia unit, and he indicated that the call bell system is available in the shower area of this room. The CIM indicated that the call bell system next to the bath tub is no longer functional and so they capped it off since they thought they only needed one call bell system in the room. The CIM indicated that the call system in the shower area of this room, is not accessible to residents or nursing staff when they are assisting residents in the bath tub at any time, including any emergency. The CIM indicated that he was not aware that a call bell system was required to be available at each bath tub location used by residents.

As such, the home is not equipped with a resident-staff communication and response system that is available at each bath location used by residents on the 1C Dementia unit.

It was further noted that the shared bathroom #122-b and tub room on the 1C Dementia unit call bell system issues were identified in previous Resident Quality Inspection #2014_289550_0016. [s. 17. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is equipped with a resident-staff communication and response system that can be easily accessed and used by residents and is available at each bath tub location, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (2) The policy must comply with such requirements as may be provided for in the regulations. 2007, c. 8, s. 29 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's written policy to minimize the restraining of residents must comply with such requirements as may be provided for in the regulations.

On August 29 and 31, 2017, resident #009 was observed by Inspector #547 wearing a physical device while seated in a wheelchair. The resident indicated to the inspector that he/she was not always able to remove the physical device all the time and that he/she did not like this as it prevented the resident from getting up and doing things.

On August 30, September 5 and 6, 2017, resident #006 was observed by Inspector #550 wearing this same physical device while seated in a wheelchair. The resident was cognitively not able to remove the physical device. It was later determined through interviews with staff and the resident's spouse that the physical device is applied to prevent the resident from getting up from the wheelchair on his/her own and falling.

A review of the documentation on the restraint flow sheet for both residents revealed that the resident's response to the restraining, the repositioning of the resident and the post-restraining care was not documented.

Inspector #550 reviewed the home's restraint policy titled "resident with restraint and / or use of devices and personal assistance devices" with a revision date of June 2017 with the home's new Administrator. It was determined that the home's current policy did not contain all the requirements under sections 109 through 113 of the Ontario Regulations 79/10, which relates to the home's written policy to minimize restraining of residents, requirements relating to restraining by a physical device and the use of a PASD, or prohibited devices that limit movement including analysis and evaluation of the restraining. The Administrator indicated to the inspector that the home's current restraint policy needs to be reviewed to ensure that it contains all the provisions required by the Legislation. [s. 29. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's written policy to minimize the restraining of residents must comply with the requirements provided for in the regulations, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On September 7, 2017 during an interview with the Director of Care, she indicated to Inspector #550 that the discontinued controlled substances are stored inside the locked medication room in a locked stationary cupboard under the counter until they are destroyed by the pharmacist. Inspector #550 observed the said stationary locked cupboard under the counter inside the first floor locked medication storage room. The door of the cupboard was equipped with a key lock which when opened gave access to controlled substances; this cupboard was not double-locked. The Director of care indicated to the inspector that she was not aware of the legislative requirement that when controlled substances are not stored in a separate locked area inside the locked medication cart, they need to be stored in a double-locked stationary cupboard inside a locked area.

As such, the discontinued controlled substances were not stored in a separate, double-locked stationary cupboard in the locked medication room. [s. 129. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has specifically failed to ensure that every medication incident involving a resident and every adverse drug reaction is:

(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the

resident and the pharmacy service provider.

Inspector #550 reviewed the home's medication incident reports for the past three months. A specified report completed by RN #110 indicated that resident #023 received a specified medication on three specified occasions, however the medication was never prescribed for this resident.

The documentation on the report and an interview with the DOC on September 5, 2017, revealed that a specified date, RN #110 received a telephone order from resident #024's physician to increase the resident's prescribed medication. RN #110 transcribe the order in the resident's chart and faxed the order to the pharmacy. She did not realized that the physician order sheet in resident #024's chart belonged to resident #023. The pharmacy processed the order for resident #023 and the medication was dispensed to the home for resident #023 instead of resident #024. On a specified date, when RN #110 noted the medication error, resident #023 had already received three doses of this medication.

The inspector reviewed resident #024's health care records. The medication administration record (MAR) sheet for a specified month indicated that the resident was administered the original dosage of this medication on three separate occasions, as per the previous physician order. The resident did not receive the new prescribed dosage as required. The inspector was not able to find any documentation indicating that resident #024 and the resident's substitute decision maker, the medical director and the pharmacy service provider were informed of the medication incident.

Inspector reviewed resident #023's health care records and was not able to find documentation indicating that the Medical Director and the pharmacy service provider were informed of the medication incident.

During an interview with the Director of Care on August 31 and September 5, 2017, she indicated to the inspector that it is the home's expectation that all medication errors and adverse drug reactions are documented on the Medication Incident Report form and that this was not done for resident #024 as they forgot. Because no medication incident report was completed for resident #024, the staff forgot to inform resident #024 and the resident's substitute decision maker of the medication incident. The Consulting Clinical Pharmacist and the home's Advisory Physician were not informed of both medication incidents as this is not the home's current practice to do so. [s. 135. (1)]

2. The licensee has failed to ensure that:
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed
(b) corrective action is taken as necessary, and
(c) a written record is kept of everything required under clauses (a) and (b).

On September 5, 2017, inspector #550 reviewed the home's medication incident reports for a specified period of time and requested to the Director of Care the documentation of their review of the medication incidents and adverse drug reactions, analysis and corrective actions taken during this period. The DOC indicated to the inspector that a medication incident report was not completed for the incident on a specified date, where resident #024 did not receive the right dose of a specified medication. She further indicated that they currently do not review and analyze the medication incidents, identify corrective actions and keep a written record of the above. [s. 135. (2)]

3. The licensee has failed to ensure that:

(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions,
(b) any changes and improvements identified in the review are implemented, and
(c) a written record is kept of everything provided for in clause (a) and (b).

On September 5, 2017, Inspector #550 requested to the Director of Care a copy of the home's last medication incidents and adverse drug reactions quarterly review, along with the documentation to indicate that the changes and improvements identified during the review were implemented. The Director of Care indicated to the inspector that they currently do not conduct a quarterly review of the medication incidents and adverse drug reactions in order to reduce and prevent medication incidents and adverse drug reactions in the home. Therefore changes and improvements are not identified. She further indicated that they will be starting this process at their next Professional Advisory Council meeting. [s. 135. (3)]

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 every medication incident involving a resident is documented on the Medication Incident Report and that the medication incidents are reported to the consulting clinical pharmacist, the physician, the residents and their substitute decision makers. Medication incidents are to be reviewed, analyzed and corrective action taken in the home. The home must also conduct a quarterly review of the medication incidents and adverse drug reactions in order to reduce and prevent medication incidents and adverse drug reactions in the home and that all these areas must be documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that training was provided for all staff who apply physical devices or who monitor residents restrained by a physical device, including:

- application of these physical devices
- use of these physical devices, and
- potential dangers of these physical devices.

During an interview on September 13, 2017, the Director of Care indicated to inspector #550 that the last training regarding the application, the use and the potential dangers of physical devices was provided to staff on June 26, 2016. She stated that 41 out of 82 employees (50%), who apply physical devices or who monitor residents restrained by a physical device did not complete the training last year. [s. 221. (1) 5.]

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 annual training is provided for all staff who apply physical devices or who monitor residents restrained by a physical device, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or the care set out in the plan is no longer necessary.

Resident #006 was admitted to the home on a specified date, with several medical conditions including cognitive impairment. On August 30, September 5 and 6, 2017, resident #006 was observed by Inspector #550 with specified physical devices applied while seated in a wheelchair. The resident was cognitively not able to remove these physical devices.

It was determined through interviews with PSW #115, RN #116, RPN #117, RPN #118 and the resident's Substitute Decision Maker, that one of the physical devices was applied to prevent the resident from getting up from the wheelchair and falling. The other physical device was used to assist the resident to maintain the resident's torso in a straight position and prevent the resident from falling forward but his/her condition has now improved and it is unsure if the resident still requires the second physical device applied for that purpose.

The inspector reviewed the resident's health care records and was not able to locate documentation indicating the need for the second physical device was ever reassessed when the resident's condition improved.

On September 6, 2017, RN #116 indicated to Inspector #550 that the need for the second physical device was not reassessed when the resident's condition improved and that the resident probably no longer needs it at this time. The need for the ongoing application of the second physical device was not determined at this time as the resident was not reassessed.

As evidenced above, resident #006 was not reassessed and the plan of care was not reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

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

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents shall:

- clearly set out what constitutes abuse and neglect
- contain an explanation of the duty under section 24 of the Act to make mandatory reports
- deal with any additional matters as may be provided in the regulations.

On August 29, 2017 the Administrator provided Inspector #547 a binder that contained the home's policy # ADM DG1217 titled "Prevention des Abus et/ou Mauvais traitements" last revised January 2017 as the current policy used in the home.

According to O. Reg 79/10 s. 2(1) "sexual abuse" is defined as:

(b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member;(mauvais traitement d'ordre sexuel)

The home's policy # ADM DG 1217 on page 3 of 7 documented sexual abuse as all kinds such as indecent touching or all other forms of abuse. (tout genre tels que des touchers indecents ou toute autre forme d'abus) This definition does not clearly define sexual abuse as identified O.Reg 79/10 s.2.

According to LTCH Act 2007, c.8, s.24.(1) indicates the Licensee's duty to make mandatory reports to the Director as 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:
(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.

The home's policy # ADM DG 1217 does not indicate this requirement. The Licensee's report on page 7/7 titled "Report required by the Ministry of Health for abuse that has occurred or may have occurred" indicated to advise by telephone of all abuse that has occurred or may have occurred in 24 hours of the identified incident. This report further indicated to complete a critical incident report in five business days.

According to O. Reg 79/10 s.98 that 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.

The home's policy # ADM DG 1217 does not indicate this requirement.

According to O. Reg 79/10 s.99 that every Licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the Licensee becomes aware of it;
(c) that the residents of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly

implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared.

The home's policy # ADM DG 1217 does not indicate these requirements.

On September 7, 2017 the Administrator and Director of Care indicated to Inspector #547 that the home had not located any evaluated incidents of abuse in the home or any written records of changes or improvements as required by this section. The Administrator indicated that a thorough review of the Licensee's prevention of abuse policy and program will be revised and updated regarding this missing or unclear information. [s. 20. (2)]

WN #9: 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 abuse of a resident by anyone that resulted in harm or risk of harm had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

A Critical Incident Report reported by the home on a specified date, regarding incidents of alleged resident to resident non-consensual touching of a sexual nature that occurred on four specified dates in a five month period of time.

Inspector #547 reviewed resident #022's health care records that documented these four incidents.

On August 31, 2017 Inspector #547 interviewed RN #102 regarding the documented incident of non-consensual touching of a sexual nature that she documented in resident #022's progress notes on a specified date. RN #102 indicated that she did not report it to the Director of the Ministry of Health (MOH)but that she thought she had left a voice mail for the home's Director of Care (DOC) about this incident as she is responsible to make this report to the Director of MOH.

On September 1, 2017 Inspector #547 interviewed RN #104 regarding the documented incident of non-consensual touching of a sexual nature that she documented in resident #022's progress notes for three separate incidents. RN #104 indicated that she did not report these incidents to the DOC as she was not sure what to do. RN #104 further indicated that she did not report these incidents immediately to the Director of MOH.

On September 7, 2017 the DOC indicated to Inspector #547 that she became aware of these incidents of non-consensual touching of sexual nature on a specified date and did not report these incidents to the Director of the MOH until a specified later date as indicated on the CIR as she was not aware that the incidents were required to be sent immediately. [s. 24. (1)]

2. A second Critical Incident Report (CIR) was reported by the home on another specified date regarding two incidents of alleged resident to resident non-consensual touching of a sexual nature of resident #029 and resident #029 by resident #022.

The DOC indicated to Inspector #547 on September 7, 2017 that she became aware of these incidents the day after these incidents occurred in the home. The DOC did not report them to the Director of the MOH until six days later. [s. 24. (1)]

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

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #022 and other residents in the home by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations.

A Critical Incident Report submitted by the Licensee on a specified date regarding incidents of alleged resident to resident non-consensual touching of a sexual nature that occurred between a five month period of time.

Resident #022 was admitted to the home on a specified date with several medical diagnoses including cognitive impairment secondary to a previous specified incident.

Inspector #547 reviewed resident #022's health care records on August 31, 2017 and the resident's care plan in place during a specified period of time, which indicated that resident #022 had behaviours directed towards nursing staff during personal care. The progress notes for resident #022 were reviewed for a three month period and noted three incidents of non-consensual touching and behaviours of a sexual nature towards residents in the home had occurred.

On a specified date at the end of this three month period, a Behaviour Supports Ontario (BSO) team meeting was held in the home and identified that resident #022 had hyper sexuality and disinhibition behaviours noted. The plan was to continue to have nursing staff supervise the resident when around other residents in the home and that BSO team will continue to be involved in assessing the resident's behaviour management needs. This information was not transcribed to the resident's plan of care.

On a specified date two weeks later, the BSO team meeting documented the ongoing presence of sexual behaviours by resident #022. BSO team meeting documented that resident #022 required supervision every 30 minutes while inside a specified unit of the home. This supervision intervention was not added to the plan of care for resident #022 and no documentation of monitoring of the resident was provided to the Inspector from the resident's health care records.

On a specified date one month later, the resident's Minimum Data Set (MDS) assessment documented that resident #022 displayed behaviours towards other residents and occasionally inappropriately touched these other residents, for which resident #022 required constant supervision. No Interventions were added to the plan of care related to this need for constant supervision.

On a specified date, RN #104 observed another incident of non-consensual touching of a sexual nature of resident #027 by resident #022.

On September 1, 2017 RN #104 indicated to Inspector #547 that registered nursing staff have the capacity to change resident's plan of care in the home's electronic documentation system at any time there is a change to be indicated. Inspector #547 inquired about the documented observations of the incident involving resident #022 and resident #029 that she had observed to be non-consensual as resident #029 had cognitive impairment and would not be able to consent to this action. RN #104 indicated that resident #022 always had inappropriate sexual behaviour with staff, but that this was the first time with another resident. RN #104 indicated that she did not update the resident's plan of care on the first specified incident date. RN #104 reported to Inspector #547 that she observed another incident, three and half months later involving resident #022 and she did not update resident #022's plan of care.

RN #104 indicated that she later received training in another Long Term Care home in Ontario, regarding prevention of abuse and returned to the home at her next shift and spoke to the Director of Care to indicate that resident #022's behaviour towards other residents had to be stopped as she now realized that this was considered sexual abuse. RN #104 further indicated that this is when they reviewed and updated resident #022's plan of care as well as the home's expectations of staff related to abuse prevention.

Inspector #547 interviewed the Director of Care on September 7, 2017 regarding the critical incident reported by the home for the identified incidents over a four month period. The DOC indicated that she was not made aware of resident #022's change in behaviours until a specified date at the end of this four month period. The DOC indicated that the registered nursing staff had documented resident #022's behaviours in the resident's progress notes however resident #022's plan of care did not change until the DOC became aware of these incidents. The DOC further indicated that resident #022's behaviours were also not reassessed until

four months after the resident to resident non-consensual touching of a sexual nature towards residents in the home was identified. [s. 54. (a)]

WN #11: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training
Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have received retraining annually relating to the following:

The Residents' Bill of Rights
The home's policy to promote zero tolerance of abuse and neglect of residents
The duty to make mandatory reports under section 24
The whistle-blowing protections

On September 1, 2017 the Director of Care informed Inspector #550 that the home has not provided staff retraining for these areas annually going back as far as 2014 according to her records.

On September 7, 2017 the Administrator indicated that education will be required for staff once the home's policy and procedures in these areas are updated. [s. 76. (4)]

WN #12: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

During an interview with the president of the Resident Council on September 6, 2017, he/she indicated to Inspector #550 that he/she could not remember if the home sought the advice of the Resident Council in developing and carrying out the satisfaction survey.

The inspector reviewed the minutes of the Resident Council for a specified period of time in 2017 and was not able to find any documentation indicating that the satisfaction survey was reviewed by the Resident Council prior to being sent to the residents.

During an interview on September 7, 2017, the assistant to the Resident Council indicated to the inspector that she was not able to find any documentation indicating that the licensee sought the advice of the Resident Council in developing and carrying out the satisfaction survey this year. She indicated that it was possibly scheduled to be discussed at one of the meetings that had to be cancelled.

As evidenced above, the licensee did not seek the advice of the Resident Council in developing and carrying out the satisfaction survey. [s. 85. (3)]

WN #13: 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 ensure that a resident's Substitute Decision Maker (SDM) and any other person specified by residents were immediately notified upon becoming aware of alleged, suspected or witnessed incidents of abuse that caused distress to residents that could potentially be detrimental to resident health or well-being.

A Critical Incident Report(CIR) was submitted to the Director of the MOH on a specified date by the Licensee related to incidents of alleged sexual abuse by resident #022 towards resident #027, resident #028, and resident #029 over a specified four month period.

Resident #022's health care records were reviewed by Inspector #547 that indicated that the DOC reviewed the resident's progress notes on a specified date at the end of this four month period and was made aware of the alleged sexual abuse incidents of resident #027, resident #028 and resident #029 that occurred in the home.

Resident #027, resident #028 and resident #029's progress notes were reviewed by Inspector #547 that revealed that the DOC informed these resident SDM's regarding these incidents of alleged sexual abuse by resident #022, 14 days after the DOC was made aware of these incidents. [s. 97. (1) (a)]

WN #14: 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 has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incidents of alleged sexual abuse.

A Critical Incident Report (CIR) that was submitted by the Licensee to the Director of the MOH on a specified date regarding four incidents of alleged resident to resident sexual abuse by resident #022 towards other residents in the home.

Inspector #547 reviewed Resident #022's progress notes that documented the details of these four incidents.

RN #102 indicated to Inspector #547 on August 31, 2017 that she reported the information to the Director of Care as she was responsible for reporting this incident to the police.

RN #104 indicated to Inspector #547 on September 1, 2017 that she did not report these incidents to any police force. RN #104 indicated that she knew these incidents were inappropriate, but was not sure what else to do.

The Director of Care indicated to Inspector #547 on September 7, 2017 that she was made aware of the incidents of non-consensual touching of a sexual nature of residents #026, #027, #028 and #029 on two specified dates. The DOC further indicated that she reported the four incidents to the police on a specified date which was not immediately after the home was made aware of these incidents of alleged sexual abuse by resident #022. [s. 98.]

2. Another Critical Incident Report (CIR) was reported by the Licensee to the Director on a specified date, approximately two weeks later, regarding incidents of alleged resident to resident sexual abuse of resident #028 and resident #029 by resident #022 that occurred at separate times on a specified date, however did not report them to the police to date. [s. 98.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The Licensee has failed to ensure that the prevention of abuse and neglect program was evaluated to ensure that:

(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the Licensee becomes aware of it;

(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the Licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of resident's, and what changes and improvements are required to prevent further occurrences;

(c) that the residents of the analysis undertaken under clause (a) are considered in the evaluation;

(d) that the changes and improvements under clause (b) are promptly implemented; and

(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared.

The home's policy # ADM DG1217 titled "Prevention des Abus et/ou Mauvais traitements" last revised January 2017 does not indicate these requirements. On Page 1 of 7 the policy indicated that the Licensee's policy is subject for annual revision. This policy was last revised January 2017 as documented on the front of the policy.

On September 7, 2017 the Administrator and Director of Care indicated to Inspector #547 that the home was not able to provide any documented analysis of every incident, review of the policies effectiveness, changes or improvements required or evaluation of the prevention of abuse program to date in his records. The Administrator indicated that a thorough review of the Licensee's prevention of abuse policy and program will be completed and updated regarding this missing or unclear information. The Administrator further indicated that the evaluation of the program shall be developed and documented for their Quality Improvement records. [s. 99.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

During an interview with RN #102 on August 31, 2017, she indicated to Inspector #550 that resident #018 keeps specified medications in his/her room that the resident self-administers. Resident #018 prepares his/her medication in his/her room and then shows the registered nurses the medication before he/she self-administers. During an interview on September 5, 2017, the resident indicated to Inspector #550 that he/she keeps in his/her room and self-administer four different prescribed medications as required.

Inspector #550 reviewed the resident #018's health care records. A specified three month medication review indicated these medications were prescribed "at bedside".

During an interview on August 31, 2017, the inspector informed RN #102 that she was not able to find a physician order indicating that resident #018 can self-administer the above medications other than an order indicating that the resident can keep these medication at bedside. RN #102 indicated she thought that when a physician ordered a medication "at bedside", this implied that the resident was permitted to self-administer that medication.

The home's policy #5-5, titled "Self-medication" dated January 2014 was reviewed by Inspector #550. It was documented under procedure:
2. The prescriber writes the medication order and add "may self-administer".

During an interview on August 31, 2017, the Director of Care indicated that when a resident self-administers any medication, the physician has to prescribe "self-administer" which was not done for resident #018. [s. 131. (5)]

Issued on this 8 day of January 2018 (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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

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
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Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : LISA KLUKE (547) - (A1)

Inspection No. / No de l'inspection : 2017_621547_0011 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 013393-17 (A1)

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

Report Date(s) / Date(s) du Rapport : Jan 08, 2018;(A1)

Licensee / Titulaire de permis : CENTRE D'ACCUEIL ROGER SEGUIN
435 Lemay Street, Clarence Creek, ON, K0A-1N0

LTC Home / Foyer de SLD : CENTRE D'ACCUEIL ROGER SEGUIN
435 Lemay Street, Clarence Creek, ON, K0A-1N0

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Steven Golden

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 CENTRE D'ACCUEIL ROGER SEGUIN, 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. 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 :

(A1)
The licensee shall ensure that residents of the home are protected from abuse by anyone; to that effect the licensee shall prepare, submit and implement a plan for achieving compliance to include the following:

1. Take immediate action to effectively protect female residents from resident #022;

2. Revise the plan of care of resident #022 to ensure the planned interventions are implemented and effective in managing the resident's responsive behaviours of a sexual nature;

3. Ensure clear directions are provided to all staff providing direct care to residents with responsive behaviours, including resident #022, to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents, in accordance with O. Reg. 79/10, section 54;

4. Revise the Zero Tolerance of Abuse and Neglect of Residents' policy, including all of the abuse definitions, with particular attention to what constitutes sexual abuse to reflect the requirements set in LTCHA, 2007 s.20 and O. Reg 79/10 s.96, s.97, s.98 and s.99;

5. Retraining of all staff on their obligations under the revised Zero Tolerance of Abuse and Neglect policy with particular attention to the requirement of every person to immediately report every alleged, suspected or witnessed incident of abuse of a resident both to the Director in accordance with LTCHA, 2007 s. 24 and to the appropriate individuals identified within the home. This retraining needs to be documented and evaluated to ensure all staff recognize resident abuse and neglect.

6. Ensure the annual training on the Zero Tolerance of Abuse and Neglect policy in accordance with LTCHA, 2007 s.76(4). Ensure that all staff, including all volunteers, supervisors and managers, and those that provide direct care to residents and/or work in the home pursuant to a contract/agreement between the Licensee and third party, receive this training.

7. The plan shall identify the time line for completing the tasks and who will be responsible for completing those tasks.

The plan is to be submitted by September to Inspector Lisa Kluke by fax #613-569- 9670.

Grounds / Motifs :

1. The Licensee has failed to protect residents in the home from alleged resident to resident sexual abuse by resident #022.

Sexual abuse is defined by the LTCH, 2007 s.2 as:

- any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than the Licensee or staff member;("mauvais traitement d'ordre sexuel")

Two Critical Incidents (CI) related to alleged resident to resident sexual abuse incidents involving resident #022 were submitted by the Licensee to the Director in June 2017:

On June 9, 2017 the home submitted information regarding four separate alleged resident to resident non-consensual touching of a sexual nature incidents that

occurred during a specified five month period in 2017.

On June 21, 2017 the home submitted information regarding two separate alleged resident to resident non-consensual touching of a sexual nature incidents that occurred on a specified date.

On August 31, 2017 Inspector #547 interviewed RN #102 regarding the documented incident of non-consensual touching of a sexual nature that occurred to resident #026 a specified date. RN #102 indicated that she immediately spoke to resident #022, who indicated to her that he/she had touched resident #026 on a specified body part. RN #102 further interviewed resident #026 who was upset that resident #022 had been touched on a specified body part and indicated that he/she did not want this to happen again. From this information, the incident that occurred on a specified date can be defined as non-consensual. RN #102 indicated that she did not report this incident to the Director of the Ministry of Health (MOH), but that she thought she had left a voice mail for the Director of Care (DOC) that day about this incident as the DOC is responsible to make this report to the Director of the MOH.

On September 1, 2017 Inspector #547 interviewed RN #104 who observed the non-consensual touching of a sexual nature of resident #029 on a specified date. RN #104 also observed the non-consensual touching of a sexual nature of resident #027 on a separate specified date. RN #104 indicated that she did not report these incidents to the Director of the MOH, as she was shocked and not sure what she was required to do. She indicated that she received training regarding abuse in another Long Term Care Home, after these incidents occurred and recognized that these incidents were abusive in nature and reported them to the DOC on her next shift she worked. She did not recall the date she reported this to the DOC, however it was sometime during a specified month.

On September 7, 2017 the DOC indicated to Inspector #547 that resident #027, #028 and #029 all had dementia and would not be able to consent to the inappropriate touching by resident #022 in a sexual nature. Nursing staff were aware of the above incidents and normalized this is a responsive behaviour for resident #022, and did not recognize this as sexual abuse of residents #027, #028 and #029 that were not able to vocalize their sentiments related to their dementia. She realized that training was required for all nursing staff to be aware to recognize sexual abuse with non-consenting residents. The DOC further confirmed that education had not been completed on an annual basis regarding Abuse prevention as required.

Furthermore, based on the information noted above, the licensee failed to comply with the following other sections of the legislation which was found to be in direct relation to this compliance order, such as:

The licensee failed to comply with:

1. LTCHA s. 20(2) whereby issues were identified with the policy to promote Zero Tolerance of Abuse and Neglect of residents, identified in this report in WN #8.

2. LTCHA s. 24 whereby six incidents of non-consensual touching of a sexual nature by resident #022 towards residents #026, #027, #028 and #029 were not reported immediately to the Director identified in this report in WN #9.

3. O. Reg 79/10 s. 97(1) whereby the Licensee failed to ensure that resident substitute decision-makers, if any, and any other person specified by residents, were notified immediately upon the licensee becoming aware of alleged, suspected or witnessed incidents of abuse of residents that has resulted in physical injury or pain to residents or that causes distress to residents that could potentially be detrimental to residents health or well being as identified in this report in WN #13.

4. O.Reg 79/10 s. 98 whereby the Licensee failed to ensure that the appropriate police force was immediately notified of six witnessed incidents of resident to resident non-consensual touching of a sexual nature, as identified in this report in WN #14.

5. O.Reg 79/10 s. 99 whereby the Licensee failed to ensure that evaluation of incidents of abuse or neglect of residents in the home is undertaken as identified in WN #15.

6. LTCHA s. 76(4) whereby the Licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations as identified in this report in WN #11.

7. O.Reg 79/10 s. 54 whereby the Licensee failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and

among residents including identifying factors based on interdisciplinary assessment and on information provided to the licensee through observations, that could potentially trigger such altercations, and identifying and implementing interventions until a specified date as identified in this report in WN #10.

The scope and severity of the evidence supporting this compliance order, as well as the compliance history related to the identified compliance issues, were reviewed. The ongoing non-compliance posed a risk to the safety of residents living in the home. (547)

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

Feb 14, 2018(A1)

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 8 day of January 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LISA KLUKE - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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Service Area Office / Bureau régional de services : Ottawa