Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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347 Preston St Suite 420
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 13, 2021	2021_683126_0013	013823-21, 014490-21, 014496-21, 014622-21	Complaint

Licensee/Titulaire de permis

DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC Long Term Care GP Inc. and Arch Venture Holdings Inc.
161 Bay Street, Suite 2100 TD Canada Trust Tower Toronto ON M5J 2S1

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

Lancaster Long Term Care Residence
105 Military Road North P.O. Box 429 Lancaster ON K0C 1N0

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

LINDA HARKINS (126)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 15, 16, 17, 20, 21, 22, 23, 24, 2021

During this inspection the following logs were inspected:
Log #013823-21: Critical Incident (CI) #2680-000011-21 and log #014490-21, CI #2680 -000013-21 related to allegation of sexual abuse
Log #014496-21: Complaint related to allegation of sexual abuse
Log # 0146622-21: Follow up to Compliance Order (CO) #001 issued on August 5, 2021 under Inspection Report # 2021_683126_0011 related to the Long-Term Care Home Act (LTCHA), s.19.1(Duty to Protect) with a compliance due date of September 7, 2021.

During the course of the inspection, the inspector reviewed two residents health care records, observed the provision of resident care and services, observed infection control practices and reviewed the plan developed by the LTC Home to ensure compliance with Order #001.

During the course of the inspection, the inspector(s) spoke with the residents, one family member, two Security Guards, one Housekeeper, several Registered Parctical Nurses (RPNs), several Registred Nurses (RNs), the Director of Care and the Administrator.

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 Compliance Order (CO) #001 issued on August 5, 2021 under Inspection Report # 2021_683126_0011 related to the LTCHA, s.19.1(Duty to Protect) with a compliance due date of September 7, 2021 to ensure resident #002 was protected from sexual abuse from resident #001.

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

On a day in 2021, Security Guard (SG) #106 who was assigned to resident #001 as 1:1, went on break and notified Registered Nurse (RN) #105 without ensuring the transferring of the supervision responsibilities to a specific staff. RN #105 was sitting at the nursing station and could only see the upper body but could not see the hands movement of resident #001 from where they were sitting. Housekeeper #104 was standing in the hallway and observed resident #001 doing non-consensual touching of sexual nature to resident #002. Both residents were immediately separated.

On another day in 2021, SG #108 who was assigned to resident #001 as 1:1, was at the nursing station monitoring resident #001 from a distance. Resident #001 was sitting in the dining room and resident #002 mobilized themselves beside resident #001 as they were wandering in the dining room. Resident #001 was observed doing non-consensual touching of sexual nature to resident #002. SG #108 immediately removed resident #002 away from resident #001.

Prior to these two incidents, on four occasions in 2021, resident #001 had done non-consensual touching of sexual nature four times to resident #002 which resulted in a (CO) #001, issued on August 5, 2021 under Inspection Report # 2021_683126_0011. Even though some interventions were implemented, resident #002 was still non-consensually touched in a sexual nature by resident #001. [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. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee shall ensure that the written plan of care provide clear directions to staff and others who provide direct care to resident #002.

Resident #002's plan care dated a specific date in 2021 was reviewed and did not include clear direction/interventions to specifically ensure that resident #002 was protected from potential non-consensual touching of sexual nature by resident #001.

In several interviews with four staff who stated they were aware of the potential for inappropriate touching by resident #001 toward resident #002. They indicated that they always try to redirect resident #002 when they get to close to resident #001. Also, they indicated that resident #002 was now wearing specific clothing to prevent inappropriate touching.

None of these interventions were written in resident #002's plan of care and does not provide clear directions to staff.

Sources: Nursing staff and the plan of care. [s. 6. (1) (c)]

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

Issued on this 15th day of October, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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 Operations Division
Long-Term Care Inspections Branch

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LINDA HARKINS (126)
Inspection No. / No de l'inspection :	2021_683126_0013
Log No. / No de registre :	013823-21, 014490-21, 014496-21, 014622-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 13, 2021
Licensee / Titulaire de permis :	DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC Long Term Care GP Inc. and Arch Venture Holdings Inc. 161 Bay Street, Suite 2100, TD Canada Trust Tower, Toronto, ON, M5J-2S1
LTC Home / Foyer de SLD :	Lancaster Long Term Care Residence 105 Military Road North, P.O. Box 429, Lancaster, ON, K0C-1N0

Nicole Gurnsey

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

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

To DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC Long Term Care GP Inc. and Arch Venture Holdings Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2021_683126_0011, CO #001;

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 must be compliant with s. 19 (1) of the Long-Term Care Homes Act, 2007.

The licensee shall ensure that resident #002 is protected from sexual abuse from anyone by completing the following:

1. Ensure 1:1 monitoring is provided to residents as per their plan of care

2. Educate all staff on the specific requirements associated with the provision of 1:1 monitoring including but not limited to:

a)Ensuring that the assigned 1:1 staff member:
-Does not monitor/observe resident from several feet away
-Does not leave the resident to assist other staff or residents.
-Does not leave the resident at break until another specific staff member is available for 1:1 monitoring.

b) Ensuring that the 1:1 and all staff members:
- Have heightened monitoring when resident #002 is in high traffic areas including the hallway and the dining room.

3. The training completed must be documented including who completed the training, when the training was completed, and what was included in the training including who the trainer was.

Grounds / Motifs :

1. 1. The licensee has failed to comply with Compliance Order (CO) #001 issued on August 5, 2021 under Inspection Report # 2021_683126_0011 related to the LTCHA, s.19.1(Duty to Protect) with a compliance due date of September 7, 2021 to ensure resident #002 was protected from sexual abuse from resident #001.

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Prior to these two incidents, on four occasions in 2021, resident #001 had done non-consensual touching of sexual nature four times to resident #002 which resulted in a (CO) #001, issued on August 5, 2021 under Inspection Report # 2021_683126_0011. Even though some interventions were implemented, resident #002 was still non-consensually touched in a sexual nature by resident #001. [s. 19. (1)]

An order was made by taking the following factors into account:

Severity: There was two non-consensual incidents of touching to resident #002

from resident #001. The two incidents were witnessed and caused minimal harm and minimal risk due to the immediate interventions at the time of the incidents.

Scope: These two incidents were isolated cases as no other incidents of sexual nature were identified during this inspection.

Compliance History: The licensee continues to be in non-compliance with s. 19(1) of the LTCHA, resulting in a compliance order (CO) being re-issued. CO #001 was issued on August 5, 2021, under inspection #2021_683126_0011 with a compliance due date of September 7, 2021.

Sources: Security Guards interviews and other staff.

(126)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 29, 2021

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 Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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 des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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 13th day of October, 2021

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : LINDA HARKINS

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