Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 28, 2018	2018_593573_0006	029172-17	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 700 MARKHAM ON L3R 9W2

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

Extendicare Starwood
114 Starwood Road NEPEAN ON K2G 3N5

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

ANANDRAJ NATARAJAN (573)

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): February 27 and 28, 2018 and March 05 - 09, 2017.

The complaint Log #029172-17 related to staff to resident alleged physical abuse was inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Support Service Manager (SSM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), staffing clerk, resident's Substitute Decision Maker (SDM) and resident.

Inspector reviewed critical incident reports, documents related to the licensee's investigation into the identified alleged incidents of abuse, licensee's "Zero Tolerance of Resident Abuse and Neglect" policy, resident health care record including care plans, assessments, progress notes and staff training records. In addition, inspector observed the provision of care and services to the resident and observed staff to resident interactions.

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

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home protected resident #001 from abuse by anyone.

In accordance with O.Reg. 79/10, section 2, verbal abuse means, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

In accordance with O.Reg. 79/10, section 2, physical abuse means, the use of physical force by anyone other than a resident that causes physical injury or pain.

The Ministry of Health and Long Term Care (MOHLTC) home emergency pager received a call from the home on an identified date and time, to report an incident of staff to resident abuse involving resident #001.

On an identified date in 2017, a Critical Incident Report was submitted to MOHLTC related to staff to resident verbal and physical abuse.

A complaint was submitted to the Director of the MOHLTC on an identified date, related to staff to resident physical abuse. The complainant was concerned for the safety of resident #001 and other residents in the home.

On an identified date and time, housekeeping staff #102 witnessed PSW #101 name calling resident #001. At the time of the incident, housekeeping staff #102 observed resident #001 lying on the floor near the resident's bed. Housekeeping staff #102 observed PSW #101, who picked resident #001 from the floor, rough handled and transferred resident #001 from the floor to the bed where resident #001 appeared to be in pain. Furthermore, housekeeping staff #102 observed PSW #101 roughly shove resident #001 in the bed and tossed the resident's legs onto the bed.

On the same day the housekeeping staff #102 reported the witnessed PSW #101 to resident #001's incident of abuse to the Support Service Manager (SSM) and the SSM reported the incident of abuse to the home's Administrator.

On February 28, 2018, Inspector #573 spoke with the home's Administrator, who indicated that on an identified date, the SSM reported that housekeeping staff #102 witnessed incident of PSW #101 being verbally and physically abusive to resident #001. The Administrator indicated to Inspector #573 that considering previous employee and labor relations experience with PSW #101, the Administrator intentionally delayed notification to the external regulatory authorities. The Administrator indicated to the

inspector that the alleged staff to resident abuse incident was not immediately investigated, and was not reported to anyone in the home, so that the PSW staff would not suspect the source of the allegations. Further, the Administrator indicated to the inspector that the Director MOHLTCH, resident #001's substitute decision maker (SDM) and police were not immediately notified intentionally to protect the witness from PSW #101.

Two days after the incident the Administrator met with resident #001 regarding the incident that occurred on an identified date. During that meeting, resident #001 was not able to recollect the incident. The Administrator indicated to Inspector #573 that no actions were taken immediately to provide support to resident #001 and no full nursing assessment was conducted on resident #001. Further, the Administrator indicated to the inspector that PSW #101 was allowed and continued to provide care and services to the residents on the unit without any additional supervision, until PSW #101 was placed on an investigation leave on an identified date, which was eight days after the incident.

The Administrator indicated to the inspector that after PSW #101 was placed on investigation leave, and an internal investigation was conducted which included the collection of staff witness statements regarding the alleged incident of abuse. The Administrator stated that the internal investigation confirmed that staff to resident verbal and physical abuse occurred and PSW #101 was terminated.

The Administrator stated to Inspector #573 that after 24 days of the incident, on an identified date the MOHLTCH Director, resident #001's substitute decision maker (SDM) and police force were notified.

The licensee also failed to comply with:

1. LTCHA, s. 20 (1) the licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with. (refer to WN #2)

2. LTCHA, s. 23 (1) (a) the licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that is reported to the licensee, is immediately investigated. (refer to WN #3)

3. LTCHA, s. 24 (1) the licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone of a resident by the licensee or staff that resulted in harm or risk of harm to resident by not immediately reporting the

suspicion and the information upon which it was based to the Director. (refer to WN #4)

4. O. Reg 79/10 s. 97 (1) (a) the licensee has failed to ensure that the resident's substitute decision maker, if any, and any other person specified by the resident are immediately notified upon becoming aware of alleged, suspected or witnessed incidents of abuse that resulted in physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well-being. (refer to WN #5)

5. O. Reg. 79/10, s. 98. The licensee has failed to ensure that the appropriate police force was 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. (refer to WN #6)

As demonstrated by this inspection report the home failed to protect resident #001 from abuse in that:

The licensee failed to immediately initiate an investigation of the alleged, suspected or witnessed staff to resident #001 abuse. PSW #101 was allowed and continued to provide care and services to resident #001 and other residents on the unit without any additional supervision, until the staff was placed on investigation leave. The procedures in the home 's Zero Tolerance of Resident Abuse and Neglect Policy #RC-02-01-02, revised April 2017, to immediately respond to any form of alleged abuse and to ensure the safety of, and to provide support to resident #001, through the completion of a full assessment was not followed. In addition, reporting procedures, including reporting to the Director, resident substitute decision makers (SDMs) and police force were not followed. [s. 19. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The licensee's Zero Tolerance of Resident Abuse and Neglect: Response and Reporting Policy #RC-02-01-02, revised April 2017, page two, bullet number two, under procedures for Administrator/ designate indicated the following: "Immediately initiate an investigation of the alleged, suspected or witnessed abuse". On page three, bullet number two, and four under procedures for all staff indicated the following: "Immediately respond to any form of alleged, suspected or witnessed abuse". "Ensure the safety of, and provide support to the abuse victim(s), through completion of full assessments, a determination of resident needs and a documented plan to meet those needs".

In accordance with O.Reg. 79/10, section 2, verbal abuse means, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

In accordance with O.Reg. 79/10, section 2, physical abuse means, the use of physical force by anyone other than a resident that causes physical injury or pain.

As cited in evidence above, on an identified date, housekeeping staff #102 reported the witnessed incident of PSW #101 being verbally and physically abusive to resident #001 to the SSM. On the same day the SSM reported to the home's Administrator.

On February 28, 2018, Inspector #573 spoke with the home's Administrator, who indicated that on an identified date, the SSM reported that housekeeping staff #102 witnessed incident of PSW #101 being verbally and physically abusive to resident #001. The Administrator indicated to Inspector #573 that considering previous employee and labor relations experience with PSW #101, the Administrator indicated to the inspector that the alleged staff to resident abuse incident was not immediately investigated, so that the PSW staff would not suspect the source of the allegations. Further, it was indicated that two days after the incident, the Administrator met with resident #001 regarding the incident that occurred on an identified date. At that time resident #001 was not able to recollect the incident. The Administrator indicated to inspector that no actions were taken immediately to provide support to resident #001 and no full nursing assessment was conducted for resident #001 as per the home's Zero Tolerance of Resident Abuse and Neglect policy. [s. 20. (1)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that is reported to the licensee, is immediately investigated.

In accordance with O.Reg. 79/10, section 2, verbal abuse means, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

In accordance with O.Reg. 79/10, section 2, physical abuse means, the use of physical force by anyone other than a resident that causes physical injury or pain.

As cited in evidence above, on an identified date, housekeeping staff #102 reported the witnessed incident of PSW #101 being verbally and physically abusive to resident #001 to the SSM. On the same day the SSM reported to the home's Administrator.

On February 28, 2018, Inspector #573 spoke with the home's Administrator, who indicated on an identified date, the SSM reported that housekeeping staff #102 witnessed incident of PSW #101 being verbally and physically abusive to resident #001. The Administrator indicated to Inspector #573 that considering previous employee and labor relations experience with PSW #101, the alleged staff to resident abuse incident was not immediately investigated, and was not reported to anyone in the home, so that PSW #101 would not suspect the source of the allegations. [s. 23. (1) (a)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

In accordance with O.Reg. 79/10, section 2, verbal abuse means, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

In accordance with O.Reg. 79/10, section 2, physical abuse means, the use of physical force by anyone other than a resident that causes physical injury or pain.

As cited in evidence above, on an identified date, housekeeping staff #102 reported the witnessed incident of PSW #101 being verbally and physically abusive to resident #001 to the SSM. On the same day the SSM reported to the home's Administrator.

On February 28, 2018, Inspector #573 spoke with the home's Administrator, who indicated on an identified date, the SSM reported that housekeeping staff #102 witnessed incident of PSW #101 being verbally and physically abusive to resident #001. The Administrator indicated to Inspector #573 that, the Director MOHLTCH was not immediately notified intentionally to protect the witnesses from PSW #101. [s. 24. (1)]

WN #5: 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 the resident's SDM was notified immediately upon becoming aware of alleged, suspected or witnessed incidents of abuse that resulted in physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

In accordance with O.Reg. 79/10, section 2, verbal abuse means, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

In accordance with O.Reg. 79/10, section 2, physical abuse means, the use of physical force by anyone other than a resident that causes physical injury or pain.

As cited in evidence above, on an identified date, housekeeping staff #102 reported the witnessed incident of PSW #101 being verbally and physically abusive to resident #001 to the SSM. On the same day the SSM reported to the home's Administrator.

On February 28, 2018, Inspector #573 spoke with the home's Administrator, who indicated on an identified date, the SSM reported that housekeeping staff #102 witnessed incident of PSW #101 being verbally and physically abusive to resident #001. The Administrator indicated to Inspector #573 that resident #001's SDM was not notified immediately of the staff to resident alleged abuse incident. [s. 97. (1) (a)]

WN #6: 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 were 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.

In accordance with O.Reg. 79/10, section 2, verbal abuse means, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

In accordance with O.Reg. 79/10, section 2, physical abuse means, the use of physical force by anyone other than a resident that causes physical injury or pain.

As cited in evidence above, on an identified date, housekeeping staff #102 reported the witnessed incident of PSW #101 being verbally and physically abusive to resident #001 to the SSM. On the same day the SSM reported to the home's Administrator.

On February 28, 2018, Inspector #573 spoke with the home's Administrator, who indicated on an identified date, the SSM reported that housekeeping staff #102 witnessed incident of PSW #101 being verbally and physically abusive to resident #001. The Administrator indicated to Inspector #573 that the staff to resident alleged verbal and physical abuse was not immediately reported to the police force. [s. 98.]

Issued on this 3rd day of April, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ANANDRAJ NATARAJAN (573)
Inspection No. / No de l'inspection :	2018_593573_0006
Log No. / No de registre :	029172-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 28, 2018
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	Extendicare Starwood 114 Starwood Road, NEPEAN, ON, K2G-3N5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sue MacGregor

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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 Act.

Specifically the licensee must ensure that:

1. If any person has reasonable grounds to suspect that resident abuse of any kind have occurred, including any suspicions, allegations or witnessed incidents of abuse, the licensee will immediately investigate and ensure that appropriate actions are taken as per the legislative requirements.

2. The mandatory reporting obligations as outlined in the LTCHA, 2007 s.24 indicates that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect by a staff member has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

3. The resident's substitute decision maker (SDM) is notified of every incident of alleged, suspected or witnessed incident of abuse as per the legislative requirements.

4. The appropriate police force have been notified immediately of all alleged, suspected, or witnessed incidents of abuse that the licensee suspects may constitute a criminal offence.

5. The licensee's "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" policy #RC-02-01-02 is complied with, including but not limited to the procedures: a) to immediately respond to any form of the alleged, suspected or witnessed abuse and b) to ensure the safety of, and provide support to the abused resident(s), through completion of full assessments.

Grounds / Motifs :

1. The licensee failed to ensure that the home protected resident #001 from abuse by anyone.

In accordance with O.Reg. 79/10, section 2, verbal abuse means, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

In accordance with O.Reg. 79/10, section 2, physical abuse means, the use of physical force by anyone other than a resident that causes physical injury or pain.

The Ministry of Health and Long Term Care (MOHLTC) home emergency pager received a call from the home on an identified date and time, to report an incident of staff to resident abuse involving resident #001.

On an identified date in 2017, a Critical Incident Report was submitted to MOHLTC related to staff to resident verbal and physical abuse.

A complaint was submitted to the Director of the MOHLTC on an identified date, related to staff to resident physical abuse. The complainant was concerned for the safety of resident #001 and other residents in the home.

On an identified date and time, housekeeping staff #102 witnessed PSW #101 name calling resident #001. At the time of the incident, housekeeping staff #102 observed resident #001 lying on the floor near the resident's bed. Housekeeping staff #102 observed PSW #101, who picked resident #001 from the floor, rough handled and transferred resident #001 from the floor to the bed where resident #001 appeared to be in pain. Furthermore, housekeeping staff #102 observed PSW #101 roughly shove resident #001 in the bed and tossed the resident's legs onto the bed.

On the same day the housekeeping staff #102 reported the witnessed PSW #101 to resident #001's incident of abuse to the Support Service Manager (SSM) and the SSM reported the incident of abuse to the home's Administrator.

On February 28, 2018, Inspector #573 spoke with the home's Administrator, who indicated that on an identified date, the SSM reported that housekeeping staff #102 witnessed incident of PSW #101 being verbally and physically abusive to resident #001. The Administrator indicated to Inspector #573 that considering previous employee and labor relations experience with PSW #101, the Administrator intentionally delayed notification to the external regulatory authorities. The Administrator indicated to the inspector that the alleged staff to resident abuse incident was not immediately investigated, and was not reported to anyone in the home, so that the PSW staff would not suspect the source of the allegations. Further, the Administrator indicated to the inspector that the Director MOHLTCH, resident #001's substitute decision maker (SDM) and police

were not immediately notified intentionally to protect the witness from PSW #101.

Two days after the incident the Administrator met with resident #001 regarding the incident that occurred on an identified date. During that meeting, resident #001 was not able to recollect the incident. The Administrator indicated to Inspector #573 that no actions were taken immediately to provide support to resident #001 and no full nursing assessment was conducted on resident #001. Further, the Administrator indicated to the inspector that PSW #101 was allowed and continued to provide care and services to the residents on the unit without any additional supervision, until PSW #101 was placed on an investigation leave on an identified date, which was eight days after the incident.

The Administrator indicated to the inspector that after PSW #101 was placed on investigation leave, and an internal investigation was conducted which included the collection of staff witness statements regarding the alleged incident of abuse. The Administrator stated that the internal investigation confirmed that staff to resident verbal and physical abuse occurred and PSW #101 was terminated.

The Administrator stated to Inspector #573 that after 24 days of the incident, on an identified date the MOHLTCH Director, resident #001's substitute decision maker (SDM) and police force were notified.

The licensee also failed to comply with:

1. LTCHA, s. 20 (1) the licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with. (refer to WN #2)

2. LTCHA, s. 23 (1) (a) the licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that is reported to the licensee, is immediately investigated. (refer to WN #3)

3. LTCHA, s. 24 (1) the licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone of a resident by the licensee or staff that resulted in harm or risk of harm to resident by not immediately reporting the suspicion and the information upon which it was based to the Director. (refer to WN #4)

4. O. Reg 79/10 s. 97 (1) (a) the licensee has failed to ensure that the resident's substitute decision maker, if any, and any other person specified by the resident are immediately notified upon becoming aware of alleged, suspected or witnessed incidents of abuse that resulted in physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well-being. (refer to WN #5)

5. O. Reg. 79/10, s. 98. The licensee has failed to ensure that the appropriate police force was 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. (refer to WN #6)

As demonstrated by this inspection report the home failed to protect resident #001 from abuse in that:

The licensee failed to immediately initiate an investigation of the alleged, suspected or witnessed staff to resident #001 abuse. PSW #101 was allowed and continued to provide care and services to resident #001 and other residents on the unit without any additional supervision, until the staff was placed on investigation leave. The procedures in the home's Zero Tolerance of Resident Abuse and Neglect Policy #RC-02-01-02, revised April 2017, to immediately respond to any form of alleged abuse and to ensure the safety of, and to provide support to resident #001, through the completion of a full assessment was not followed. In addition, reporting procedures, including reporting to the Director, resident substitute decision makers (SDMs) and police force were not followed.

The severity of this issue was determined to be a level 3 as there was actual harm/ risk to the resident. The scope of the issue was a level 1 as it related to one resident reviewed. The home had a level 2 compliance history as they had previous non-compliance unrelated with this section of the Regulation.

A Compliance Order was issued based on the severity of actual harm/ risk to the resident.

(573)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2018

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

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 28th day of March, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Anandraj Natarajan

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