Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 19, 2016	2015_433625_0007	033228-15	Critical Incident System

Licensee/Titulaire de permis

GERALDTON DISTRICT HOSPITAL
500 HOGARTH AVENUE WEST GERALDTON ON P0T 1M0

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

GERALDTON DISTRICT HOSPITAL
500 HOGARTH AVENUE WEST GERALDTON ON P0T 1M0

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

KATHERINE BARCA (625)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 1, 2, and 3, 2015.

This inspection was completed after a Critical Incident Report was submitted for an incident of resident abuse that occurred in the fall of 2015.

During the course of the inspection, the inspector(s) spoke with the Chief Nursing Officer (CNO), the Long-Term Care Manager (LTC Manager), the RAI Coordinator, the Education Coordinator, the Quality Improvement Nurse, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family and the Ontario Provincial Police (OPP).

The Inspector also reviewed clinical records, the home's policies and procedures related to resident abuse and incident reporting, staff training records, staff clinical worksheets, correspondence written by the home to an SDM, a video recording, staff witness statements, internal Incident Reports, toured the home and conducted observations of residents and the provision of resident care and services on the Long-Term Care (LTC) unit.

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.
- **9 WN(s)**
- **1 VPC(s)**
- **6 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from abuse.

A Critical Incident Report was submitted for an incident that occurred in fall of 2015. The incident was identified in the report as an assault. The report stated that person #002 was found abusing resident #001.

A review of person #002’s health care record by Inspector #625, revealed orders and progress notes made by the person’s physician from spring to fall of 2015. The orders and notes identified ongoing and increasing behaviours exhibited by the person, instructed staff on interventions to use and indicated that the person abused a resident.

A review of person #002’s progress notes from the beginning of 2015 to the fall of 2015, identified that person #002 was witnessed by staff on multiple occasions to display responsive behaviours that were abusive, or had the potential to become abusive, towards residents in the home.

During interviews with Inspector #625, the LTC Manager and Chief Nursing Officer (CNO) identified incidents involving the person’s interactions with residents, as captured in the progress notes, as abuse towards residents.

During the period of time that these incidents transpired, the following occurred:

(A) The licensee failed to ensure that all policies related to resident abuse or neglect were complied with.

(i) The home's policy WVHP-11 "Workplace Violence & Harassment – Resident Abuse" reviewed October 2013, defined sexual abuse as any form of non-consensual physical sexual relations with a resident; any non-consensual touching of a resident that is of a sexual nature; behaviour of a sexual nature exhibited towards a resident that is unwanted by the resident and sexual assault of a resident.

The home's policy N-A2 "Abuse and Neglect of Residents" reviewed October 2015, stated that staff must report all instances of suspected resident abuse immediately to the LTC Manager, to the CNO, or to the charge nurse who would then report suspected abuse to administration on-call.

The home's policy N-A2 "Abuse and Neglect of Residents" reviewed October 2015, was not complied with as a review of person #002’s progress notes by Inspector #625 identified documentation of abuse exhibited towards residents, including two entries in the spring of 2015, where the person displayed responsive behaviours towards residents

#001 and #003.

During interviews with Inspector #625, the LTC Manager and CNO stated that they did not have knowledge of the two incidents that occurred in the spring of 2015. The LTC Manager stated they had not been notified by staff of the first incident that occurred in spring of 2015, or that person #002 engaged in the activity documented in the second incident. When asked by Inspector #625 if the CNO had knowledge of previous interactions between person #002 and resident #003, they stated that they had been notified of limited behaviours exhibited by person #002 to resident #003, but did not indicate knowledge of the two incidents that occurred in the spring of 2015 when specifically asked.

(ii) The home's policy WVHP-11 "Workplace Violence & Harassment – Resident Abuse" revised October 2013, stated that completion of an internal Incident Report was required when responding to resident abuse.

A review of person #002's progress notes by Inspector #625 identified documentation of abusive behaviours exhibited towards residents in 2015, including entries from the beginning of 2015 to the fall of 2015, when the person was witnessed to display responsive behaviours towards residents #001 and #003.

During an interview on December 9, 2015 with Inspector #625, the LTC Manager stated that they had been aware of two of the incidents that occurred, and that incident reports were required.

During an interview on December 2, 2015 with Inspector #625, Nurse #105 provided internal Incident Report forms involving person #002 which consisted of internal Incident Report forms for three incidents occurring from spring to Fall of 2015. Nurse #105 stated that there were no other incident reports involving the person for 2014 or 2015. They stated that Incident Reports were required for any incidents of the person displaying specific responsive behaviours.

During an interview on December 3, 2015 with Inspector #625, the CNO stated that, had internal Incident Reports been completed as required, the home could have taken additional actions and assessed person #002's behaviours properly, possibly avoiding some of the later incidents, including an incident that occurred in the summer of 2015.

(B) The licensee failed to ensure that all staff working on, or having responsibility for, the

long-term care unit were trained in abuse prevention, recognition, response, and reporting requirements as identified in the Long-Term Care Homes Act, 2007 and Ontario Regulation 79/10.

(i) The licensee failed to ensure that all staff received retraining annually related to the Residents' Bill of Rights, the home's duty to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and whistle-blowing protections.

A review of training provided to staff in 2014 and 2015, identified that The Residents' Bill of Rights, the home's policies to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and the whistle-blowing protections were not listed.

During an interview on December 8, 2015 with Inspector #625, RPN #107 stated that they did not review the policy addressing zero tolerance of abuse and neglect, have not received training on the Residents' Bill of Rights, were not aware of the requirements for mandatory reporting and were not familiar with the term whistle-blowing protection. The RPN stated that they had not known that the incident that occurred in the fall of 2015 was required to be reported and to what extent.

During an interview on December 1, 2015 with Inspector #625, RPN #101 stated that they have had no training on abuse since they were hired several years prior.

During interviews with the Education Coordinator, the LTC Manager and the CNO, all three stated that annual training was not provided to staff on 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 or whistle-blowing protections.

(ii) The licensee failed to ensure that all staff who provided direct care to residents, received training related to abuse recognition and prevention annually, or as determined by the licensee, based on the assessed training needs of the individual staff member.

During a review of 2014 and 2015 documents listing training provided to direct care staff, abuse recognition and prevention were not listed.

During interviews with the Education Coordinator, the LTC Manager and the CNO, all three stated that annual training related to abuse recognition and prevention was not

provided to direct care staff. The LTC Manager also stated that the training was not provided based on the assessed training needs of individual staff members.

(C) The licensee failed to ensure that staff were familiar with the current care plans for each person or resident they provided care to including, but not limited to, interventions to address harmful or potentially harmful interactions.

A review of person #002's care plan, from spring to winter of 2015, listed specific responsive behaviours.

The person's care plan from spring to fall of 2015 contained interventions to address the responsive behaviours which provided direction to staff on how to manage the person's responsive behaviours.

During an interview on December 2, 2015 with Inspector #625, RPN #109 stated that, on the date of the incident of abuse that occurred in fall of 2015, they had entered the LTC unit and spent 15 to 20 minutes with RPNs #101 and #107, assisting a resident. A review of email correspondence from RPN #109 to the Quality Improvement Nurse dated two days after the incident of abuse occurred in the fall of 2015, indicated that they left the room they were assisting in to retrieve an item and saw resident #001 seated in a common area.

During an interview on December 2, 2015 with Inspector #625, RPN #101 stated that, on the date of the incident of abuse that occurred in the fall of 2015, they saw person #002 in the same area as resident #001. The two staff on the unit, RPN #101 and #107, provided care to a resident in their room leaving the person unsupervised for approximately 20 minutes. RPN #101 was called to the hallway by RPN #109 who had witnessed person #002 abusing resident #001.

A review of a statement dated two days after the incident of abuse in the fall of 2015 from RPN #101, indicated that, after initially responding to the interaction between person #002 and resident #001 on the date of the incident, the person's body had an injury. The two RPNs left the person and the resident together and went to retrieve an item. RPN #101 then noted the person attempting to again abuse resident #001.

During the interview, when asked to indicate the interventions in person #002's care plan to address their responsive behaviours at the time of the incident, RPN #101 stated that there were interventions around removing the resident and providing activities to them.

The RPN #101 was not able to recall interventions related to supervising the person's whereabouts and interactions with residents.

During an interview on December 8, 2015 with Inspector #625, RPN #107 stated that care plans are reviewed once monthly on the night shift but, if they were not the staff member reviewing the care plan, they would not be aware of the content. RPN #107 stated that they don't review care plans for the persons or residents they provide care to, but ask other staff members for direction as they don't have much time to sit down and read care plans. The RPN stated they were not aware of any prior incidents involving the person until after the incident in the fall of 2015 occurred.

RPNs #101 and #107, who worked on the date and shift of the reported incident in the fall of 2015, were not familiar with the person's care plan interventions related to responsive behaviours and minimizing the risk of harm to residents.

In summary, the licensee failed to ensure residents were protected from abuse by:

(A) failing to ensure that policies related to abuse were complied with including the notification of management as to the nature and occurrence of all incidents of abuse, and the completion of internal Incident Reports to monitor and track incidents of abuse;

(B) failing to ensure that staff received training on abuse prevention, recognition, response, and reporting requirements as identified in the Long-Term Care Homes Act, 2007 and Ontario Regulation 79/10; and

(C) failing to ensure that staff were familiar with and provided care as outlined in person #002's care plan. [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 policies that promote zero tolerance of abuse were complied with.

(A) The home's policy N-A2 "Abuse and Neglect of Residents" reviewed October 2015, stated that:

(i) the charge nurse was required to report suspected abuse to administration on-call;

(ii) administration on-call would initiate an investigation of abuse allegations immediately;

(iii) staff must report all instances of suspected resident abuse immediately to the LTC Manager, to the CNO, or to the charge nurse who would then report suspected abuse to administration on-call; and

(iv) the LTC Manager or administration on-call would complete a MOHLTC Critical Incident Report and contact the MOHLTC directly by telephone.

The home's policy N-A2 "Abuse and Neglect of Residents" reviewed October 2015, was not complied with as follows:

(i) During an interview on December 3, 2015 with Inspector #625, the CNO stated that management was not notified at the time of the incident of abuse that occurred in the fall of 2015, they were notified when they next attended work. They stated that the home's expectation is that administration on-call is to be notified at the time of the incident;

(ii) During the same interview, the CNO also stated that, as a result of administration on-call not being notified of the incident immediately, the investigation was delayed and did not commence immediately;

(iii) A review of person #002's progress notes by Inspector #625 identified documentation of abuse exhibited towards residents including two incidents that occurred in the spring of 2015, when the person displayed responsive behaviours towards residents #001 and resident #003.

During interviews with Inspector #625, the LTC Manager and CNO stated that they did not have knowledge of the two incidents that occurred in the spring of 2015. The LTC Manager stated they had not been notified by staff of the first incident that occurred in spring of 2015, or that person #002 engaged in the activity documented in the second incident. When asked by Inspector #625 if the CNO had knowledge of previous interactions between person #002 and resident #003, they stated that they had been notified of limited behaviours exhibited by person #002 to resident #003, but did not indicate knowledge of the two incidents that occurred in the spring of 2015 when specifically asked.

(iv) A review of person #002's progress notes from the beginning of 2015 to the fall of 2015, by Inspector #625, identified documentation of abuse exhibited towards residents including entries when the person was witnessed displaying responsive behaviours towards resident #001 and resident #003.

A review of the Critical Incident System by Inspector #625 determined that reports to the Director had not been submitted for any of the five incidents of abuse towards residents documented in person #002's progress notes.

During an interview on December 3, 2015 with Inspector #625, the CNO stated that MOHLTC Critical Incident System Reports were not completed for any of the five incidents, nor was the Director notified of the incidents by telephone.

(B) The home’s policy WVHP-11 "Workplace Violence & Harassment – Resident Abuse" revised October 2013, stated that, when responding to resident abuse, documentation of the incident was required on an internal Incident Report form and in the resident’s chart.

A review of person #002’s progress notes by Inspector #625 identified documentation of abusive behaviours exhibited towards residents in 2015, including entries from the beginning of 2015 to the fall of 2015, when the person was witnessed displaying responsive behaviours.

During an interview on December 2, 2015 with Inspector #625, Nurse #105 was asked to provide all internal Incident Reports involving person #002. The Nurse provided internal Incident Report forms for three incidents occurring from spring to Fall of 2015 and stated that there were no other incident reports for person #002 for 2014 or 2015.

During a phone interview on December 9, 2015 with Inspector #625, the LTC Manager identified that completion of internal Incident Reports was required for three incidents that occurred in the spring of 2015.

Upon review of resident #001's health care record by Inspector #625, no documentation was found for an incident of abuse that occurred in the summer of 2015 between person #002 and resident #001.

During an interview on December 9, 2015 with Inspector #625, the LTC Manager confirmed that incidents of abuse involving more than one person and/or resident required documentation in both health care records.

The licensee did not ensure that the written policy that promotes zero tolerance of abuse was complied with. The licensee specifically failed to ensure that the charge nurse reported abuse to administration on-call, that administration on-call initiated an investigation of abuse allegations immediately and, when responding to resident abuse, that documentation of the incidents was completed on internal Incident Report forms and in the charts of the residents involved.

The severity has been determined to be the potential for actual harm to occur. The scope was widespread and represented a systemic failure that has the potential to affect a large number of residents in the home. There is a history of unrelated non-compliance. [s. 20. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to immediately report to the Director abuse of a resident that resulted in harm or risk of harm.

A review of person #002's chart identified documentation made by the person's physician related to their behaviour during the spring to fall of 2015. The documentation stated that person #002 exhibited specific responsive behaviours.

A review of person #002's care plan, from the beginning of 2015 to the winter of 2015, listed inappropriate behaviours which included incidents of abusive responsive behaviours.

A review of person #002's progress notes by Inspector #625 identified documentation of abusive behaviours exhibited towards residents in 2015, including entries from the beginning of 2015 to the fall of 2015, when the person was witnessed displaying responsive behaviours.

A progress note, dated winter of 2015, indicated that person #002 was witnessed abusing resident #003, and that a message was left with the Manager. During an interview with the LTC Manager on December 9, 2015, they stated that they were aware of the incident that occurred in the winter of 2015, and contacted the person who witnessed it. The witness confirmed what they saw, person #002 was abusing resident

#001, and the Manager requested that the witness provide a statement in writing. Documentation entered in the spring of 2015 by the LTC Manager read that the Manager had a discussion with person #002 regarding abuse of residents.

During the same interview, the Manager stated that they witnessed person #002 abuse resident #001 in the spring of 2015. Documentation entered by the LTC Manager in the spring of 2015 read that they had witnessed person #002 abuse resident #001. The Manager had a discussion with person #002 and with person #002's family member related to abuse of residents, the vulnerability of resident #001 and the implementation of an intervention.

During an interview with the CNO on December 3, 2015, they stated that they had signed off on an internal Incident Report for an incident that occurred during the summer of 2015 and that they didn't notify the MOHLTC. The internal Incident Report dated the summer of 2015 read that person #002 was attempting to abuse resident #001.

During interviews with Inspector #625, the LTC Manager and CNO stated that the Director was not notified of five the incidents that occurred between the beginning of 2015 to the summer of 2015, but stated that the Director should have been made aware of the incidents of abuse towards residents. The CNO verified that Critical Incident Reports were not submitted to the Director for any of the five dates identified and that the incident that occurred in the fall of 2015 was not reported to the Director immediately, but the next day.

Therefore, the licensee has failed to immediately notify the Director of the six incidents of abuse that occurred between the beginning of 2015 and the fall of 2015.

The severity was determined to be minimum risk to residents and the scope demonstrated widespread, systemic prevalence. The home has a history of previous unrelated non-compliance. [s. 24. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 received retraining annually related to the Residents' Bill of Rights, the home's duty to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and whistle-blowing protections.

During a review of the training provided to staff in 2014 and 2015, it was noted that The Residents' Bill of Rights, the home's policies to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and the whistle-blowing protections were not listed.

During an interview on December 8, 2015 with Inspector #625, RPN #107 stated that they did not review the policy addressing zero tolerance of abuse and neglect, have not received training on the Residents' Bill of Rights, were not aware of the requirements for mandatory reporting and were not familiar with the term whistle-blowing protection.

During an interview on December 1, 2015 with Inspector #625, RPN #101 stated that they have had no training on abuse since they were hired several years prior.

During an interview on December 2, 2015 with Inspector #625, the Education Coordinator stated that they do not provide training related to the Long-Term Care Homes Act including requirements identified in s. 76. (4) and that specific annual training was not offered.

During an interview on December 9, 2015 with Inspector #625, the LTC Manager stated that no annual training was provided to staff on 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 or whistle-blowing protections.

During an interview on December 3, 3015 with Inspector #625, the CNO stated that no annual training was completed on the items required under s. 76. (4).

The scope of this issue is widespread as all staff were affected. The severity is minimal risk of harm to residents. The home had previous related non-compliance issued under r. 221. (2) during Resident Quality Inspection #2015_333577_0011 in May 2015. [s. 76. (4)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identified the training and retraining requirements for all staff, including training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care.

During a review of policies N-A2 "Abuse and Neglect of Residents" revised October 2015 and WVHP-11 "Workplace Violence & Harassment – Resident Abuse" revised October 2013, the training and retraining requirements for all staff including training on the relationship between power imbalances between staff and residents, and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care were not identified in the policies.

During an interview on December 3, 2015 with Inspector #625, the CNO stated that the home's policy does not identify the training and retraining requirements for staff training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care.

The severity of this non-compliance was minimal risk and the scope of this issue was widespread as all staff in the home were affected. The home has a history of unrelated non-compliance. [s. 96. (e)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents, receive training related to abuse recognition and prevention annually, or as determined by the licensee, based on the assessed training needs of the individual staff member.

During a review of 2014 and 2015 documents listing training provided to direct care staff, abuse recognition and prevention were not included.

During an interview on December 2, 2015 with Inspector #625, the Education Coordinator stated that the home did not provide training to direct care staff related to the Long-Term Care Homes Act requirements, abuse recognition and prevention, and that the home offered no specific annual training.

During an interview on December 9, 2015 with Inspector #625, the LTC Manager stated that no training related to abuse recognition and prevention was provided to direct care staff annually, or when indicated based on assessed training needs of individual staff members.

During an interview on December 3, 3015 with Inspector #625, the CNO stated that no annual training was provided to direct care staff related to abuse recognition and prevention.

The scope of this non-compliance was widespread as it involved every staff member. The severity was determined to be the potential for actual harm to occur. The home had similar non-compliance issued under s. 221. (2) during Resident Quality Inspection #2015_333577_0011 in May 2015. [s. 221. (2)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: 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 incident of abuse that the license suspected may have constituted a criminal offence.

A review of person #002's health care record, from the beginning of 2015 to the fall of 2015, identified progress notes entered when the person was witnessed abusing resident #001 and resident #003.

In spring of 2015, the LTC Manager documented in person #002's health care record, that they had explained to the person what abuse was and that some of their responsive behaviours could be abusive to residents in the home. The following month, the LTC Manager documented witnessing person #002 displaying specific responsive behaviours to resident #001 and questioned the person. The LTC Manager documented that resident #001 had a diagnosis that made them vulnerable, and that person #002 was worried about the police being called.

During an interview with Inspector #625 on December 9, 2015, the LTC Manager reviewed the definition of sexual abuse as defined in Ontario Regulation 79/10, 2 (1) as 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. During the interview, the LTC Manager stated that the police were required to have been notified of three incidents that occurred in the spring of 2015, but were not.

During an interview with Inspector #625 on December 9, 2015, an external consultant to the home, consultant #110, referenced consultation notes from the spring of 2015 of a phone consultation between consultant #110 and the LTC Manager about an incident that had occurred. Consultant #110 stated that the notes read that the LTC Manager was concerned that disclosing the incident to the family may result in the family wanting to lay charges and identified the incident discussed as one incident documented to have occurred in the spring of 2015.

A review of person #002's progress notes from spring to fall of 2015 contained one entry, during the fall of 2015, that indicated the Ontario Provincial Police (OPP) were contacted for an incident that occurred, greater than 13 hours after the incident.

During an interview on December 3, 2015 with RPN #101, they stated that they should have called the OPP the night of the incident.

During an interview on December 3, 2015 with Inspector #625, the CNO stated that the police were not immediately notified of the abuse that occurred in the fall of 2015, and had not been notified of any incident of abuse that occurred from the spring of 2015 until the notification they received regarding the incident that occurred in fall of 2015.

The scope was determined to be a pattern as the practice that occurred repeatedly. The severity was determined to be the potential for actual harm to occur. The home has previous unrelated non-compliance. [s. 98.]

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 that ensures 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, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, that policy was in compliance with and was implemented in accordance with all applicable requirements under the Act.

A review of the home's policy WVHP-11 "Workplace Violence & Harassment – Resident Abuse" revised October 2013, identified content not in compliance with the Long-Term Care Homes Act, 2007 and Regulation 79/10 including:

(A) Reporting to the MOHLTC all confirmed or suspected incidents of abuse (page 1);

(B) Reference to the Nursing Home Act (page 8);

(C) Notification of the MOHLTC by phone within 24 hours of determining that abuse may have/has/is likely to have taken place (page 11);

(D) Completion of an Abuse Report Form forwarded to the MOHLTC Regional Office within five business days of having determined that abuse has taken place (page 11);

(E) Obtaining an Abuse Report Form from the MOHLTC Form Registry, on the Long-Term Care Homes Branch website, or from the MOHLTC Regional Office (page 12);

(F) Completion of the investigation within one month of the initial report to the MOHLTC (page 12);

(G) If circumstances prevent the completion of the report within one month, completion of

the final report submitted within the time frame specified by the Regional Office (page 12);

The content of the home's policy WVHP-11 "Workplace Violence & Harassment – Resident Abuse" revised October 2013, is not in compliance with the Long-Term Care Homes Act, 2007, Regulation 79/10 and applicable requirements as:

(A) The licensee is required to immediately investigate and report every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee. Long-Term Care Homes Act, 2007, s. 23. (1) (a) (i) and s. 23 (2);

(B) Effective July 1, 2010, the Long-Term Care Homes Act, 2007 replaced the Nursing Homes Act;

(C) 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. Long-Term Care Homes Act, 2007, s. 24. (1) 2;

(D) Written reports are completed electronically and submitted online using the Critical Incident System, Abuse Report Forms are not in use.

Submission of reports occurs to the Central Intake Assessment and Triage Team, not to the MOHLTC Regional Office.

A licensee is required to make the report under the Long-Term Care Homes Act, 2007, s. 23. (2) within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. Ontario Regulation 79/10, s. 104 (2);

(E) Written reports are completed electronically and submitted online using the Critical Incident System, Abuse Report Forms are not in use;

(F) and (G) If not everything required under Ontario Regulation 79/10, s. 104 (1) can be provided in a report within 10 days, the license shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director (within 21 days). Ontario Regulation 79/10, s. 104 (3).

The scope is isolated to one policy and the severity is minimal risk. The home has a history of unrelated noncompliance. [s. 8. (1) (a)]

WN #9: 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 Substitute Decision Maker (SDM) was notified within 12 hours of the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident.

Person #002's progress note from the summer of 2015, included documentation that the person abused resident #001. Notification of resident #001's SDM was not documented in resident #001's progress notes.

A review of an internal Incident Report from the summer of 2015, reflected that resident #001's SDM was not notified of the incident of abuse.

A review of a letter from the home provided to resident #001's SDM in the fall of 2015, referred to incident that occurred in the summer of 2015 and stated that the home was not able to confirm that the SDM had been notified of the incident.

During interviews with the RAI Coordinator and resident #001's SDM, both stated that resident #001's SDM had not been notified of the incident that occurred in the summer of 2015 until the fall of 2015, greater than 3 months after the incident.

The scope of this issue was isolated to one resident and the severity was determined to be minimal risk to the resident. The home has a history of unrelated noncompliance. [s. 97. (1) (b)]

Issued on this 26th day of February, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KATHERINE BARCA (625)
Inspection No. / No de l'inspection :	2015_433625_0007
Log No. / Registre no:	033228-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 19, 2016
Licensee / Titulaire de permis :	GERALDTON DISTRICT HOSPITAL 500 HOGARTH AVENUE WEST, GERALDTON, ON, P0T-1M0
LTC Home / Foyer de SLD :	GERALDTON DISTRICT HOSPITAL 500 HOGARTH AVENUE WEST, GERALDTON, ON, P0T-1M0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lucy Bonanno

To GERALDTON DISTRICT HOSPITAL, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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

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 shall:

a) Review and revise all policies related to resident abuse and neglect to ensure that they are in compliance with the Long-Term Care Homes Act, 2007 and Ontario Regulation 79/10.

b) Train all staff working on, or having responsibility for, the long-term care unit on the revised abuse and neglect policies, specifically related to abuse prevention, recognition, response, and reporting requirements as identified in the Long-Term Care Homes Act, 2007 and Ontario Regulation 79/10.

c) Develop and implement a system to monitor compliance with the home's abuse and neglect policies.

d) Develop and implement a system to ensure that staff are familiar with the current care plans for each person and resident they provide care to including, but not limited to, interventions to address harmful or potentially harmful interactions.

e) Immediately report to the Director all incidents of alleged, suspected or witnessed abuse.

f) Immediately notify the appropriate police force of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

g) Notify the resident's SDM immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of a 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 notify the SDM within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Grounds / Motifs :

1. The licensee has failed to ensure that residents are protected from abuse.

A Critical Incident Report was submitted for an incident that occurred in fall of 2015. The incident was identified in the report as an assault. The report stated

that person #002 was found abusing resident #001.

A review of person #002's health care record by Inspector #625, revealed orders and progress notes made by the person's physician from spring to fall of 2015. The orders and notes identified ongoing and increasing behaviours exhibited by the person, instructed staff on interventions to use and indicated that the person abused a resident.

A review of person #002's progress notes from the beginning of 2015 to the fall of 2015, identified that person #002 was witnessed by staff on multiple occasions to display responsive behaviours that were abusive, or had the potential to become abusive, towards residents in the home.

During interviews with Inspector #625, the LTC Manager and Chief Nursing Officer (CNO) identified incidents involving the person's interactions with residents, as captured in the progress notes, as abuse towards residents.

During the period of time that these incidents transpired, the following occurred:

(A) The licensee failed to ensure that all policies related to resident abuse or neglect were complied with.

(i) The home's policy WVHP-11 "Workplace Violence & Harassment – Resident Abuse" reviewed October 2013, defined sexual abuse as any form of non-consensual physical sexual relations with a resident; any non-consensual touching of a resident that is of a sexual nature; behaviour of a sexual nature exhibited towards a resident that is unwanted by the resident and sexual assault of a resident.

The home's policy N-A2 "Abuse and Neglect of Residents" reviewed October 2015, stated that staff must report all instances of suspected resident abuse immediately to the LTC Manager, to the CNO, or to the charge nurse who would then report suspected abuse to administration on-call.

The home's policy N-A2 "Abuse and Neglect of Residents" reviewed October 2015, was not complied with as a review of person #002's progress notes by Inspector #625 identified documentation of abuse exhibited towards residents, including two entries in the spring of 2015, where the person displayed responsive behaviours towards residents #001 and #003.

During interviews with Inspector #625, the LTC Manager and CNO stated that they did not have knowledge of the two incidents that occurred in the spring of 2015. The LTC Manager stated they had not been notified by staff of the first incident that occurred in spring of 2015, or that person #002 engaged in the activity documented in the second incident. When asked by Inspector #625 if the CNO had knowledge of previous interactions between person #002 and resident #003, they stated that they had been notified of limited behaviours exhibited by person #002 to resident #003, but did not indicate knowledge of the two incidents that occurred in the spring of 2015 when specifically asked.

(ii) The home's policy WVHP-11 "Workplace Violence & Harassment – Resident Abuse" revised October 2013, stated that completion of an internal Incident Report was required when responding to resident abuse.

A review of person #002's progress notes by Inspector #625 identified documentation of abusive behaviours exhibited towards residents in 2015, including entries from the beginning of 2015 to the fall of 2015, when the person was witnessed to display responsive behaviours towards residents #001 and #003.

During an interview on December 9, 2015 with Inspector #625, the LTC Manager stated that they had been aware of two of the incidents that occurred, and that incident reports were required.

During an interview on December 2, 2015 with Inspector #625, Nurse #105 provided internal Incident Report forms involving person #002 which consisted of internal Incident Report forms for three incidents occurring from spring to Fall of 2015. Nurse #105 stated that there were no other incident reports involving the person for 2014 or 2015. They stated that Incident Reports were required for any incidents of the person displaying specific responsive behaviours.

During an interview on December 3, 2015 with Inspector #625, the CNO stated that, had internal Incident Reports been completed as required, the home could have taken additional actions and assessed person #002's behaviours properly, possibly avoiding some of the later incidents, including an incident that occurred in the summer of 2015.

(B) The licensee failed to ensure that all staff working on, or having responsibility

for, the long-term care unit were trained in abuse prevention, recognition, response, and reporting requirements as identified in the Long-Term Care Homes Act, 2007 and Ontario Regulation 79/10.

(i) The licensee failed to ensure that all staff received retraining annually related to the Residents' Bill of Rights, the home's duty to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and whistle-blowing protections.

A review of training provided to staff in 2014 and 2015, identified that The Residents' Bill of Rights, the home's policies to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and the whistle-blowing protections were not listed.

During an interview on December 8, 2015 with Inspector #625, RPN #107 stated that they did not review the policy addressing zero tolerance of abuse and neglect, have not received training on the Residents' Bill of Rights, were not aware of the requirements for mandatory reporting and were not familiar with the term whistle-blowing protection. The RPN stated that they had not known that the incident that occurred in the fall of 2015 was required to be reported and to what extent.

During an interview on December 1, 2015 with Inspector #625, RPN #101 stated that they have had no training on abuse since they were hired several years prior.

During interviews with the Education Coordinator, the LTC Manager and the CNO, all three stated that annual training was not provided to staff on 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 or whistle-blowing protections.

(ii) The licensee failed to ensure that all staff who provided direct care to residents, received training related to abuse recognition and prevention annually, or as determined by the licensee, based on the assessed training needs of the individual staff member.

During a review of 2014 and 2015 documents listing training provided to direct care staff, abuse recognition and prevention were not listed.

During interviews with the Education Coordinator, the LTC Manager and the CNO, all three stated that annual training related to abuse recognition and prevention was not provided to direct care staff. The LTC Manager also stated that the training was not provided based on the assessed training needs of individual staff members.

(C) The licensee failed to ensure that staff were familiar with the current care plans for each person or resident they provided care to including, but not limited to, interventions to address harmful or potentially harmful interactions.

A review of person #002's care plan, from spring to winter of 2015, listed specific responsive behaviours.

The person's care plan from spring to fall of 2015 contained interventions to address the responsive behaviours which provided direction to staff on how to manage the person's responsive behaviours.

During an interview on December 2, 2015 with Inspector #625, RPN #109 stated that, on the date of the incident of abuse that occurred in fall of 2015, they had entered the LTC unit and spent 15 to 20 minutes with RPNs #101 and #107, assisting a resident. A review of email correspondence from RPN #109 to the Quality Improvement Nurse dated two days after the incident of abuse occurred in the fall of 2015, indicated that they left the room they were assisting in to retrieve an item and saw resident #001 seated in a common area.

During an interview on December 2, 2015 with Inspector #625, RPN #101 stated that, on the date of the incident of abuse that occurred in the fall of 2015, they saw person #002 in the same area as resident #001. The two staff on the unit, RPN #101 and #107, provided care to a resident in their room leaving the person unsupervised for approximately 20 minutes. RPN #101 was called to the hallway by RPN #109 who had witnessed person #002 abusing resident #001.

A review of a statement dated two days after the incident of abuse in the fall of 2015 from RPN #101, indicated that, after initially responding to the interaction between person #002 and resident #001 on the date of the incident, the person's body had an injury. The two RPNs left the person and the resident together and went to retrieve an item. RPN #101 then noted the person attempting to again abuse resident #001.

During the interview, when asked to indicate the interventions in person #002's care plan to address their responsive behaviours at the time of the incident, RPN #101 stated that there were interventions around removing the resident and providing activities to them. The RPN #101 was not able to recall interventions related to supervising the person's whereabouts and interactions with residents.

During an interview on December 8, 2015 with Inspector #625, RPN #107 stated that care plans are reviewed once monthly on the night shift but, if they were not the staff member reviewing the care plan, they would not be aware of the content. RPN #107 stated that they don't review care plans for the persons or residents they provide care to, but ask other staff members for direction as they don't have much time to sit down and read care plans. The RPN stated they were not aware of any prior incidents involving the person until after the incident in the fall of 2015 occurred.

RPNs #101 and #107, who worked on the date and shift of the reported incident in the fall of 2015, were not familiar with the person's care plan interventions related to responsive behaviours and minimizing the risk of harm to residents.

In summary, the licensee failed to ensure residents were protected from abuse by:

(A) failing to ensure that policies related to abuse were complied with including the notification of management as to the nature and occurrence of all incidents of abuse, and the completion of internal Incident Reports to monitor and track incidents of abuse;

(B) failing to ensure that staff received training on abuse prevention, recognition, response, and reporting requirements as identified in the Long-Term Care Homes Act, 2007 and Ontario Regulation 79/10; and

(C) failing to ensure that staff were familiar with and provided care as outlined in person #002's care plan. (625)

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 15, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall:

a) Ensure that all staff working on, or having responsibility for, the long-term care unit receive training on the revised written policies to promote zero tolerance of abuse and neglect of residents including, but not limited to, the roles of each staff member in identifying, responding to and reporting abuse and neglect.

b) Evaluate the knowledge of staff post-training and ensure that staff demonstrate knowledge and understanding of the home's written policies to promote zero tolerance of abuse and neglect of residents.

c) Maintain records of the training provided including, but not limited to, dates, times, attendees, trainers, materials taught and staff post-training evaluations.

Grounds / Motifs :

1. The licensee has failed to ensure that the written policies that promote zero tolerance of abuse were complied with.

(A) The home's policy N-A2 "Abuse and Neglect of Residents" reviewed October 2015, stated that:

(i) the charge nurse was required to report suspected abuse to administration on-call;

(ii) administration on-call would initiate an investigation of abuse allegations

immediately;

(iii) staff must report all instances of suspected resident abuse immediately to the LTC Manager, to the CNO, or to the charge nurse who would then report suspected abuse to administration on-call; and

(iv) the LTC Manager or administration on-call would complete a MOHLTC Critical Incident Report and contact the MOHLTC directly by telephone.

The home's policy N-A2 "Abuse and Neglect of Residents" reviewed October 2015, was not complied with as follows:

(i) During an interview on December 3, 2015 with Inspector #625, the CNO stated that management was not notified at the time of the incident of abuse that occurred in the fall of 2015, they were notified when they next attended work. They stated that the home's expectation is that administration on-call is to be notified at the time of the incident;

(ii) During the same interview, the CNO also stated that, as a result of administration on-call not being notified of the incident immediately, the investigation was delayed and did not commence immediately;

(iii) A review of person #002's progress notes by Inspector #625 identified documentation of abuse exhibited towards residents including two incidents that occurred in the spring of 2015, when the person displayed responsive behaviours towards residents #001 and resident #003.

During interviews with Inspector #625, the LTC Manager and CNO stated that they did not have knowledge of the two incidents that occurred in the spring of 2015. The LTC Manager stated they had not been notified by staff of the first incident that occurred in spring of 2015, or that person #002 engaged in the activity documented in the second incident. When asked by Inspector #625 if the CNO had knowledge of previous interactions between person #002 and resident #003, they stated that they had been notified of limited behaviours exhibited by person #002 to resident #003, but did not indicate knowledge of the two incidents that occurred in the spring of 2015 when specifically asked.

(iv) A review of person #002's progress notes from the beginning of 2015 to the fall of 2015, by Inspector #625, identified documentation of abuse exhibited

towards residents including entries when the person was witnessed displaying responsive behaviours towards resident #001 and resident #003.

A review of the Critical Incident System by Inspector #625 determined that reports to the Director had not been submitted for any of the five incidents of abuse towards residents documented in person #002's progress notes.

During an interview on December 3, 2015 with Inspector #625, the CNO stated that MOHLTC Critical Incident System Reports were not completed for any of the five incidents, nor was the Director notified of the incidents by telephone.

(B) The home's policy WVHP-11 "Workplace Violence & Harassment – Resident Abuse" revised October 2013, stated that, when responding to resident abuse, documentation of the incident was required on an internal Incident Report form and in the resident's chart.

A review of person #002's progress notes by Inspector #625 identified documentation of abusive behaviours exhibited towards residents in 2015, including entries from the beginning of 2015 to the fall of 2015, when the person was witnessed displaying responsive behaviours.

During an interview on December 2, 2015 with Inspector #625, Nurse #105 was asked to provide all internal Incident Reports involving person #002. The Nurse provided internal Incident Report forms for three incidents occurring from spring to Fall of 2015 and stated that there were no other incident reports for person #002 for 2014 or 2015.

During a phone interview on December 9, 2015 with Inspector #625, the LTC Manager identified that completion of internal Incident Reports was required for three incidents that occurred in the spring of 2015.

Upon review of resident #001's health care record by Inspector #625, no documentation was found for an incident of abuse that occurred in the summer of 2015 between person #002 and resident #001.

During an interview on December 9, 2015 with Inspector #625, the LTC Manager confirmed that incidents of abuse involving more than one person and/or resident required documentation in both health care records.

The licensee did not ensure that the written policy that promotes zero tolerance of abuse was complied with. The licensee specifically failed to ensure that the charge nurse reported abuse to administration on-call, that administration on-call initiated an investigation of abuse allegations immediately and, when responding to resident abuse, that documentation of the incidents was completed on internal Incident Report forms and in the charts of the residents involved.

The severity has been determined to be the potential for actual harm to occur. The scope was widespread and represented a systemic failure that has the potential to affect a large number of residents in the home. There is a history of unrelated non-compliance. (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2016

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The licensee shall:

a) Ensure staff are trained to identify and report all alleged, suspected and witnessed incidents of abuse immediately to the Director.

b) Ensure staff are familiar with and understand how to use the Licensee Reporting of Emotional Abuse Decision Tree, the Licensee Reporting of Financial Abuse Decision Tree, the Licensee Reporting of Physical Abuse Decision Tree, the Licensee Reporting of Sexual Abuse Decision Tree, the Licensee Reporting of Verbal Abuse Decision Tree and the Licensee Reporting of Neglect Decision Tree.

c) Evaluate the knowledge of staff post-training and ensure that staff demonstrate the knowledge and understanding required to identify and report alleged, suspected and witnessed incidents of abuse to the Director immediately, and to use the MOHLTC Decision Trees competently.

d) Maintain records of the training provided including, but not limited to, dates, times, attendees, trainers, materials taught and post-training staff evaluations.

e) Development and implement a monitoring system to ensure that abuse is reported as required by this section.

Grounds / Motifs :

1. The licensee has failed to immediately report to the Director abuse of a resident that resulted in harm or risk of harm.

A review of person #002's chart identified documentation made by the person's physician related to their behaviour during the spring to fall of 2015. The documentation stated that person #002 exhibited specific responsive behaviours.

A review of person #002's care plan, from the beginning of 2015 to the winter of 2015, listed inappropriate behaviours which included incidents of abusive responsive behaviours.

A review of person #002's progress notes by Inspector #625 identified documentation of abusive behaviours exhibited towards residents in 2015, including entries from the beginning of 2015 to the fall of 2015, when the person

was witnessed displaying responsive behaviours.

A progress note, dated winter of 2015, indicated that person #002 was witnessed abusing resident #003, and that a message was left with the Manager. During an interview with the LTC Manager on December 9, 2015, they stated that they were aware of the incident that occurred in the winter of 2015, and contacted the person who witnessed it. The witness confirmed what they saw, person #002 was abusing resident #001, and the Manager requested that the witness provide a statement in writing. Documentation entered in the spring of 2015 by the LTC Manager read that the Manager had a discussion with person #002 regarding abuse of residents.

During the same interview, the Manager stated that they witnessed person #002 abuse resident #001 in the spring of 2015. Documentation entered by the LTC Manager in the spring of 2015 read that they had witnessed person #002 abuse resident #001. The Manager had a discussion with person #002 and with person #002's family member related to abuse of residents, the vulnerability of resident #001 and the implementation of an intervention.

During an interview with the CNO on December 3, 2015, they stated that they had signed off on an internal Incident Report for an incident that occurred during the summer of 2015 and that they didn't notify the MOHLTC. The internal Incident Report dated the summer of 2015 read that person #002 was attempting to abuse resident #001.

During interviews with Inspector #625, the LTC Manager and CNO stated that the Director was not notified of five the incidents that occurred between the beginning of 2015 to the summer of 2015, but stated that the Director should have been made aware of the incidents of abuse towards residents. The CNO verified that Critical Incident Reports were not submitted to the Director for any of the five dates identified and that the incident that occurred in the fall of 2015 was not reported to the Director immediately, but the next day.

Therefore, the licensee has failed to immediately notify the Director of the six incidents of abuse that occurred between the beginning of 2015 and the fall of 2015.

The severity was determined to be minimum risk to residents and the scope demonstrated widespread, systemic prevalence. The home has a history of

previous unrelated non-compliance. (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2016

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall:

a) Provide training to all staff in the areas of the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports and the whistle-blowing protections afforded by section 26.

b) Provide training to all staff prior to performing their responsibilities, annually and at any other time determined necessary by the licensee in the areas of the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports and the whistle-blowing protections afforded by section 26.

c) Evaluate the knowledge of staff post-training and ensure that staff demonstrate knowledge and understanding of the content.

d) Maintain records of the training provided including, but not limited to, dates, times, attendees, trainers, materials taught and post-training staff evaluations.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff received retraining annually related to the Residents' Bill of Rights, the home's duty to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and whistle-blowing protections.

During a review of the training provided to staff in 2014 and 2015, it was noted

that The Residents' Bill of Rights, the home's policies to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and the whistle-blowing protections were not listed.

During an interview on December 8, 2015 with Inspector #625, RPN #107 stated that they did not review the policy addressing zero tolerance of abuse and neglect, have not received training on the Residents' Bill of Rights, were not aware of the requirements for mandatory reporting and were not familiar with the term whistle-blowing protection.

During an interview on December 1, 2015 with Inspector #625, RPN #101 stated that they have had no training on abuse since they were hired several years prior.

During an interview on December 2, 2015 with Inspector #625, the Education Coordinator stated that they do not provide training related to the Long-Term Care Homes Act including requirements identified in s. 76. (4) and that specific annual training was not offered.

During an interview on December 9, 2015 with Inspector #625, the LTC Manager stated that no annual training was provided to staff on 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 or whistle-blowing protections.

During an interview on December 3, 3015 with Inspector #625, the CNO stated that no annual training was completed on the items required under s. 76. (4).

The scope of this issue is widespread as all staff were affected. The severity is minimal risk of harm to residents. The home had previous related non-compliance issued under r. 221. (2) during Resident Quality Inspection #2015_333577_0011 in May 2015. (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2016

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 96. Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,

(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;

(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

(e) identifies the training and retraining requirements for all staff, including,

(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and

(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Order / Ordre :

The licensee shall:

a) Review the policies N-A2 "Abuse and Neglect of Residents", revised October 2015 and WVHP-11 "Workplace Violence & Harassment – Resident Abuse", revised October 2013, and update the policies, as required, to include training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care.

b) Review the policies N-A2 "Abuse and Neglect of Residents", revised October 2015 and WVHP-11 "Workplace Violence & Harassment – Resident Abuse", revised October 2013, and update the policies, as required, to ensure that all requirements provided for under r. 96. are contained in the policies.

c) Provide training to all staff on the revised policies.

d) Evaluate the knowledge of staff post-training and ensure that staff demonstrate knowledge and understanding of the content related to Ontario Regulation 79/10 s. 96.

e) Maintain records of the training provided including, but not limited to, dates, times, attendees, trainers, materials taught and post-training staff evaluations.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identified the training and retraining requirements for all staff, including training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care.

During a review of policies N-A2 "Abuse and Neglect of Residents" revised October 2015 and WVHP-11 "Workplace Violence & Harassment – Resident Abuse" revised October 2013, the training and retraining requirements for all staff including training on the relationship between power imbalances between staff and residents, and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care were not identified in the policies.

During an interview on December 3, 2015 with Inspector #625, the CNO stated that the home's policy does not identify the training and retraining requirements for staff training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care.

The severity of this non-compliance was minimal risk and the scope of this issue was widespread as all staff in the home were affected. The home has a history of unrelated non-compliance. (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2016

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

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Order / Ordre :

The licensee shall:

a) Provide training to all staff who provide direct care to residents on abuse recognition and prevention.

b) Ensure that all staff who provide direct care to residents receive training, as a condition of continuing to have contact with residents, in abuse recognition and prevention annually or, if the licensee assesses the training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs.

c) Evaluate the knowledge of staff post-training and ensure that staff demonstrate knowledge and understanding of the content.

d) Maintain records of the training provided including, but not limited to, dates, times, attendees, trainers, materials taught and post-training staff evaluations.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff who provide direct care to residents, receive training related to abuse recognition and prevention annually, or as determined by the licensee, based on the assessed training needs of the individual staff member.

During a review of 2014 and 2015 documents listing training provided to direct care staff, abuse recognition and prevention were not included.

During an interview on December 2, 2015 with Inspector #625, the Education Coordinator stated that the home did not provide training to direct care staff related to the Long-Term Care Homes Act requirements, abuse recognition and prevention, and that the home offered no specific annual training.

During an interview on December 9, 2015 with Inspector #625, the LTC Manager stated that no training related to abuse recognition and prevention was provided to direct care staff annually, or when indicated based on assessed training needs of individual staff members.

During an interview on December 3, 3015 with Inspector #625, the CNO stated that no annual training was provided to direct care staff related to abuse recognition and prevention.

The scope of this non-compliance was widespread as it involved every staff member. The severity was determined to be the potential for actual harm to occur. The home had similar non-compliance issued under s. 221. (2) during Resident Quality Inspection #2015_333577_0011 in May 2015. (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 19th day of February, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Katherine Barca

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