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

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Inspection de soins de longue durée

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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
Dec 15, 2016	2016_397607_0016	020117-16, 023485-16	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF NORTHUMBERLAND
983 Burnham Street COBOURG ON K9A 5J6

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

GOLDEN PLOUGH LODGE
983 BURNHAM STREET COBOURG ON K9A 5J6

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

JULIET MANDERSON-GRAY (607), LYNDA BROWN (111)

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): July 7, 13, 14, 15, 19 - 20, September 07, 08, 09, 12, 13 and 14, 2016

During this Inspection, the following intakes were reviewed and inspected upon Log's # 017074-16, 020117-16, 026804-16, 025239-16, 023485-16 and 020565-16.

Summary of the Intakes:
1) #017074-16: regarding staff to resident alleged abuse
2) #020117-16: regarding resident to resident alleged abuse
3) #026804-16: regarding an alleged resident to resident abuse
4) #025239-16: regarding an alleged resident to resident abuse
5) #023485-16: regarding an alleged resident to resident abuse
6) #020565-16: Complaint regarding resident care

During the course of the inspection, the inspector(s) spoke with the Medical Director, Director of Care, Assistant Director Care, Assistant Director of Care Clinical, Physiotherapist (PT), Physiotherapist Assistant (PTA), Registered Nurses (RN), Registered Practical Nurses (RPN), Life Enrichment Aide (LE), and Personal Support Workers (PSW) and family members.

During the course of the inspection the inspector reviewed clinical health records, observed staff to resident interactions, reviewed home specific policies related to falls, reporting of complaints, responsive behaviours, skin and wound and abuse.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

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

12 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 has failed to ensure that residents were protected from physical, verbal, sexual and emotional abuse by resident #002.

Under O.Reg.79/10, s. 2(1) For the purposes of the definition of "abuse" in subsection 2(1) of the Act, "physical abuse" means, subject to subsection (2) (c) the use of physical force by a resident that causes physical injury to another resident; "sexual abuse" means, subject to subsection (3) (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member; "emotional abuse" means, subject to subsection (1), (b) the use of any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences. “Verbal abuse” means, any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences.

Re: Three Intakes (Log # 023485-16 & 020117-16) for resident #002 and (Log # 020565-16) for resident #003:

Review of the progress notes for resident #002 by two Inspectors during the inspection, indicated that since admissions to an identified date, when the responsive behaviours ceased, there were ongoing incidents of either witnessed or suspected physical, verbal, sexual and/or emotional abuse by resident #002 towards other cognitively impaired residents as follows:

1. Eight residents were the recipient of resident #002's witnessed or suspected verbal,

physical, or sexual abuse, on more than one occasion (resident #003, #005, #006, #007, #009, #010, #011 and #012).
2. There were nine additional incidents of either suspected and/or witnessed verbal, physical, emotional or sexual abuse by resident #002, where the recipient residents were not identified.

The following three incidents were reported to the Director but not reported to the police:
1. On an identified date and time, staff witnessed resident #002 was physically abusive towards resident #010, causing the resident to fall, and being transferred to hospital with sustained injuries.
2. On an identified date and time, the staff witnessed resident #002 was being sexually inappropriate towards resident #005, the resident touched resident #005's body part. The Director was not notified of this incident until an identified date, five months later, after an Inspector spoke with the DOC.
3. On an identified date and time, staff witnessed resident #002 being physically and emotional abusive towards resident #003. Resident #003 fell to the floor, sustained injuries to a body part and became unconscious for approximately two minutes. Resident #003 was not transferred to hospital until approximately two hours later.

In addition, there were 14 incidents of suspected and/or witnessed verbal, emotional, physical or sexual abuse that were documented in resident #002's progress notes towards other residents, that were not investigated, had no documented evidence to indicate the residents that were the recipients of the alleged abuse were assessed for injury or distress and there were no documented evidence that the incidents were reported to the Substitute Decision Makers (SDM's), the Director, and the police.

Interview with the Assistant Director of Care (ADOC) #110 on an identified date by an Inspector, confirmed that resident #002 and resident #005 were not able to give consent to touching and/or to behaviours of a sexual nature. Interview with the DOC on the same day by the inspector, indicated that he/she did not perceive the incidents of non-consensual sexual behaviours by resident #002 directed towards resident #005, to be abusive, and as such, they were not reported.

Interview with Registered Practical Nurse (RPN) #128 on an identified date, by an Inspector, indicated the behaviours resident #002 exhibited towards resident #003, were sexual in nature and he/she did not report the incidents to anyone.

Interview with Registered Nurse (RN) #127 by an Inspector, indicated recalling the

incident that occurred on an identified date, but was unable to recall which two residents were the recipient of resident #002's sexually inappropriate behaviours, and could not recall what 'acting sexual' referred to in her note. RN #127 further indicated that it was probably resident #002, "inappropriately touching the resident's body part.” The RN indicated he/she reported the incident to ADOC #107, and further indicated the Director and the police were not contacted regarding the incident, as he/she did not think it was sexual abuse. The RN further indicated to the inspector that he/she perceived sexual abuse to be more like sexual intercourse than that of non-consensual touching.

Interview of ADOC #107, by the inspector, indicated awareness of the above identified incident, because he/she had gone to speak with resident #002 along with RN #127, as the RN was afraid of speaking to the resident by him/herself. The ADOC could not recall who the two recipient residents were or what 'acting sexual' referred to. The ADOC indicated one of the recipient residents was probably resident #003, and it was probably resident #002 inappropriately touching him/her. The ADOC confirmed the SDM, police and the Director were not notified of the incident.

In addition, there were four incidents of witnessed emotional abuse documented in the progress notes of resident #002 towards other residents.

Interview with the Director of Care (DOC) and both ADOC’s (#107 and #110) by an Inspector, all confirmed that all of the above specified incidents were not reported to the SDM’s, the Director or the Police.

A Compliance Order was warranted as the scope and severity was demonstrated by the following:
1. The home's compliance history indicated LTCHA, 2007; S.19 (1) was issued as a Compliance Order, during a Critical Incident Inspection on October 16, 2014, (inspection # 2014_270531_0024). In addition, LTCHA, 2007, S.20 (1) was issued as a Voluntary Plan of Correction, during a Resident Quality Inspection on March 7, 2016, (inspection # 2016_195166_0007). LTCHA, 2007, S.24 (1) was issued as a Written Notification, during a Complaint Inspection on February 6, 2014, (inspection # 2014_049143_0007),during a follow up inspection on February 11, 2015, (inspection # 2015_348143_0010), and during a Complaint Inspection on February 11, 2015, (inspection # 2015_236572_0005).
2. There was actual harm of physical, sexual, verbal and emotional abuse by resident #002 towards multiple cognitively impaired residents.
3. The licensee’s Prevention of Abuse policy was not complied with, as many of the incidents did not identify the residents who were abused, did not have documented

evidence of the incidents on the recipient resident s' charts of the witnessed or suspected abuse, to indicate if the residents were assessed for injuries or distress, as well as, the policy did not meet the legislative requirement as identified under LTCHA, 2007, s.20 (1) (2). (Refer to WN #03)
4. The SDM's of resident #002 and the recipient residents of the suspected or witnessed abuse were not always notified, as identified under O. Reg. 79/10, s.97(1).(Refer to WN #09)
5. All of the suspected or witnessed incidents of resident to resident abuse were not reported to the police, as identified under O.Reg.79/10, s.98. (Refer to WN #10)
6. The incidents of suspected or witnessed sexual and/or physical abuse which occurred on nine different occasions, were not reported to the Director, as identified under LTCHA, 2007, s.24(1).(Refer to WN #06)
7. When the residents demonstrated ongoing verbal and/or physical aggression, and sexually inappropriate behaviours, the behavioural triggers were not identified where possible, and strategies to manage the responsive behaviours were not identified where possible, as identified under O.Reg. 79/10, s.53 (4). (Refer to WN #08)
8. The incidents of suspected or witnessed sexual and/or physical abuse which occurred on nine different occasions, were not immediately investigated by the home, as identified under LTCHA, 2007, s.23(1)(2).(Refer to WN #05)
9. The Licensee did not ensure that a report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, on or at an earlier date if required by the Director of alleged resident to resident sexual abuse between resident #005 and resident #002, as identified under LTCHA, 2007, s. 104. (2) (Refer to WN #011). [s. 19. (1)]

2. The licensee has failed to ensure that residents were protected from physical and emotional abuse by resident #020.

Re: Intake Log #025239-16 for resident #020 and #021:

A report from the home was received by the Director on an identified date, for a resident to resident physical abuse. Resident #020 was witnessed squeezing the body part of resident #021 resulting in injuries to the resident.

The following were incidents of suspected emotional and physical abuse that were documented in resident #020's progress notes towards other residents, that were not investigated, had no documented evidence to indicate the residents of the alleged abuse were assessed for injury or distress and no documented evidence that the incidents were

reported to the Substitute Decision Makers (SDM's), the Director, and the police. Review of the progress notes for resident #020 by an Inspector, indicated the following:

1. There were two incidents of resident to resident physical abuse by resident #020 towards resident #021 where injuries were sustained. One of the incident was not reported to the Director or the Police.
2. There were additional incidents of suspected resident to resident physical abuse and/or emotional abuse towards resident #021, #022, #023, #024, #025, #026, #027, #028 and #029 by resident #20, but there were no documented evidence of an assessment of those residents to indicate whether an injury, pain or distress was caused to the recipient residents.
3. Resident #027 was the recipient of five incidents of either physical and/or emotional abuse, and there were no documented evidence of an assessment of resident #027 to determine if any injury or pain was sustained.
4. Resident #021 was the recipient of nine incidents of either physical abuse and/or physical aggression and there was no documented evidence of an assessment of resident #021 to determine if any injury or pain had been sustained.
5. Resident #022 was the recipient of four incidents of physical aggression and there were no documented evidence of an assessment of resident #022 to determine if any injury or pain was sustained.
6. Resident #023 was the recipient of three incidents of either physical abuse and/or physical aggression, and there were no documented evidence of an assessment of resident #023 to determine if there were any injuries sustained.
7. The resident also physical aggressive with a visiting family member on an identified date.

Interview with Registered Practical Nurse (RPN) #125 on an identified date, by an Inspector, indicated that when there is an incident involving two identified residents with responsive behaviours, the documentation should include information about both residents. The RPN did not know whom the residents were and could not locate any information to determine if the residents were assessed for pain or injuries.

Interview with RPN #128 on an identified date by an Inspector, confirmed that he/she does not consistently document resident's assessments when there are incidents of responsive behaviour.

Interview with Registered Nurse (RN) #132 on an identified date, by the inspector, indicated that it is the expectation that when there is an incident of responsive behaviour

involving two residents, staff are to document on and assess both residents.

A Compliance Order was warranted as the scope and severity was demonstrated by the following:
1. The licensee did not immediately investigate the incidents of suspected physical abuse between resident #020 and multiple residents, as identified under LTCHA, 2007, s. 23 (1) (a) (Refer to WN #005).
2. The licensee did not follow its Reporting and Elimination of resident abuse policy, by immediately reporting all the allegations of alleged resident to resident physical abuse between resident #020 and multiple residents as identified under LTCHA, 2007, s. 20. (1) (Refer to WN #003).
3. The licensee failed to comply with O. Reg. 79/10, s. 53. related to Responsive behaviours, by not ensuring behavioural triggers have been identified to resident demonstrating responsive behaviour (where possible), and strategies were identified and implemented to manage the behavioural triggers where possible. s. 53. (4) (Refer to WN #008)
4. The incidents of suspected or witnessed physical abuse which occurred on an identified date by resident #020 towards resident #021 was not reported to the Director, as identified under LTCHA, 2007, s.24 (1). (Refer to WN #06)
5. The SDM's of resident #020 and the recipient residents of the suspected or witnessed abuse were not always notified, as identified under O. Reg. 79/10, s.97(1).(Refer to WN #09)
6. The Licensee has failed to comply with O. Reg. 79/10, s. 98 by not ensuring the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute criminal offence. s. 98 (Refer to WN #010). [s.19. (1)] (607) [s. 19. (1)]

3. The licensee has failed to ensure that residents were protected from physical and verbal abuse by resident #013.

Re: Intake Log #026804-16 for resident #013 and #014:

A report was received by the Director for an alleged resident to resident physical abuse that occurred on an identified date and time, between resident #013 and #014. Both residents sustained injuries.

A review of the progress notes for resident #013, by the inspector, indicated there were two additional incidents of resident to resident physical abuse by the resident. These

incidents of suspected and/or witnessed physical or verbal abuse by resident #013 towards other unidentified residents, were not investigated, had no documented evidence to indicate the identified residents of the alleged abuse were assessed for injuries or distress, and/or were reported to the Substitute Decision Makers (SDM's), the Director, and the police. There was no documentation in the progress notes of resident #013 to indicate the incidents were investigated to identify the recipient residents. The incidents were documented as follows:

1. On an identified date, resident #013 was sitting in a mobility device outside of dining area. An unidentified resident was sitting in a mobility aid near the resident. Resident #013 was physical aggressive towards the unidentified resident.
2. On an identified date and time, an unidentified resident was seated in a mobility aid in the corridor and observed resident #013 attempting to enter his/her room. When the unidentified resident approached the resident, resident #013 was physically aggressive towards the resident.

In both of the above identified incidents, there was no indication of who the unidentified resident was or whether both residents were assessed for injuries or pain.

Interview with Registered Nurse (RN) #132 on an identified date, by an inspector, indicated that it is the expectation that when there is an incident of responsive behaviour involving two residents, staff are to document on and assess both residents.

A Compliance Order was warranted due to the scope and severity as demonstrated in both of the above identified incidents, where there was no documentation to indicate who the recipient residents were, or to indicate an assessment was completed, in order to determine if physical abuse had occurred as per the licensee's policy. In addition, the following areas of non-compliance were identified:

1. The Licensee failed to comply with O. Reg. 79/10, s. 53. related to Responsive behaviours, by not ensuring behavioural triggers have been identified to resident demonstrating responsive behaviour (where possible), and strategies were identified and implemented to manage the behavioural triggers where possible. s. 53. (4) (Refer to WN #008)
2. The Licensee did not follow its Reporting and Elimination of Resident Abuse Policy, by not immediately reporting all the allegations of alleged resident to resident physical abuse between resident #013 and multiple residents as identified under LTCHA, 2007, s. 20. (1) (Refer to WN #003).

3. The SDM's of resident #013 and the recipient residents of the suspected or witnessed abuse were not always notified, as identified under O. Reg. 79/10, s.97(1).(Refer to WN #09)
4. The licensee did not immediately investigate the incidents of suspected physical abuse between resident #013 and an unidentified residents, as identified under LTCHA, 2007, s. 23 (1)(a) (Refer to WN #005). [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan.

Re: Intake (Log # 020565-16) for resident #003:

A written complaint letter was received by the Director on an identified date, by the family member of resident #003. The complaint indicated that on an identified date there was a resident to resident physical abuse involving resident #003, and that there was a delay in the assessment of the resident.

Review of the progress notes of resident #003, by an Inspector, during the inspection, indicated there were two incidents of resident to resident physical abuse by resident #002 towards resident #003 as follows:
1. On an identified date, resident #003 was pushed to the floor by resident #002 resulting in loss of consciousness for one to two minutes and sustained injuries. The resident was transferred to hospital via ambulance for assessment. The resident returned from hospital the following day with treatment to injuries sustained.
2. On another identified date and time, resident #003 was pushed by resident #002 and hit his/her body part against the wall. The resident then fell to the floor resulting injury. An hour and a half later, resident #003 was transferred to hospital. The family member had expressed concerns about the care provided to the resident by the home and the home failing to provide appropriate medical intervention to limit the resident anxiety and agitation. The family member also indicate that the home did not take the appropriate steps to provide resident #003's safety.

Review of the home's internal incident report by an Inspector, indicated the family member was contacted when the incident occurred and was notified of the resident being transferred to hospital. The incident report also indicated the family members were at the hospital an hour after the incident, awaiting the resident's arrival.

Review of the email sent by Registered Nurse (RN) #116 to the Assistant Director of Care (ADOC) #110 indicated that at an identified time, resident #002 pushed resident #003 to the floor and the resident went unconscious. The RN indicated the family member was contacted regarding the fall and transferred to hospital. The RN #116 further indicated an hour and a half later, the family member of resident #003 had called to ask if the ambulance transfer service was contacted, as the family were at the hospital and the resident had not yet arrived; at which time, the RN #116 then contacted the ambulance transfer service. The paramedics arrived two hours later, and questioned RN #116 as to why he/she had waited that long to contact them.

Telephone interview with RN #116 on an identified date, by an Inspector, confirmed that the resident fell on a certain date and time, and the ambulance transfer service was not contacted for approximately two hours.

The plan of care was not provided based on the assessed need of resident #003, as the resident sustained physical abuse resulting in injury, and was not transferred to hospital for a period of approximately two hours. Resident #003 sustained another injury when there was an incident of physical abuse by resident #002, on another identified date, and

the resident was not transferred to hospital for a period of approximately four hours after the incidents occurred. [s. 6. (7)]

2. The licensee has failed to ensure when the resident was reassessed, the plan of care was revised when the resident's care needs change, specifically related to resident #002.

Re: Intake Log #023485-16 & #020117-16 for resident #002:

Review of the health care records for resident #002 indicated the following:
1. The resident sustained 12 falls since admission.
2. The resident was re-assessed by Physiotherapist (PT) on an identified date, (after the 10th fall). The PT recommended the following: tilt mobility aid when fatigued, need for increased supervision, and a low bed.
3. A referral to the PT was completed on an identified date after the 12th fall. The PT assessed the resident's transfer status and made two recommendations.
4. Review of the Fall-Root Cause Review assessments indicated nine of the assessments that were initiated by the registered staff were listed as in progress. There was no assessment completed for one of the identified fall and four other assessments were incomplete. All completed assessments indicated the resident was at moderate risk for falls.

Review of the care plan for resident #002 (currently in place) indicated the resident was at risk for falls due to fall/risk injury. A fall prevention intervention was added on an identified date and the plan of care indicated that the resident should have this intervention in place while in bed if needed, and always when in mobility aid and functioning properly.

Observation of resident #002, during this inspection, by the Inspector indicated the resident was sitting in a mobility aid, and one of the intervention recommended by the PT was not in place.

Interview of Personal Support Worker (PSW) #119 indicated resident #002 was a high risk for falls due to previous history of falls.

The plan of care was not revised when the resident care needs changed related to falls risk. The resident's level of risk was not identified as high risk either in the written plan of care when the resident began having multiple falls, and when the resident was confined to a mobility aid [s. 6. (10) (b)]

WN #3: 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).

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

Findings/Faits saillants :

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

A review of the home's "Reporting and Elimination of Resident Abuse" policy with an identified date (page 5 of 18) directs:
-"Clinical staffs responsible for the care of the resident(s) (i.e. Registered Nurses)

involved in the alleged witnessed or suspected incident of abuse are to, conduct a head to toe physical assessment on the victim and document findings if physical abuse is alleged".
-"Employees who witnessed the alleged incident of resident abuse or neglect are expected to: Report any witnessed, suspected or alleged abuse to their Supervisor/Manager immediately".

Re: Intake Log #017074-16 for resident #001:

A report was received by the Director on an identified date, for an incident related to staff to resident alleged abuse. The report indicated resident #001 reported that his/her care was hurried and rough on the evening on an identified date, that caused pain to his/her body part. The report indicated that after the above incident, a head to toe assessment was completed on resident #001.

A review of the clinical health record for resident #001, by an Inspector, had no documented evidence that a head to toe assessment was completed.

Interview with Registered Practical Nurse (RPN) #102 and the DOC on an identified date, by the inspector, confirmed that a head to toe assessment was not completed for resident #001, and the licensee's policy was not followed. [s. 20. (1)]

2. Re: Intake Log #026804-16 for resident #013 and #014:

A report was received by the Director for an alleged resident to resident physical abuse that occurred on an identified date and time, between resident #013 and #014, where both residents sustained injuries.

A review of the progress notes for resident #013, by the Inspector, indicated there were two documented incidents where two unidentified residents were the recipients of suspected physical abuse by resident #013.

In both of the identified incidents, there was no documentation to indicate who the recipients were, or to indicate an assessment was completed, in order to determine if physical abuse had occurred as per the licensee's policy.

Interview with Registered Practical Nurse (RPN) #125 on an identified date, by the Inspector, indicated that when there is an incident of responsive behaviour involving one

or more residents, the documentation should include the responsive behaviours involving both residents, but was not able to respond as to why the above identified residents were not assessed for pain or injuries.

Interview with RN #132, indicated to the inspector that it is the expectation that when there is an incident of responsive behaviour involving two residents, that staff are to document on and assess both residents. [s. 20. (1)]

3. Re: Intake Log #025239-16 for resident #020 and #021:

A report was received by the Director on an identified date, for a resident to resident physical abuse. Resident #020 was witnessed squeezing the body part of resident #021 resulting in injuries.

Review of the progress notes for resident #020 indicated there were 11 additional incidents of suspected resident to resident physical abuse by resident #020 towards other residents, in addition to those identified in WN #1.

Interview with Registered Nurse (RN) #132, by the Inspector, indicated that it is the expectation that when there is an incident of responsive behaviour involving two residents, that staff are to document an assessment of both residents. [s. 20. (1)]

4. Re: Intake Logs #020117-16 & 023485-16 for resident #002, #003 and #005:

A report was received by the Director on an identified date for a resident to resident physical abuse. Resident #002 was witnessed pushing resident #003 to the floor resulting in injury.

Review of the clinical health records for resident #002 and resident #005 indicated there were two documented incidents where resident #005 was the recipient of suspected sexual abuse from resident #002.

There were nine additional incidents of either suspected and/or witnessed incidents of physical, sexual, or emotional abuse where the recipient residents were not identified and there was no documented evidence to indicate those residents were assessed for pain, injury or distress. There were also documented instances of witnessed or suspected resident to resident physical, sexual, and/or emotional abuse by resident #002 towards eight other specified residents (see WN # 08) and no documented evidence to

indicate if the recipient residents were assessed for pain, injury or distress.

Interview with Registered Practical Nurse (RPN) #128 by the Inspector, confirmed the responsive behaviours that resident #002 exhibited towards resident #005 were non consensual touching and behaviours of a sexual nature and he/she did not report the incidents to anyone.

Interview with the Director of Care (DOC) on an identified date, by the Inspector, indicated that he/she did not perceive the above incidents of sexual behaviours by resident #002 directed toward resident #005, of non-consensual touching to be abusive and as such were not reported.[s. 20. (1)]

5. The licensee has failed to ensure the policy to promote zero tolerance of abuse and neglect of residents: (c) provided for a program, that complies with the regulations, for preventing abuse and neglect,(e) contained procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents is complied with.

Review of the home's policy "Prevention, Reporting and Elimination of Resident Abuse" (revised on an identified date) indicated under procedure:
-on page 4/18, document facts of the alleged or witnessed abuse or neglect as soon as possible,
-on page 5/18, clinical staff responsible for the care of the resident(s) (i.e.Registered Nurses) involved in the alleged, witnessed or suspected incident of abuse are to: conduct a head-to-toe physical assessment on the victim and document findings if physical abuse is alleged; if necessary, contact a physician or other health practitioner for further assessment, treatment and follow-up; document factual information in appropriate locations (e.g. Resident chart)

This policy only included documenting when "physical abuse is alleged" and does not include verbal, emotional or sexual. This policy also did not provide procedures for "preventing" abuse. [s. 20. (2)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any written complaints that were received concerning the care of a resident or the operation of the home, were immediately forwarded to the Director.

Re: Intake Log #020565-16 for resident #003:

Review of the home's complaints logs for an identified time period, by an Inspector, during the inspection, indicated the following:
1. On an identified date, a complaint form was completed by the Director of Care (DOC) regarding a written complaint letter received by the family of resident #033. The written complaint letter had an identified date, regarding concerns of negative interactions between Registered Practical Nurse (RPN) #125 and the resident. The DOC confirmed the written complaint was not forwarded to the Director.
2. On an identified date, a second complaint form was completed by the DOC regarding a verbal complaint received (the same day) by a family member of resident #034. The verbal complaint was regarding an allegation of staff to resident neglect by RPN #133 towards the resident. The alleged RPN refused to provide continence care to the resident and the complainant reported the RPN was rude. Both the DOC & Assistant Director of Care (ADOC) #110 were involved in the investigation. The DOC & ADOC confirmed the Director was not informed of the allegation of staff to resident neglect.
3. On an identified date, a complaint form was completed by the DOC regarding a written complaint received by the family member of resident #035. The written complaint was regarding a near miss medication administration error and booking of medical appointments/transportation for the resident. The DOC & ADOC #110 confirmed this written complaint was not forwarded to the Director.
4. On an identified date, a complaint form completed by the DOC regarding an allegation of staff to resident neglect. The allegation indicated Personal Support Worker (PSW) #137 refused to reposition resident #037 "a couple of weeks ago." The resident reported being in distress due to not repositioned. The home's investigation notes determined the incident occurred five months prior. The DOC & ADOC confirmed the allegation was not

reported to the Director.
5. On an identified date, a complaint form was completed by the DOC regarding an allegation by RN #103 of staff to resident abuse towards resident #036 that occurred earlier in the day. The allegation indicated resident #036 reported PSW #136 was aggressive while transferring the resident into bed. The RN indicated the incident was witnessed and confirmed by Physiotherapist Assistant (PTA) #134 and indicated the resident reported having emotional distress.

The DOC confirmed the Director was not informed of the allegation of staff to resident rough handling. [s. 22. (1)]

WN #5: 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).

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, 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

Re: Intake Log #020117-16 for resident #002 and #005:

Review of the clinical health records for resident #005 and resident #002, indicated there were two documented incidents where resident #005 was the recipient of suspected sexual abuse from resident #002, and there was no indication the incidents were investigated and appropriate actions were taken.

Interview with Registered Practical Nurse (RPN) #128 on an identified date, by the Inspector, confirmed the responsive behaviours that resident #002 exhibited towards resident #005 were non consensual touching and behaviours of a sexual nature and he/she did not report the incidents to anyone.

Interview with the DOC on an identified date, by the Inspector, confirmed that he/she was not aware of the above identified incident between resident #002 and resident #005 until the inspector brought it to his/her attention. Upon conclusion of the inspection, on an identified date, the DOC had not yet completed an investigation into the incident between the two residents. [s. 23. (1) (a)]

2. Re: Intake Log # 023485-16 for resident #002:

Review of the progress notes for resident #002, by two Inspectors during the inspection, indicated since admissions to an identified date, when the responsive behaviours ceased, there were ongoing incidents of either witnessed or suspected physical, sexual, or emotional abuse by resident #002 towards other cognitively impaired residents as follows:
1. Eight residents were the recipient of resident #002's witnessed or suspected verbal, physical, or sexual abuse on more than one occasion (resident #003, #005, #006, #007, #009, #010, #011 & #012).
2. There were nine additional incidents of either suspected and/or witnessed incidents of verbal, physical or sexual, abuse by resident #002 where the recipient residents were not identified or an investigation completed to identify who the residents were. In addition to the nine incidents, there were three incidents that were reported to the Director, but there was no documented evidence of an investigation or the investigation was not conducted immediately.

Interview with Registered Nurse (RN) #127, indicated being able to recall the incident that occurred on an identified date, but unable to recall which" two residents" were the

recipient of resident #002's sexually inappropriate behaviour' and could not recall what 'acting sexual' referred to in the progress note. The RN indicated that ADOC #107 that was notified of the incident.

Interview of Director of Care (DOC) and Assistant Director of Cares (ADOC's) (#107 & #108), by an Inspector, all confirmed that the above incidents had no documented evidence they were investigated. Interview of ADOC #107 indicated awareness of the above identified incidents, because he/she "went to speak to" resident #002 with RN #127, as the RN "was afraid of speaking with the resident by him/herself". The ADOC could not recall who the two recipient residents were or what 'acting sexual' referred to. The ADOC indicated one of the recipient residents was probably resident #003 and it was probably resident #002, touching the resident inappropriately. The ADOC confirmed the investigation was not documented. [s. 23. (1) (a)]

3. Re: Intake Log #025239-16 for resident #020 and #021:

A report was received by the Director for an alleged resident to resident physical abuse that occurred on an identified date and time, between resident #020 and #021, where resident #21 sustained injuries.

Review of the progress notes for resident #020 indicated on an identified date, an unidentified Personal Support Worker (PSW) witnessed the resident "standing over" resident #021 while sitting in a mobility aid and was physical aggressive with the resident.

Review of the progress notes for resident #021 indicated the resident sustained injuries to a body parts.

Interview with DOC on an identified date, by the Inspector, confirmed this incident was not investigated. [s. 23. (1) (a)]

4. Re: Intake Log #026804-16 for resident #013 and #014:

A report was received by the Director for an alleged resident to resident physical abuse that occurred on an identified date and time, between resident #013 and #014, where both residents sustained injuries.

A review of the progress notes for resident #013, by the Inspector, indicated there were

two additional incidents of resident to resident physical abuse by the resident. These incidents of suspected and/or witnessed physical or verbal abuse by resident #013 towards other unidentified residents, were not investigated, had no documented evidence to indicate the identified residents of the alleged abuse were assessed for injuries or distress. There was no documentation in the progress notes of resident #013 to indicate the incidents were investigated to identify the recipient residents.

Interview of Director of Care (DOC) and Assistant Director of Cares (ADOC's) (#107 & #108), during the inspection, confirmed that the above incidents had no documented evidence they were investigated. [s. 23. (1) (a)]

5. The licensee has failed to ensure the results of the abuse or neglect investigation were reported to the Director.

Re: Intake Log #017074-16 for resident #001:

A report was received by the Director on an identified date, for an allegation of staff to resident physical abuse. The report was amended on an identified date, and there was no documentation of the outcome of the investigation.

Review of the home's investigation notes and interview with the DOC on an identified date, failed to locate documented evidence to indicate whether the outcome of the allegation was determined to be founded or unfounded. [s. 23. (2)]

WN #6: 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 ensure the person who had reasonable grounds to suspect abuse of a resident by anyone that had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

Re: Three Intakes Logs #023485-16 & 020117-16 for resident #002 and Log #020565-16 for resident #003:

Review of the progress notes for resident #002 by two Inspectors, during the inspection, indicated since admissions to an identified date, when the responsive behaviours ceased, there were ongoing incidents of either witnessed or suspected verbal, physical, or sexual abuse by resident #002 towards other cognitively impaired residents as follows: (see WN #001).
1. Eight residents were the recipient of resident #002's witnessed or suspected verbal, physical, or sexual abuse and on more than one occasion (resident #003, #005, #006, #007, #009, #010, #011 & #012).
2. There were nine additional incidents of either suspected and/or witnessed incidents of verbal, physical or sexual, abuse where the recipient residents of resident #002 abuse were not identified.
3. Only three incidents were reported to the Director.

Interview with DOC and both ADOC's by an Inspector, during the inspection, confirmed only the three incidents were reported to the Director. [s. 24. (1)]

2. Re: Intake Log #025239-16 for resident #020 and #021:

A report was received by the Director for an alleged resident to resident physical abuse that occurred on an identified date and time, between resident #020 and #021, where resident #21 sustained injuries.

Review of the progress notes for resident #020 indicated on an identified date and time, an unidentified Personal Support Worker (PSW) witnessed the resident being physically abusive with resident #021, resulting in resident #021 sustaining injuries.

Interview with DOC on an identified date, by the Inspector, confirmed this incident of suspected resident to resident physical abuse was not reported to the Director. [s. 24. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen, the resident been assessed and, if required, a post-fall assessment had been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Re: Intake Logs #020117-16 & 023485-16 for resident #002 as per WN #2:

Interview with Assistant Director of Care (ADOC) #110 (Fall Prevention Chair) by an Inspector, indicated when a resident has fallen, the Registered Nurse/ Registered Practical Nurse (RN/RPN) is to complete an electronic falls assessment progress note, then complete the Falls Risk Assessment Tool, and the Post Fall Assessment and Analysis Tool in the home's electronic plan of care, to determine causative factors and possible interventions to prevent further falls. The ADOC indicated the home is currently trialling the Falls Intervention Assessment Tool (FIAT) which is to be completed within 24 hours of a fall and this was initiated on an identified date.

Review of the home's Post Fall Management policy, under procedure for all registered staff, indicated upon the resident sustaining a fall the following are to be completed: the Post Fall Assessment and Analysis Tool, print a copy and attach to the Falls Note in the home's electronic plan of care.

Review of the health care records for resident #002, by an Inspector, indicated the following:
1. Resident #002 sustained 12 falls since admissions.
2. There was a "Fall-Root Cause Review" Tool completed in the home's electronic plan of care on nine identified dates and four were incomplete.
3. All of the completed Fall Root Cause Tools indicated the resident was at 'moderate' risk for falls despite the resident sustaining ongoing falls. This tool was not the tool that the ADOC or the home's policy indicated was to be completed. There was no Fall Root Cause Tool completed for the falls that occurred on three identified dates. Three other tools initiated related to the resident's fall were left incomplete. There was no documented evidence the Falls Risk Assessment Tool or the FIAT tool was completed as per the ADOC. [s. 49. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure the behavioural triggers were identified for resident #002 demonstrating responsive behaviours (where possible) and strategies were identified and implemented to manage the behavioural triggers where possible.

Re: Three Intake Logs #023485-16 & 020117-16 and Log # 020565-16 for resident #002 & #003:

A review of the progress notes for resident #002 from an identified date on admissions to when the resident's responsive behaviours ceased, revealed ongoing incidents of demonstrated physically and/or verbally aggressive, and sexually inappropriate responsive behaviours by the resident that were directed towards multiple residents as follows.
1. From admissions to when the responsive behaviours ceased, there were ongoing incidents of either witnessed or suspected verbal, physical, or sexual abuse by resident #002 towards other cognitively impaired residents (see WN #001).
2. Eight residents were the recipient of resident #002's witnessed or suspected verbal, physical, or sexual abuse and on more than one occasion (resident #003, #005, #006, #007, #009, #010, #011 & #012).
3. There were nine additional incidents of either suspected and/or witnessed incidents of verbal, physical or sexual abuse, where the recipient residents of resident #002 were not identified.
4. In addition to WN #1, there were 17 incidents of suspected and/or witnessed verbal, emotional, physical or sexual abuse that were documented in resident #002's progress notes towards other residents, that were not investigated, had no documented evidence

to indicate the residents of the alleged abuse were assessed for injury or distress and no documented evidence that the incidents were reported to the Substitute Decision Makers (SDM's), the Director, and the police.

Review of the home's policy "Responsive Behaviours" (EC17-01) revised October 2013, indicated:
-on page 6/17, after the incident: if aggressive incidents are frequent or worrying, they must be discussed with the registered Staff who can refer the Elder to a psychiatrist specializing in geriatrics (PASE) or a community psychiatric nurse which are available through organizations as PASE.
On page 8/17, Elder Monitoring and Internal Reporting Protocols: charting in progress notes of PSW binders under Behavioural Progress notes; charting in computerized progress notes in the behavioural section using behaviour intervention time spent evaluation (BITE); Behaviour Support Ontario (BSO) white board, and shift to shift reporting.

The first time a report was received by the Director for resident to resident physical abuse was when resident #002 pushed resident #010 resulting in the resident sustaining injuries, the actions taken by the home for resident #002 to prevent a recurrence included: review of medications, Dementia Observation Tool (DOS) implemented and review by BSO team and one to one PSW for evenings. Review of the home's internal investigation completed by RN #132, indicated the resident was new and staff members were not aware of resident's history on admission related to responsive behaviours. Review of admission notes from Community Care Access Centre (CCAC) indicated the resident had history of physical aggression/angry behaviour, inappropriate sexual behaviour and verbally aggression. The one to one was not put into place until the following day, when another incident occurred and one to one monitoring of resident #002 was put in place. A PASE referral was not completed until an identified date, after the Inspector spoke with the physician regarding resident #002 responsive behaviours. After the second report was submitted, the report indicated the actions taken by the home to prevent a recurrence included DOS form started, reviewed by behaviour assessment tool (BAT) team, referral to PASE, and possible removal of resident to another unit. After the third report was submitted on an identified date, (for the incident that occurred five months earlier at the direction of the Inspector), the report indicated the action taken by the home to prevent a recurrence included: re-evaluate and update the interventions of the care plan for resident #002.

The monitoring record used was the DOS (behavioural flow sheet) and was initiated on an identified date and continued for four weeks. This tool was discontinued despite the responsive behaviours continuing.

Interview with Registered Practical Nurses (RPN) #125 and #128 on an identified date, by an Inspector indicated that when there is an incident involving two residents, the documentation should include assessments of both residents, but was not able to respond as to why some of the above identified residents were not assessed for pain or injury.

Interview with the Medical Director (MD) on an identified date by the Inspector, indicated he/she participates in the home's Behavioural Support Committee (BSO) and resident #002 was "not discussed" by the committee regarding his/her responsive behaviours. The MD also indicated a referral would be made to the Psychiatric Assessment Services for the Elderly (PASE) to assist in managing the resident's behaviours.

A review of resident #002's written plan of care, by two Inspectors, during the inspection, related to responsive behaviours indicated the resident can be verbally and physically aggressive, and has inappropriate sexual behaviours.

The written plan of care did not identified responsive behaviours of inappropriate sexual, verbal, emotional and physical abuse towards several residents, and was not revised to indicate all these responsive behaviours or related triggers. The only additional strategy considered was initiated four months later on an identified date, despite the resident continuing to demonstrate inappropriate sexual, verbal and physical aggression. The strategy of PASE referral was only considered as a result of the inspection and on the direction of the Inspector. The licensee failed to ensure that when resident #002 demonstrated ongoing responsive behaviours (verbal/physical/sexual) towards multiple vulnerable residents, that the behaviours and triggers were identified. When the strategies used were demonstrated to be ineffective, that other strategies were considered in the revision of the plan. [s. 53. (4) (a)]

2. Re: Intake Log #026804-16 for resident #013 and #014:

Review of the plan of care for resident #013 indicated the resident has a diagnosis of cognitive impairment and uses a mobility aid for locomotion. The plan of care for the resident (in place at the time and after the above identified incidents) indicated the resident demonstrated verbal/physical responsive behaviours.

A review of the progress notes also indicated that there were four additional incidents of physical and/or emotional abuse that were directed towards other residents that resulted in either injuries sustained to the residents by resident #013, and there were no documented evidence to indicate the residents' were assessed for injuries or pain.

Observation of resident #013 during this inspection indicated the resident is cognitively impaired and uses a mobility aid independently around the unit. No responsive behaviours were noted during the inspection.

Interviews with Personal Support Workers PSW #100 and #126 on an identified date, by the Inspector, indicated that resident #013 can be verbally and physically aggressive towards residents and staff. PSW #126 further indicated that in the four years he/she has been working at the home, he/she had witnessed the resident hit at least two residents and also indicated that he/she would redirect resident #013 when such behaviours occurred.

Review of the written care plan, interviews with the PSWS #126 and #100, on an identified date, by the inspector, indicated the plan of care failed to identify other triggers, including other residents. The resident also demonstrated swearing and wandering into other resident's bed/rooms, and gets angry if other residents gets in his/her way and he/she can't get through. The plan of care also failed to identify strategies to manage these triggers. [s. 53. (4) (a)]

3. Re: Intake Log #025239 for resident #020 and #021:

Observation and interview of resident #020 on identified date and time indicated the resident was cognitively impaired and ambulated independently around the unit.

A review of the written plan of care for resident #020 (in place at the time and after the above identified incidents), by the Inspector, indicated the resident demonstrated responsive behaviours of verbal/physical aggression related to cognitive impairments.

A review of the progress notes for resident #020, by the Inspector, indicated the resident had ongoing responsive behaviours of physical aggression and/or physical abuse towards multiple residents. There were two incidents of resident to resident physical abuse by resident 020 towards resident #021 where injuries were sustained.

There were additional incidents of suspected resident to resident physical abuse and/or emotional abuse towards resident #021, #022, #023, #024, #025, #026, #027, #028 and #029 by resident #020, but there were no documented evidence of an assessment of those residents to indicate whether an injury, pain or distress was caused to the recipient residents.

1. Resident #027 was the recipient of five incidents of either physical and/or emotional abuse.
2. Resident #021 was the recipient of nine incidents of either physical abuse and/or physical aggression.
3. Resident #022 was the recipient of four incidents of physical aggression: two separate incidents.
4. Resident #023 was the recipient of three incidents of either physical abuse and/or physical aggression.
5. The resident also was physical abusive with a visiting family member on an identified date.

In addition to the above identified incidents of responsive behaviours by resident #020, there were five incidents where the resident was physical and/or emotional abusive towards resident #021 x 2 , #026, #029 and a family member and there were no documented evidence of an assessment to determine if there were injuries or pain.

Interview with Personal Support Workers (PSWs) #129, #130 and #131 on an identified date and time, by an inspector, indicated that resident #020 can be verbally and physically aggressive towards residents and staff. PSW #129 indicated witnessing the resident being physical aggressive with at least four residents, and in one case a staff member. PSW #129 further indicated if the resident behaviour "gets really bad they would call a code white". There was no documentation in the resident's plan of care that "code white" was ever initiated. The PSW also indicated the police was never contacted related to the resident's behaviours. The PSW indicated the strategies used to manage the residents responsive behaviour is to separate residents, relocate in the dining room, and also have DOC and RN's spends one to one time with the resident to de-escalate the behaviour.

A review of the Responsive Behaviour flow sheets (DOS) indicated the resident was on half hour monitoring for 24 hours on four different time periods during 2016.

The Licensee has failed to ensure the behavioural triggers have been identified for the

resident demonstrating responsive behaviours (where possible), and strategies were identified and implemented to manage the behavioural triggers where possible as evidenced by the plan of care failed to identify triggers that included other specified residents. The plan of care failed to identify the responsive behaviours, related to verbal, physical and emotional abuse that are directed towards residents and staff. The plan of care also failed to identify other strategies to manage all these triggers, including, the use of referral to specialized services, when and for how long monitoring/assessment tools would be used (DOS), and when to use code white, specifically related to resident #020. [s. 53. (4) (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 the resident's SDM and any other person specified by the resident was immediately notified upon becoming aware of alleged, suspected or witnessed incidents of abuse of the resident that resulted in a 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.

Re: Intake Logs # 023485-16 & 020117-16 for resident #002 & #003:

Review of the progress notes for resident #002 indicated from admissions to an identified

date when the responsive behaviours ceased, there were ongoing incidents of either witnessed or suspected verbal, physical, or sexual abuse by resident #002 towards other cognitively impaired residents.

There were nine incidents of either suspected and/or witnessed verbal, physical or sexual, abuse by resident #002, where the recipient residents' were not identified nor there were no documented evidence to indicate the recipient residents Substitute Decision Makers (SDM's) were notified of the incidents.

2. Re: Intake Log #026804-16 for resident #013 and #014:

A report was received by the Director for an alleged resident to resident physical abuse that occurred on an identified date and time, between resident #013 and #014, where both residents sustained injuries.

A review of the progress notes for resident #013, by the Inspector, indicated there were two documented incidents, where two unidentified residents were the recipients of suspected physical abuse from resident #013.

In both of the above identified incidents, there were no documentation to indicate who the recipient residents were, or to indicate the Substitute Decision Makers (SDMs) were notified. [s. 97. (1) (a)]

3. Re: Intake Log #025239 for resident #020 and #021:

A review of the progress notes for resident #020, by Inspector #607, indicated the resident had ongoing responsive behaviours of physical aggression and/or physical abuse towards multiple residents. There were two incidents of resident to resident physical abuse by resident #020 towards resident #021 where injuries were sustained.

There were additional incidents of suspected resident to resident physical abuse and/or emotional abuse towards resident, #021, #022, #023, #024, #025, #026, #027, #028 and #029 by resident #020, but there were no documented evidence of an assessment of those residents to indicate whether an injury, pain or distress was caused to the recipient residents.
1. Resident #027 was the recipient of five incidents of either physical and/or emotional abuse.
2. Resident #021 was the recipient of nine incidents of either physical abuse and/or

physical aggression.
3. Resident #022 was the recipient of four incidents of physical aggression.
4. Resident #023 was the recipient of three incidents of either physical abuse and/or physical aggression.
5. The resident also physical with a visiting family member.

In addition to the above identified incidents of responsive behaviours by resident #020, there were five incidents where the resident was physical and/or emotional abusive towards resident #021 x 2, #026, #029 and a family member and there were no documented evidence of an assessment to determine if there were injuries or pain.

In all of the above identified incidents, there were no documentation to indicate the Substitute Decision Makers (SDM's) were notified. [s. 97. (1) (a)]

WN #10: 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 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.

Re: Intake Log #017074-16 for resident #001:

A report was received by the Director on an identified date for an allegation of staff to resident physical abuse. The report did not indicated the police was notified.

Interview with Director of Care (DOC) on an identified date by the inspector, and a review of the home's investigations notes confirmed that the police was not notified.

The licensee has failed to ensure 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, specifically related to resident #001. [s. 98.]

2. Re: Intake Log #025239-16 for resident #020 and #021:

A report was received by the Director for an alleged resident to resident physical abuse, between resident #020 and #021, where resident #21 sustained injuries.

Review of the progress notes for resident #020 indicated on an identified date, an unidentified Personal Support Worker (PSW) witnessed the resident "standing over" resident #021 while sitting in a mobility aid and was physical aggressive with the resident. Review of the progress notes for resident #021 indicated the resident sustained injuries to various body parts.

Interview with DOC on an identified date by the Inspector, confirmed this incident of suspected resident to resident physical abuse was not reported to the Police.

The licensee has failed to ensure 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, specifically related to resident #020. [s. 98.]

3. Re: Intake Logs #023485-16 and 020117-16 for resident #002 and Log # 020565-16 for resident #003:

Review of the progress notes by Inspector #111, for resident #002 indicated the following:
1. From admissions to an identified date, when the responsive behaviours ceased, there were ongoing incidents of either witnessed and/or suspected verbal, physical, or sexual abuse by resident #002 towards other cognitively impaired residents.
2. Eight residents were the recipient of resident #002's witnessed and/or suspected verbal, physical, or sexual abuse on more than one occasion (resident #003, #005, #006, #007, #009, #010, #011 and resident #012).
3. There were nine incidents of either suspected and/or witnessed incidents of verbal, physical or sexual abuse, where the recipient residents of resident #002 were not identified.
4. Three incidents were reported to the Director as the recipient residents sustained

serious injuries requiring transfer to hospital, but were not reported to the police.
5. There were 16 incidents of suspected and/or witnessed physical or sexual abuse by resident #002 towards identified residents and the alleged abuses were not reported to the police.
6. There were seven incidents of witnessed and/or suspected verbal abuse by resident #002 towards other residents.

Interview of DOC and two Assistant Director of Cares (ADOC's) confirmed that the above incidents were not reported to the Police. [s. 98.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident:
(ii) names of any staff members or other persons who were present at or discovered the incident, and
(iii) names of staff members who responded or are responding to the incident

Re: Intake Log #017074-16 for resident #001:

A report was received by the Director on an identified date for an allegation of staff to resident physical abuse. The report identified one Personal Support Worker (PSW) #122, and one Registered Nurse (RN) #109 that were either present and or either discovered the incident.

Interview with RPN #102 on an identified date, and review of the home's investigation notes indicated that PSW #104, RPN #102 and #123 were also either present or discovered the incident, but was not identified in the report.

The licensee has failed to ensure that the report to the Director included the names of the staff who were present or either discovered the incident specifically related to resident #001. [s. 104. (1) 2.]

2. The licensee has failed to ensure that the report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

Related to Intake Log #020117-16 for resident #002 and 005:

A report was received by the Director on an identified date for resident to resident physical abuse. Resident #002 was witnessed to have pushed resident #003 resulting in a fall and injury.

The inspector brought forward a concern related to sexual behaviours directed towards resident #005 by resident #002 found documented in the progress to the Director of Care (DOC) on an identified date. The DOC confirmed that he/she was not aware of the above identified behaviours between the two residents. The DOC confirmed that a report was not submitted regarding the above incident.

Upon conclusion of the inspection, the home was yet to submit a report related to above identified incident.

The licensee failed to ensure that a report to the Director was made within 10 days of becoming aware of allegations of sexual abuse specifically related to resident #005. [s. 104. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed of resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition in the home no later than one business day after the occurrence of the incident, followed by a report required under subsection (4)

Review of the health care record for resident #002 indicated on an identified date, the resident was brought to the auditorium for pub night by a Life Enrichment Aide (LE). The resident wandered out of the activities area as the LE was busy serving other residents. An off-duty Personal Support Worker (PSW) went to search for the resident and unable to locate the resident. A visitor reported the resident was wandering out in the parking lot. The resident was returned to the home with no injury. The receptionist reported that the resident exited the front door after a visitor was leaving. There was no documented evidence the Director was notified of a missing resident for less than three hours without injury.

Interview with DOC indicated the resident was located outside in the parking lot a short time later, the resident was returned to the home without injury, and confirmed the Director was not notified of the missing resident incident.[s. 107. (3)]

Issued on this 22nd day of December, 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

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) :	JULIET MANDERSON-GRAY (607), LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2016_397607_0016
Log No. / Registre no:	020117-16, 023485-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 15, 2016
Licensee / Titulaire de permis :	THE CORPORATION OF THE COUNTY OF NORTHUMBERLAND 983 Burnham Street, COBOURG, ON, K9A-5J6
LTC Home / Foyer de SLD :	GOLDEN PLOUGH LODGE 983 BURNHAM STREET, COBOURG, ON, K9A-5J6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Clare Dawson

To THE CORPORATION OF THE COUNTY OF NORTHUMBERLAND, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that:

1. All members of the management team of the home, including Registered Nurses and Registered Practical Nurses are educated on:

A. The Long-Term Care Act, 2007 (LTCHA) and Ontario Regulation (O. Reg.) 79/10, specifically related to the following sections:
LTCHA s.24 – Reporting certain matters to the Director
LTHCA s.23 – Licensee must investigate, respond and act
LTHCA s.20 – Policy to promote zero tolerance
O. Reg. 79/10 s. 2 - Definition of abuse
O. Reg. 79/10 s. 53 – Responsive behaviours
O. Reg. 79/10 s. 55 – Behaviours and altercations
O. Reg. 79/10 s. 97 – Notification re incidents
O. Reg. 79/10 s. 98 – Police notification
O. Reg. 79/10 s.104 – Licensee who reports investigations under s.23 (2) of the LTCHA

B. The Licensee's "Prevention Reporting and Elimination of Abuse" policy, which only included documenting when "physical abuse is alleged" and does not include verbal, emotional or sexual abuse. This policy also did not provide procedures for "preventing" abuse. This policy is to be reviewed and revised and education is to be provided to all staff once revised, including actions to be taken when there is a suspicion, allegation or witnessed incident of emotional, verbal, sexual and physical abuse and the reporting of incident.

2. A process is developed and put in place whereby the Director of Care and/or

delegates are reviewing all documentation and communication from the front line staff at least daily to determine if any resident abuse has occurred in the home; and this shall continue until compliance is achieved.

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

4. Any resident currently exhibiting responsive behaviours, including sexual, verbal, emotional and physical aggression is assessed, the incidents and assessments are documented, and the plan of care is reviewed and revised.

5. Residents that are identified as having responsive behaviours are referred to the Behaviour Support Ontario (BSO) Team to support staff who provide direct care to these residents with the identification of triggers and the implementation of strategies to manage those responsive behaviours.

6. The licensee`s" Responsive Behaviours" policy #EC17-01 is complied with, including ensuring clear direction is provided to all staff about the referral process to the BSO Team and when to refer to the external Psychogeriatric Resources.

The plan shall be submitted to LTCH Inspector and is to identify who will be responsible for each item and expected completion dates.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents were protected from physical, verbal, sexual and emotional abuse by resident #002.

Under O.Reg.79/10, s. 2(1) For the purposes of the definition of "abuse" in subsection 2(1) of the Act, "physical abuse" means, subject to subsection (2) (c) the use of physical force by a resident that causes physical injury to another resident; "sexual abuse" means, subject to subsection (3) (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member; "emotional abuse" means, subject to subsection (1), (b) the use of any threatening or intimidating gestures, actions, behaviour or remarks by a

resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences. "Verbal abuse" means, any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences.

Re: Three Intakes (Log # 023485-16 & 020117-16) for resident #002 and (Log # 020565-16) for resident #003:

Review of the progress notes for resident #002 by two Inspectors during the inspection, indicated that since admissions to an identified date, when the responsive behaviours ceased, there were ongoing incidents of either witnessed or suspected physical, verbal, sexual and/or emotional abuse by resident #002 towards other cognitively impaired residents as follows:

1. Eight residents were the recipient of resident #002's witnessed or suspected verbal, physical, or sexual abuse, on more than one occasion (resident #003, #005, #006, #007, #009, #010, #011 and #012).
2. There were nine additional incidents of either suspected and/or witnessed verbal, physical, emotional or sexual abuse by resident #002, where the recipient residents were not identified.

The following three incidents were reported to the Director but not reported to the police:
1. On an identified date and time, staff witnessed resident #002 was physically abusive towards resident #010, causing the resident to fall, and being transferred to hospital with sustained injuries.
2. On an identified date and time, the staff witnessed resident #002 was being sexually inappropriate towards resident #005, the resident touched resident #005's body part. The Director was not notified of this incident until an identified date, five months later, after an Inspector spoke with the DOC.
3. On an identified date and time, staff witnessed resident #002 being physically and emotional abusive towards resident #003. Resident #003 fell to the floor, sustained injuries to a body part and became unconscious for approximately two minutes. Resident #003 was not transferred to hospital until approximately two hours later.

In addition, there were 14 incidents of suspected and/or witnessed verbal,

emotional, physical or sexual abuse that were documented in resident #002's progress notes towards other residents, that were not investigated, had no documented evidence to indicate the residents that were the recipients of the alleged abuse were assessed for injury or distress and there were no documented evidence that the incidents were reported to the Substitute Decision Makers (SDM's), the Director, and the police.

Interview with the Assistant Director of Care (ADOC) #110 on an identified date by an Inspector, confirmed that resident #002 and resident #005 were not able to give consent to touching and/or to behaviours of a sexual nature. Interview with the DOC on the same day by the inspector, indicated that he/she did not perceive the incidents of non-consensual sexual behaviours by resident #002 directed towards resident #005, to be abusive, and as such, they were not reported.

Interview with Registered Practical Nurse (RPN) #128 on an identified date, by an Inspector, indicated the behaviours resident #002 exhibited towards resident #003, were sexual in nature and he/she did not report the incidents to anyone.

Interview with Registered Nurse (RN) #127 by an Inspector, indicated recalling the incident that occurred on an identified date, but was unable to recall which two residents were the recipient of resident #002's sexually inappropriate behaviours, and could not recall what 'acting sexual' referred to in her note. RN #127 further indicated that it was probably resident #002, "inappropriately touching the resident's body part." The RN indicated he/she reported the incident to ADOC #107, and further indicated the Director and the police were not contacted regarding the incident, as he/she did not think it was sexual abuse. The RN further indicated to the inspector that he/she perceived sexual abuse to be more like sexual intercourse than that of non-consensual touching.

Interview of ADOC #107, by the inspector, indicated awareness of the above identified incident, because he/she had gone to speak with resident #002 along with RN #127, as the RN was afraid of speaking to the resident by him/herself. The ADOC could not recall who the two recipient residents were or what 'acting sexual' referred to. The ADOC indicated one of the recipient residents was probably resident #003, and it was probably resident #002 inappropriately touching him/her. The ADOC confirmed the SDM, police and the Director were not notified of the incident.

In addition, there were four incidents of witnessed emotional abuse documented in the progress notes of resident #002 towards other residents.

Interview with the Director of Care (DOC) and both ADOC's (#107 and #110) by an Inspector, all confirmed that all of the above specified incidents were not reported to the SDM's, the Director or the Police.

A Compliance Order was warranted as the scope and severity was demonstrated by the following:
1. The home's compliance history indicated LTCHA, 2007; S.19 (1) was issued as a Compliance Order, during a Critical Incident Inspection on October 16, 2014, (inspection # 2014_270531_0024). In addition, LTCHA, 2007, S.20 (1) was issued as a Voluntary Plan of Correction, during a Resident Quality Inspection on March 7, 2016, (inspection # 2016_195166_0007). LTCHA, 2007, S.24 (1) was issued as a Written Notification, during a Complaint Inspection on February 6, 2014, (inspection # 2014_049143_0007),during a follow up inspection on February 11, 2015, (inspection # 2015_348143_0010), and during a Complaint Inspection on February 11, 2015, (inspection # 2015_236572_0005).
2. There was actual harm of physical, sexual, verbal and emotional abuse by resident #002 towards multiple cognitively impaired residents.
3. The licensee's Prevention of Abuse policy was not complied with, as many of the incidents did not identify the residents who were abused, did not have documented evidence of the incidents on the recipient resident s' charts of the witnessed or suspected abuse, to indicate if the residents were assessed for injuries or distress, as well as, the policy did not meet the legislative requirement as identified under LTCHA, 2007, s.20 (1) (2). (Refer to WN #03)
4. The SDM's of resident #002 and the recipient residents of the suspected or witnessed abuse were not always notified, as identified under O. Reg. 79/10, s.97(1).(Refer to WN #09)
5. All of the suspected or witnessed incidents of resident to resident abuse were not reported to the police, as identified under O.Reg.79/10, s.98. (Refer to WN #10)
6. The incidents of suspected or witnessed sexual and/or physical abuse which occurred on nine different occasions, were not reported to the Director, as identified under LTCHA, 2007, s.24(1).(Refer to WN #06)
7. When the residents demonstrated ongoing verbal and/or physical aggression, and sexually inappropriate behaviours, the behavioural triggers were not identified where possible, and strategies to manage the responsive behaviours

were not identified where possible, as identified under O.Reg. 79/10, s.53 (4). (Refer to WN #08)
8. The incidents of suspected or witnessed sexual and/or physical abuse which occurred on nine different occasions, were not immediately investigated by the home, as identified under LTCHA, 2007, s.23(1)(2).(Refer to WN #05)
9. The Licensee did not ensure that a report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, on or at an earlier date if required by the Director of alleged resident to resident sexual abuse between resident #005 and resident #002, as identified under LTCHA, 2007, s. 104. (2) (Refer to WN #011). [s. 19. (1)]

2. The licensee has failed to ensure that residents were protected from physical and emotional abuse by resident #020.

Re: Intake Log #025239-16 for resident #020 and #021:

A report from the home was received by the Director on an identified date, for a resident to resident physical abuse. Resident #020 was witnessed squeezing the body part of resident #021 resulting in injuries to the resident.

The following were incidents of suspected emotional and physical abuse that were documented in resident #020's progress notes towards other residents, that were not investigated, had no documented evidence to indicate the residents of the alleged abuse were assessed for injury or distress and no documented evidence that the incidents were reported to the Substitute Decision Makers (SDM's), the Director, and the police. Review of the progress notes for resident #020 by an Inspector, indicated the following:

1. There were two incidents of resident to resident physical abuse by resident #020 towards resident #021 where injuries were sustained. One of the incident was not reported to the Director or the Police.
2. There were additional incidents of suspected resident to resident physical abuse and/or emotional abuse towards resident #021, #022, #023, #024, #025, #026, #027, #028 and #029 by resident #20, but there were no documented evidence of an assessment of those residents to indicate whether an injury, pain or distress was caused to the recipient residents.
3. Resident #027 was the recipient of five incidents of either physical and/or emotional abuse, and there were no documented evidence of an assessment of resident #027 to determine if any injury or pain was sustained.

4. Resident #021 was the recipient of nine incidents of either physical abuse and/or physical aggression and there was no documented evidence of an assessment of resident #021 to determine if any injury or pain had been sustained.
5. Resident #022 was the recipient of four incidents of physical aggression and there were no documented evidence of an assessment of resident #022 to determine if any injury or pain was sustained.
6. Resident #023 was the recipient of three incidents of either physical abuse and/or physical aggression, and there were no documented evidence of an assessment of resident #023 to determine if there were any injuries sustained.
7. The resident also physical aggressive with a visiting family member on an identified date.

Interview with Registered Practical Nurse (RPN) #125 on an identified date, by an Inspector, indicated that when there is an incident involving two identified residents with responsive behaviours, the documentation should include information about both residents. The RPN did not know whom the residents were and could not locate any information to determine if the residents were assessed for pain or injuries.

Interview with RPN #128 on an identified date by an Inspector, confirmed that he/she does not consistently document resident's assessments when there are incidents of responsive behaviour.

Interview with Registered Nurse (RN) #132 on an identified date, by the inspector, indicated that it is the expectation that when there is an incident of responsive behaviour involving two residents, staff are to document on and assess both residents.

A Compliance Order was warranted as the scope and severity was demonstrated by the following:
1. The licensee did not immediately investigate the incidents of suspected physical abuse between resident #020 and multiple residents, as identified under LTCHA, 2007, s. 23 (1)(a) (Refer to WN #005).
2. The licensee did not follow its Reporting and Elimination of resident abuse policy, by immediately reporting all the allegations of alleged resident to resident physical abuse between resident #020 and multiple residents as identified under LTCHA, 2007, s. 20. (1) (Refer to WN #003).
3. The licensee failed to comply with O. Reg. 79/10, s. 53. related to Responsive

behaviours, by not ensuring behavioural triggers have been identified to resident demonstrating responsive behaviour (where possible), and strategies were identified and implemented to manage the behavioural triggers where possible. s. 53. (4) (Refer to WN #008)
4. The incidents of suspected or witnessed physical abuse which occurred on an identified date by resident #020 towards resident #021 was not reported to the Director, as identified under LTCHA, 2007, s.24 (1). (Refer to WN #06)
5. The SDM's of resident #020 and the recipient residents of the suspected or witnessed abuse were not always notified, as identified under O. Reg. 79/10, s.97(1).(Refer to WN #09)
6. The Licensee has failed to comply with O. Reg. 79/10, s. 98 by not ensuring the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute criminal offence. s. 98 (Refer to WN #010). [s.19. (1)] (607) [s. 19. (1)]

3. The licensee has failed to ensure that residents were protected from physical and verbal abuse by resident #013.

Re: Intake Log #026804-16 for resident #013 and #014:

A report was received by the Director for an alleged resident to resident physical abuse that occurred on an identified date and time, between resident #013 and #014. Both residents sustained injuries.

A review of the progress notes for resident #013, by the inspector, indicated there were two additional incidents of resident to resident physical abuse by the resident. These incidents of suspected and/or witnessed physical or verbal abuse by resident #013 towards other unidentified residents, were not investigated, had no documented evidence to indicate the identified residents of the alleged abuse were assessed for injuries or distress, and/or were reported to the Substitute Decision Makers (SDM's), the Director, and the police. There was no documentation in the progress notes of resident #013 to indicate the incidents were investigated to identify the recipient residents. The incidents were documented as follows:

1. On an identified date, resident #013 was sitting in a mobility device outside of dining area. An unidentified resident was sitting in a mobility aid near the resident. Resident #013 was physical aggressive towards the unidentified

resident.
2. On an identified date and time, an unidentified resident was seated in a mobility aid in the corridor and observed resident #013 attempting to enter his/her room. When the unidentified resident approached the resident, resident #013 was physically aggressive towards the resident.

In both of the above identified incidents, there was no indication of who the unidentified resident was or whether both residents were assessed for injuries or pain.

Interview with Registered Nurse (RN) #132 on an identified date, by an inspector, indicated that it is the expectation that when there is an incident of responsive behaviour involving two residents, staff are to document on and assess both residents.

A Compliance Order was warranted due to the scope and severity as demonstrated in both of the above identified incidents, where there was no documentation to indicate who the recipient residents were, or to indicate an assessment was completed, in order to determine if physical abuse had occurred as per the licensee's policy. In addition, the following areas of non-compliance were identified:

1. The Licensee failed to comply with O. Reg. 79/10, s. 53. related to Responsive behaviours, by not ensuring behavioural triggers have been identified to resident demonstrating responsive behaviour (where possible), and strategies were identified and implemented to manage the behavioural triggers where possible. s. 53. (4) (Refer to WN #008)
2. The Licensee did not follow its Reporting and Elimination of Resident Abuse Policy, by not immediately reporting all the allegations of alleged resident to resident physical abuse between resident #013 and multiple residents as identified under LTCHA, 2007, s. 20. (1) (Refer to WN #003).
3. The SDM's of resident #013 and the recipient residents of the suspected or witnessed abuse were not always notified, as identified under O. Reg. 79/10, s.97(1).(Refer to WN #09)
4. The licensee did not immediately investigate the incidents of suspected physical abuse between resident #013 and an unidentified residents, as identified under LTCHA, 2007, s. 23 (1)(a) (Refer to WN #005). [s. 19. (1)] (607)

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 : Jan 18, 2017

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
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 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 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 15th day of December, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Juliet Manderson-Gray

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