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
Jun 29, 2016	2016_287548_0014	013493-16	Resident Quality Inspection

Licensee/Titulaire de permis

THE OTTAWA JEWISH HOME FOR THE AGED
10 Nadolny Sachs Private Ottawa-Carleton ON K2A 4G7

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

HILLEL LODGE
10 NADOLNY SACHS PRIVATE OTTAWA ON K2A 4G7

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

RUZICA SUBOTIC-HOWELL (548), GILLIAN CHAMBERLIN (593), RENA BOWEN (549)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 24, 25, 26, 27, 30, 31, 2016 and June 1, 2 and 3, 2016

Log #: 014698-16 was inspected on related to alleged sexual abuse

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Nursing (DON), Director of Social Work, Programs and Services (DSWPS), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs)/Health Care Aides (HCAs), Family members, RAI coordinator, Maintenance Worker, Director of Food and Nutrition Services (DFNS), Director of Environmental Services (DES), Private Care Givers, Behavioural Supports Ontario (BSO) nurse, Director of Food and Nutritional Services (DFNS) and Family Council President.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

15 WN(s)
4 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. Sexual abuse is defined by the LTCHA, 2007 as “any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member; (“mauvais traitement d’ordre sexuel”)”

1. The Licensee failed to protect resident #045 from sexual abuse by resident #041.

Resident #045 was admitted to the home on a specified day in February 2011. Resident #045 Minimum Data Set assessment (MDS) completed on a specified day in February 2016 indicated that the resident has short term and long term memory problems, cognitive skills for daily decision-making is severely impaired and never/rarely made decisions.

A progress notes dated on a specified day in April 2016 indicated that RPN #106 observed resident #041 to touch resident's #045 inappropriately in a sexual manner. During an interview on June 3, 2016 RPN #106 indicated that the resident #041 was removed from the area. In addition, RPN #106 indicated to Inspector #548 that she did inform the Director of Care of the sexual touching by resident #041 to resident #045 on the same day, by phone.

On June 3, 2016 during an interview RPN #106 confirmed that the Power of Attorney (POA) and police were not notified. The MOHLTC was not notified.

The Licensee failed to protect resident #047 from sexual abuse by resident #041.

Resident #047 was admitted to the home on a specified day in January, 2014. The Minimum Data Set assessment dated on a specified day in April 2016 indicates that resident #047 has short term and long term memory problems, cognitive skills for daily decision-making is moderately impaired – decisions are poor; cues or supervision is required.

Progress notes dated on a specified day in April 2016 indicated that resident #041 was found by the PSW trying to kiss resident #047. The progress note reads: that resident #041 was removed and resident #047 was removed from the area.

On June 3, 2016 RPN #124 indicated that this situation was brought forward to the ethics committee to discuss. RPN #124 indicated that she did not report it to the DOC, the police nor inform the resident's POA. On June 3, 2016 during an interview with the Director of Social Work, Programs and Services (DSWPS) she indicated that the MOHLTC was not notified of the incident between resident #041 and resident #047.

A Critical Incident Report was submitted to the MOHLTC on a specified day in May, 2016 for the incident on the specified day in April, 2016. The incident of a witnessed sexual abuse from resident #041 to an unidentified co-resident (resident #047). On June 3, 2016 co-resident was identified by the DSWPS as resident #047.

The incident on a specified day in April, 2016 is described in the progress notes that resident #041 was found by a PSW in resident's #047 room at the bedside with resident's #041 genitalia at resident's #047 hand. Resident #047 was asleep. Resident #041 was subsequently removed from the room.

On June 1, 2016 during an interview the DOC indicated that the reporting process at the home for after-hour incidents is for PSWs to report any alleged or suspected abuse to registered nursing staff and the registered practical nurse is to inform the registered nurse in charge who is expected to call the after-hour pager. She indicated that the staff member who observed the incident did not immediately report it and the registered nurse did not call the after-hour pager.

On June 3, 2016 the DSWPS indicated that resident #047 is capable to understand that an incident transpired although she was not informed of the incident nor was the family for fear of upsetting the resident.

On June 21, 2016 the DON indicated that resident #047 was not informed, nor ther family

of the incident for fear of upsetting the resident.

2. The Licensee failed to immediately investigate and take appropriate action.
Section 23 of the LTCHA, 2007 required the Home to immediately investigate and take appropriate action relating to every alleged, suspected or witnessed incident of abuse of a resident by anyone.

The home addressed witnessed incidents of a sexual nature with the removal or distraction of resident #041.

Prior to the CIR, the home was aware that resident #041 wanted to initiate a sexual relationship with resident #048; which was discussed with the POA at a the resident care conference on a specified day in July, 2015. The DON, on June 21, 2016, indicated that the POA agreed the resident be moved to another unit to diminish contact between resident #041 and resident #048. The resident's #041 behaviours of a sexual nature are recorded on a home document dated on a specified date in August, 2015 that indicated the resident #041 is having a sexual relationship with an incapable resident (resident #048). In addition, it is recorded that resident #041 is seeking out a sexual relationship with resident #048 and resident #048 wants the same relationship based on observations exhibited by resident #048; smiling, happy, loves attention. The document indicated that the conduct is in public and visitors, other residents and staff have considered the behaviour as not acceptable in public areas. Resident #041 was eventually moved to another unit. From staff interviews with the DSWPS and RPN #113 on June 3, 2016 both indicated resident #041 sought out a relationship of a sexual nature with resident #048.

The risk of resident #041 seeking out other residents when moved to another unit was identified in a the same document. The home continued to be aware of resident’s #041 behaviour as indicated in meeting minutes from the Multidisciplinary Assessment Committee for specified days in March and April 2016. The committee meets on a weekly basis and resident #041 behaviours are recorded as "disruptive (behaviour), removing clothing and inappropriate behaviours, wandering into resident rooms”. During an interview on June 3, 2016 RPN #124 reported that resident’s #041 inappropriate sexual behaviours were discussed at these meetings.

As indicated in a progress note entry resident #041 is transferred to another unit on a specified day in April, 2016. That same day the resident #041 is found kissing a unidentified resident on the cheek while in the resident's room. On a specified day in

April, 2016 it is recorded in the progress notes that the resident #041 is wandering and looking for other residents. The following day in the progress notes a registered nurse wrote that resident #041 likes to talk and kiss residents and is reminded that the behaviour is inappropriate.

The resident #041 was also known to make gestures to staff members as recorded in the progress note entry dated for a specified day in March, 2016 where the staff member writes that resident #041 made sexual advances to the staff member. The staff member redirected the resident.

On a specified day in April, 2106 the BSO nurse recommends behaviour monitoring re: "sexual behaviour". The resident is seen again by BSO several days later and the medication regime is reviewed. During an interview on June 1, 2016 the DON indicated that behavioural monitoring and one-to-one care was implemented related to the resident's #041 sexual behaviours.

For a specified period of time in March, 2106 to April, 2016 the resident #041 is found to be wandering into other resident rooms and around the unit. In addition, there are three recorded instances where the resident is found without pants/clothes on and each time is redirected by staff.

On a specified day in April 2016 a progress note entry by a registered practical nurse indicated that the resident was found in resident's #046 room with clothing removed, sitting on the bed attempting to have resident #046 engaged in a sexually inappropriate manner. Resident #041 was removed from the room.

3 . The Licensee failed to immediately report.
Section 24 of the LTCHA, 2007 requires a person who has reasonable ground to suspect that any of the following has occurred or may occur shall immediately report the suspicion and information upon which it is based to the Director: 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.

On June 3, 2016 the DSWPS indicated staff were "interjecting" and "uncomfortable with public displays" of a sexual nature from resident #041 to resident #048. From staff interviewed it was confirmed that the incidents involving resident #45 and #47 were not reported to the MOHLTC.

On June 1, 2016 during an interview the DOC indicated that the reporting process at the home for after- hour incidents is for PSWs to report any alleged or suspected abuse to registered nursing staff and the registered practical nurse is to inform the registered nurse in charge who is expected to call the after-hour pager. She indicated that the staff member who observed the incident (CIR) did not immediately report it and the registered nurse did not call the after-hour pager. Although, the home’s policy titled: Zero-Tolerance Policy on Abuse-Quality Management 2015/ZTPA indicated that witnessed or suspected abuse or complaints of abuse should be reported immediately to the Executive Director (or delegate). In addition, the policy reads: any person may report witnessed or suspected abuse to any of the following: The Executive Director (or delegate) and the toll-free Long-Term Care ACTION Line.

Furthermore, the incident as described in the critical incident report was submitted to the MOHLTC several days after the mandatory reporting requirements stipulated.

4. The Licensee failed to ensure the resident’s substitute decision-maker are notified immediately upon the becoming aware of an alleged, suspected or witnessed incident.

The POA’s for resident’s #045 and #046 have not been notified as indicated by interviewed registered nursing staff, RPN #106, RPN #124 and the DSWPS. Although the home’s policy titled: Zero-Tolerance Policy on Abuse-Quality Management 2015/ZTPA specifies that the resident's family member, substitute decision makers or others specified in the plan of care are to be notified.

5. The Licensee failed to ensure that the appropriate police force is immediately notified on any alleged, suspected or witnessed incident of abuse of a resident.

On two separate interviews on June 3, 2016 with RPN #106 and DSWPS, both indicated that staff are not instructed to notify police for alleged sexual abuse between residents. RPN #106 and RPN #124 indicated the police were not notified of the incidents observed between resident #041 to resident’s #045 and #047.

Both RPN #106 and RPN #124 confirmed that although they were aware of the incidents they had not notified the POA, the police nor the MOHLTC for the incidents involving resident #041 to resident’s #045, #046, #047 and #048. During the inspection, the DON indicated that incidents of a sexual nature are not reported to the police however, agreed that the incidents were of a sexual nature involving residents #045, #046, #047, #048 and warranted reporting to the MOHLTC and the police.

6. The Licensee failed to report to the director a description of the individuals involved in the incident, including the names of all the residents.

The reported critical incident submitted to the MOHLTC on a specified day in May, 2016 did not include a description of the co-resident involved in the incident (refer to WN# 15- The Licensee failed to comply with O.Reg 79/10,s. 104. Licensee's who report investigations under s.23 (2) of Act).

The home's policy titled: MOHLTC- Reportable Matters revision date: September 4, 2015 specifies that a description of the individuals involved in the incident will be included in the report submitted to MOHLTC.

7. The Licensee failed to ensure at a minimum the policy to promote zero tolerance of abuse and neglect of residents:
Clearly set out what constitutes abuse and neglect;
Shall provide for a program, that complies with the regulation, for preventing abuse and neglect
Shall contain an explanation of the duty under section 24 to make mandatory reports;
Shall set out the consequences for those who abuse or neglect residents.

The home's policy titled: Zero-Tolerance Policy on Abuse-Quality Management 2015/ZTPA, Abuse and Neglect of a Resident-Actual or Suspected- Nursing 2015\ANRAS, revision date September 2, 2015 , MOHLTC- Reportable Matters- Administration 2015/MRM revision date: September 4, 2015 and Abuse and Neglect of a Resident- Actual or Suspected, revision date September 2, 2015 were reviewed.

On June 3, 2016 during an interview DSWPS indicated that she is aware that sexual abuse is not defined and not included in the education for all staff. On June 21, 2016 the DON confirmed the that staff training on resident to resident sexual abuse is absent.

On June 1, 2016 the DON indicated during an interview that sexual abuse is not a usual occurrence in the home however, resident #041 has a history of a sexual nature with several residents and the licensee was aware on a specified day in August, 2015 and on a weekly basis from a specified period of time in March, 2016 to April, 2016 of the resident's #041 behaviour.

In this matter, the Licensee failed to protect resident's #045, #046, #047 and #048 from

sexual abuse by resident #041. A compliance order is warranted as the scope was identified as widespread with serious allegation of sexual abuse involving several residents and previous issuance of non-compliance related to s. 20 (2) and s. 24 (1) in February 26, 2015. [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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident’s linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The Licensee failed to ensure the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Resident #036 is at risk for falls, has a falls history and has several fall prevention interventions.

The resident's health care record was reviewed.

The resident's care plan dated for a specified day in May 2016 indicated fall prevention interventions to include the use of fall mat beside the bed, bed to the lowest level and the daily use of a bed alarm.

On June 1, 2016 Inspector #548 observed the resident's #036 bed alarm to not produce a notification sound when the Inspector put pressure on and off the sensor pad. PSW # 119 indicated that she was caring for the resident that day and that the bed alarm system may need to be rebooted to work. PSW # 119 made several attempts to produce a notification sound by demonstrating how the system works by pressing up and down on the bed to mimic the resident rising out of the bed and then rebooted the system. RN #113 entered the room and mimicked the same movements by putting pressure on and off the sensor pad and then rebooted the system. The movements made by the PSW and RN did not produce a notification sound. The RN #113 indicated that the bed alarm systems are monitored by the PSWs when they assist residents out of bed, should the system not alarm they would notify the registered nursing staff.

On June 1, 2016 Maintenance worker #122 observed the systems components: control unit and bed sensor pad in the presence of Inspector #548. He noted that the control input was damaged and would require replacement.

On June 1, 2016 during an interview PSW # 119 indicated that she assisted the resident from the bed after morning care by transferring the resident to the wheelchair and the bed alarm did not produce a notification sound. RN #113 indicated that she was not made aware the bed alarm was not working.

On June 1, 2016 during an interview the DON indicated the system is monitored by the PSWs and when the bed alarm is not working it is expected that they notify registered nursing staff to have replaced. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure equipment required to manage the risk for falls be in a good state of repair, to be implemented voluntarily.

WN #3: 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 failed to 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.

Resident #037 has been identified as risk for falls, has a falls history and requires assistance with activities of daily living.

The resident’s #037 health care record was reviewed. There are three recorded un-witnessed fall incidents on specified days in May, 2015, March, 2016 and February, 2016.

The resident’s care plan dated for a specified day in May 2016 identified the resident at risk for falls and fall interventions.

On June 1, 2016 during an interview Resident #037 indicated that there were no injuries sustained from the falls.

On June 1, 2016 during an interview RN #113 indicated that post-fall incident reports are conducted however, she was uncertain if the home had a post-fall assessment tool.

On June 1, 2016 during an interview the DON indicated that a post-fall assessment must be completed for all witnessed and un-witnessed falls. She indicated that the home's process for all fall incidents includes the completion of a form titled: Morse Fall Risk Assessment by the interdisciplinary team, a tool specifically designed for falls. The DON confirmed that that since the inception of electronic reporting in 2013 she is aware that post- fall assessments are not being completed, as required by the home.

A review of the home's policy titled: "Falls Prevention and Management- reference code: Nursing 2015/FPM", date reviewed August 18, 2015, found that the multidisciplinary team will conduct the Morse fall Risk Assessment following any change of status and after a fall, if applicable. [s. 49. (2)]

2. The Licensee failed to 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.

Resident #036 has been identified as high risk for falls and requires assistance with transferring and mobility.

The resident's #036 health care record was reviewed. The resident's recorded fall incidents are for specified days in March 2016 and April 2016.

The resident's care plan dated for a specified day in May 2016 identified the resident as high risk for falls and specifies fall prevention interventions.

On June 1, 2016 during an interview RN #113 indicated that post-fall incident reports are conducted for both witnessed and un-witnessed falls and was not aware if the home had a post- fall assessment tool.

On June 1, 2016 during an interview the DON indicated that a post-fall assessment must be completed for all falls-both witnessed and un-witnessed. She indicated that the home's process for all fall incidents includes the completion of a form titled: Morse Fall Risk Assessment by the interdisciplinary team, a tool specifically designed for falls. The

DON confirmed that since the inception of electronic reporting in 2013 she is aware that post- fall assessments are not being completed, as required by the home.

A review of the home's policy titled: "Falls Prevention and Management- reference code: Nursing 2015/FPM", date reviewed August 18, 2015, found that the multidisciplinary team will conduct the Morse fall Risk Assessment following any change of status and after a fall, if applicable. [s. 49. (2)]

3. The licensee has failed to ensure that when a resident has fallen, the resident was assessed and where the condition or circumstances of the resident required, a post fall assessment was conducted using a clinically appropriate instrument that was specifically designed for falls.

A review of resident #018's progress notes found that the resident sustained an un-witnessed fall in their room on a specified day in May 2016, resulting in visible injuries. Two days after the fall, the resident was transferred to hospital where it was discovered the resident sustained a significant injury from the fall. Several days later the resident returned from hospital with orders for palliative care and passed away the next day.

A review of resident #018's current care plan found that the resident had a history of falls and was at risk of falls due to unsteady gait and other diagnoses. Several interventions were documented to manage this risk.

A review of resident #018's health care record found no post falls assessment was completed for the fall sustained on a specified day in May 2016.

During an interview with Inspector #593, June 1, 2016, RPN #116 reported that if a resident falls, it depended on the resident and the fall as to the level of post falls assessment completed, if there was an injury, then they were required to complete the whole post falls assessment protocol. RPN #116 added that they were unsure of the cause of the fall for resident #018 as it was unwitnessed however, they believed that the resident must have lost their balance as the resident previously ambulated on their own. RPN #116 further reported that they were unaware of the Morse Falls Risk Assessment tool.

During an interview with Inspector #593, June 2, 2016, the DON reported that a post falls assessment should have been completed for resident #018 by the nursing staff using the Morse Falls Risk Assessment tool.

A review of the home's policy titled: "Falls Prevention and Management- reference code: Nursing 2015/FPM", date reviewed August 18, 2015, found that the multidisciplinary team will conduct the Morse fall Risk Assessment following any change of status and after a fall, if applicable. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance where circumstances and conditions require a resident is assessed with a clinically appropriate post- fall tool, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(d) includes alternative beverage choices at meals and snacks; O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's menu cycle included alternative beverage choices at snacks for residents requiring texture modified fluids.

During the morning nourishment pass on May 30, 2016, in a specified home area, Inspector #593 observed the cart with a selection of fluids being offered to residents by PSW #120. Included, was one carton of honey thickened apple juice. There were no other beverage choices available and being offered to residents requiring honey thickened fluids.

During the afternoon nourishment pass on May 31, 2016, in the specified home area, Inspector #593 observed the cart with a selection of fluids being offered to residents by PSW #121. Included in these fluids, was one carton of honey thickened cranberry juice. There were no other beverage choices available and being offered to residents requiring

thickened fluids. A thickened cranberry juice was observed to be given to residents #042 and #043 however, no beverage choice was given to these residents.

During the morning nourishment pass on June 1, 2016, in the same home area, Inspector #593 observed the cart with a selection of fluids being offered to residents by PSW #120. Included in these fluids, was one carton of nectar thickened cranberry juice and one carton of honey thickened apple juice. There was no other beverage choice available and being offered to residents requiring thickened fluids. A thickened cranberry juice was observed to be given to resident #043 and a thickened apple juice was observed to be given to resident #042, however no beverage choice was given to either resident.

During an interview with Inspector #593, June 1, 2016, PSW #120 reported that the dietary staff prepares the nourishment cart and there was always only one choice for thickened fluids available. When asked if residents requiring thickened fluids get a beverage choice, PSW #120 responded “no”.

During an interview with Inspector #593, May 31, 2016, PSW #121 reported that they were unsure if the thickened fluids were available in other varieties. PSW #121 added that the dietary staff prepares the nourishment cart and they just serve whatever is provided on the cart.

During an interview with Inspector #593, June 1, 2016, the Director of Food and Nutrition Services #110 reported that the home have a variety of commercially thickened beverages available as well as powdered thickener. #110 added that it is the home’s expectation that residents requiring thickened fluids are provided the same choices as residents receiving regular fluids.

A review of the home’s policy titled: Nourishments- Reference code: Nursing 2011/N, revised October 25, 2011, found that the food services department supplies mid-morning refreshments and nourishments for all residents. This includes items such as juice, milk and tea and coffee. [s. 71. (1) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home`s menu cycle includes beverage choice at snack times for those residents requiring modified fluids, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. On May 27,2017 on a specified home area at 1010 hours it was observed by Inspector #548 the medication room door to be propped open with a white garbage container between the door and the edge of the door frame. Several residents were in the vicinity of the medication room; sitting in the resident lounge area. Inspector #548 entered the room and observed prepared medication left on top of the cart in a medication cup. The medication cup contained Acetaminophen, Trazadone and Vitamin D, as confirmed by RPN#106. The medication cart was unlocked and all resident drugs and government stocked drugs were noted to be accessible.

The inspector stood for three minutes in the room. RPN #106 entered the room and indicated that she left the room with the door ajar and propped open for a short period of time to attend to a resident. RPN #106 indicated the home's policy is to keep the medication room door closed and locked at all times. RPN further indicated there are several residents who are ambulatory on the unit.

On May 31,2016 it was observed in specified resident room prescription cream Clotrimaderm HC 1% on top of the bed side drawers next to the resident.

On May 27,2016 the DON indicated the home's policy and expectation for all medications are to be secure and locked. [s. 130. 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure all drugs are secured and locked, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

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).

Findings/Faits saillants :

1. The Licensee failed to ensure that the written plan of care for each resident sets out (c) clear directions to staff and others who provide direct care to the resident.

1. Resident #034 requires extensive assistance for all activities of daily living due to cognitive loss. The resident`s #034 health care record was reviewed. The resident`s care plan dated for a specified day in April, 2016 specifies that two PSW`s are to use a Sling Lift and a large green sling for transferring between surfaces.

A Resident care conference dated for a specified day in March, 2016 indicated that the resident requires two persons for transferring on and off the toilet.

The PSW Flow sheets were reviewed from for a specified period of time in May, 2016. PSWs are prompted to record on the flow sheet how the resident moves between surfaces to and from the bed, chair, wheelchair and standing position. During this period of time it is recorded that the resident is a two person physical assist with exceptions on specified dates in May, 2016 where it is recorded for one instance that the resident was transferred with one person physical assistance and later that day it is recorded that the resident is a two or more person physical assist. On a specified day in May, 2016 there are two instances where it is recorded that the resident is a one person physical assist.

A Physiotherapy Reassessment dated for a specified day in April 2016 indicated that it is not applicable for the resident to use a sling.

On May 30, 2016 during an interview RN #114 indicated the resident #034 requires a two

person physical assistance to transfer between surfaces. On the same day PSW # 125 indicated the resident required two person assistance and sometimes a lift.

2.Resident #034 requires extensive assistance for all activities of daily living due to cognitive loss. The resident`s #034 health care record was reviewed.

The Minimum Data Set quarterly review assessment on a specified day in January 2016 indicated the resident #034 is frequently incontinent of bladder on a daily basis with some control present.

On May 30, 2016 during an interview RN #114 indicated the resident #034 would be on a toileting plan. On the same day PSW #125 indicated the resident is toileted twice once in the morning and then after lunch, the resident may at times request to be toileted and wears an incontinence product.

PSW flow sheets were reviewed for a specified period of time in May 2016. It is recorded that the resident is frequently incontinent of urine and occasionally incontinent of bowel.

The resident`s care plan dated for a specified day in April 2016 does not indicate any interventions related to toileting.

As such, the plan of care does not set out clear directions to staff and others who provide care to residents related to transferring between surfaces and toileting needs. [s. 6. (1) (c)]

2. The Licensee failed to ensure the care set out in the plan of care is provided to the resident as specified in the plan.

Resident #034 has been identified as a risk of falls, is known to attempt to climb out of bed and is confused due to a neurological cognitive deficit.

The resident’s #034 health care record was reviewed.

The resident’s #034 care plan dated for a specified day in April 2016 indicated that a fall prevention intervention would be the use of a mattress with raised edges to decrease the risk of climbing out the bed.

The Minimum Data Set assessment reference and RAP triggered item dated for a

specified day in April 2016 indicated the resident #034 had a fall within the last 31 to 180 days and the majority of the falls where in the residents room.

On May 27, 2016 during an interview PSW #111 indicated the resident is known to attempt to climb out of bed and was not sure what type of mattress was specified in the care plan. On May 27, 2016 Inspector #548 observed in the presence of the PSW #111 that the resident's bed does not have raised edges.

On May 27,2016 the DON indicated that all the mattresses at the home are the same and the resident's mattress was changed in 2013 and is the one that is currently in use. [s. 6. (7)]

3. The licensee has failed to ensure that that the care set out in the plan of care is provided to the resident as specified in the plan.

Resident #002 was admitted to the home February 3, 2015. At the time of admission the Registered Dietitian ordered: diet as tolerated, regular texture, regular consistency. The Registered Dietitian also assessed resident #002 as being a moderate nutritional risk.

Inspector #549 reviewed resident #002's progress notes dated for a specified day in April 2016 written by the Registered Dietitian which indicated that the resident has been feeling overwhelmed with portion sizes, as well as having difficulty managing mixed consistencies such as mushroom or vegetable soup. The resident also sometimes has difficulty scooping food from the plate onto the utensil. Diet had been modified to provide 1/2 portions on a blue, rimmed plate.

Resident #002's care conference notes dated April 26, 2016 indicate that the resident's health had deteriorated recently due to stomach flu and a fall. Resident #002 was temporarily on puree diet and tolerated well.

On May 9, 2016 the Registered Dietitian ordered the puree texture to be discontinued and start a regular texture diet, finely cut-up.

On May 24, 2016 resident #002 was assessed by the Registered Dietitian to be a high nutritional risk.

Inspector #549 observed resident #002's lunch meal service on May 27, 2016. The

resident was served a full portion of baked penne casserole with a tomato based sauce and waxed beans on a white dinner plate. Resident #002 requested that to be given something else as the resident did not like what was served and also indicated that it was too much food. The PSW left the resident and returned with a full portion of egg salad on a piece of lettuce, mixed vegetables, sliced tomatoes and cucumbers. Resident #002 was visibly upset and requested that the plate be taken away and a smaller portion of the food be put on the plate. The PSW returned with a smaller portion of the egg salad, a few slices of tomatoes and a piece of cucumber. The tomato slices and the piece of cucumber on the resident’s plate was observed by Inspector #549 not to be to finely cut-up.

During an interview on May 27, 2016 the Director of Food and Nutritional Services (DFNS) indicated that there is a dietary binder in each servery. The dietary binder has a Master Servery Report which indicates the resident’s diet, texture and any special instructions for the meal service. The DFNS indicated that the dietary aide is to refer to the binder when plating the resident’s meals.

The Director of Food and Nutritional Services (DFNS) and Inspector #549 reviewed the Master Servery Report dated May 26, 2016 which indicated that resident #002 is to receive a diet as tolerated (DAT), texture finely chopped, small portions on a blue rimmed plate.

On May 27, 2016 the DFNS confirmed to Inspector #549 that resident #002 did not receive her meal on a blue rimmed plate, small portion or finely chopped at the lunch meal service.

Inspector #549 reviewed resident #002’s current plan of care last reviewed on a specified day in May 2016 which indicated that the resident is a high nutritional risk and to provide the diet as ordered using a blue rimmed plate.

In summary the care set out in the plan of care is not being provided to resident #002 related to the resident’s dietary needs. [s. 6. (7)]

4. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #043 as specified in the plan.

A review of resident #043’s current care plan found that the resident has difficulty swallowing with an intervention documented to ensure snacks and beverages offered at

activities comply with diet and fluid restrictions. A review of resident #043's progress notes found that resident #043 required nectar thick fluids since October 2014.

During the afternoon nourishment pass on May 31, 2016, in a home area, Inspector #593 observed the cart with a selection of fluids being offered to residents by PSW #121. Included in these fluids, was one carton of honey thickened cranberry juice. A honey thickened cranberry juice was observed to be given to resident #043 and assistance was provided by PSW #121 for resident #043 to consume this fluid.

During an interview with Inspector #593, May 31, 2016, PSW #121 reported that resident #043 required thickened fluids however, they were unsure of the consistency they required. PSW #121 added that they just serve whatever is provided on the cart by the dietary staff.

A review of the dining care binder located on the home area nourishment cart, found documented that resident #043 required nectar thick fluids.

During an interview with Inspector #593, June 1, 2016, the DFNS reported that it was the expectation of the home that staff refer to the dining care binder for all dietary requirements to ensure that the residents receive the correct fluid consistency. DFNS added that there was an annual in-service for staff where this process is covered.

A review of the home's policy titled: Nourishments- Reference code: Nursing 2011/N, revised October 25, 2011, found that the nursing staff and/or designate will serve nourishments according to the residents' diet order. [s. 6. (7)]

WN #7: 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 are complied with.

The DON provided to the Inspector #548 home's policies, relevant documentation, investigative notes and resident's health care record. The health record, the home's investigation notes and relevant documentation and policies were reviewed. A component of the policy is a memorandum dated February 12, 2015 from the MOHLTC addressed to the home that explicitly cites the legislative reporting requirements and the definitions of abuse.

The DON provided to the Inspector #548 the home's policies and relevant

documentation.

The home's policy titled: Zero-Tolerance Policy on Abuse-Quality Management 2015/ZTPA, Abuse and Neglect of a Resident-Actual or Suspected- Nursing 2015\ANRAS, revision date September 2, 2015 , MOHLTC- Reportable Matters-Administration 2015/MRM revision date: September 4, 2015 and Abuse and Neglect of a Resident- Actual or Suspected, revision date September 2, 2015 were reviewed.

1. Resident #045 (see WN #1).

2. Resident #047 (see WN #1).

3. A Critical Incident Report (see WN #1). The incident of witnessed sexual abuse from resident #041 to an unidentified co-resident (refer to WN# 15- The Licensee failed to comply with O.Reg 79/10,s. 104. Licensees who report investigations under s.23 (2) of Act).

The home's policy titled: Zero-Tolerance Policy on Abuse specifies:
- the resident's family member, substitute decision makers or others specified in the plan of care will be notified
- that witnessed or suspected abuse of a resident should be reported immediately to the executive director/ delegate

The home's policy titled: Abuse and Neglect of a Resident-Actual or Suspected, reference code: Nursing 2015\ANRAS, revision date September 2, 2015 specifies that if a staff member becomes aware of potential or actual abuse they are to:
- notify the RN/RPN
- the RN/RPN will notify the Charge RN
- immediately notify the DON/Executive director (designate)
- notify the family/POA
- immediately notify the MOHLTC
- notify the police

On June 3, 2016 RPN #106 indicated the staff are not instructed to notify police for alleged sexual abuse and the DSWPS indicated that the home is hesitant to inform the police for matters of a "sexual nature".

Resident #041 had a history of sexual touching and kissing residents as indicated with

resident #045 on specified day in April, 2016, with resident #047 on specified day in April, 2016 and with the submission of critical incident related to resident #047.

The home’s policy titled: MOHLTC- Reportable Matters revision date: September 4, 2015 specifies that a description of the individuals involved in the incident will be included in the report submitted to MOHLTC.

The reported critical incident submitted to the MOHLTC on a specified day in May 2016 did not include a description of the co-resident involved in the incident (refer to WN# 15- The Licensee failed to comply with o.Reg 79/10,s. 104. Licensees who report investigations under s.23 (2) of Act).

The home’s policy titled: Zero-Tolerance Policy on Abuse-Quality Management 2015/ZTPA, Abuse and Neglect of a Resident-Actual or Suspected- Nursing 2015\ANRAS, revision date September 2, 2015 , MOHLTC- Reportable Matters- Administration 2015/MRM revision date: September 4, 2015 and Abuse and Neglect of a Resident- Actual or Suspected, revision date September 2, 2015 were reviewed.

Policy titled: Zero-Tolerance Policy on Abuse-Quality Management 2015/ZTPA indicated that witnessed or suspected abuse or complaints of abuse should be reported immediately to the Executive Director (or delegate). In addition, the policy reads: any person may report witnessed or suspected abuse to any of the following: The Executive Director (or delegate) and the toll-free Long-Term Care ACTION Line.

The home’s policies do not:
- contain an explanation of the duty to report under section 24 for the following requirements:
- a definition of sexual abuse
- set out consequences for those who abuse or neglect residents

On June 3, 2016 during an interview DSWPS indicated that she is aware that sexual abuse is not defined.

The licensee has failed to ensure that the homes' Abuse and Neglect Zero Tolerance policy contains an explanation of the duty under section 24 of the Act to make mandatory reports.

Policy titled: Zero-Tolerance Policy on Abuse-Quality Management 2015/ZTPA indicated

that witnessed or suspected abuse or complaints of abuse should be reported immediately to the Executive Director (or delegate). In addition, the policy reads: any person may report witnessed or suspected abuse to any of the following: The Executive Director (or delegate) and the toll-free Long-Term Care ACTION Line. [s. 20. (1)]

2. The licensee has failed to ensure that the homes' Abuse and Neglect Zero Tolerance policy contains an explanation of the duty under section 24 of the Act to make mandatory reports.

Policy titled: Zero-Tolerance Policy on Abuse-Quality Management 2015/ZTPA indicated that witnessed or suspected abuse or complaints of abuse should be reported immediately to the Executive Director (or delegate). In addition, the policy reads: any person may report witnessed or suspected abuse to any of the following: The Executive Director (or delegate) and the toll-free Long-Term Care ACTION Line.

The home's policies did not contain an explanation of the duty to report under section 24 for the following requirements:
-Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to a
resident.
- 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.
- Unlawful conduct that resulted in harm or a risk of harm to a resident. [s. 20. (2)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to immediately report.

Ontario Regulation 79/10 section 2. (1) abuse definition states the following: sexual abuse" means,
(a) subject to subsection (3), any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or
(b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member; ("mauvais traitement d'ordre sexuel")

A critical incident report was submitted to the MOHLTC on a specified day in May 2016 related to a witnessed incident of sexual abuse from resident #041 to resident #047.

The DON provided to the Inspector #548 home's policies, relevant documentation, investigative notes and resident's health care record. The health records, the home's investigation notes and relevant documentation and policies were reviewed.

On June 1, 2016 during an interview the DON indicated that reporting process at the home for after hour incidents is for PSWs to report any alleged or suspected abuse to registered nursing staff and the registered practical nurse is to inform the registered

nurse in charge who is expected to call the after-hour pager. She indicated that the staff member who observed the incident did not immediately report it and the registered nurse did not call the after-hour pager.

The DON investigative notes dated for a specified date in April 2016 indicated that she received a message of the incident and checked the MOHLTC decision tree regarding abuse and determined it was “not clear as nothing happened, but the potential is there”. During the inspection, the DON agreed the incident was between resident #041 and #047 was one of a sexual nature.

On June 1, 2016 during an interview with Inspector #548 the DON indicated that she called the MOHLTC to find out if the incident was reportable. The DON investigative notes are dated for a specified date in April 2016 and the critical incident report was completed several days later on a specified day in May 2016.

On June 1, 2016 during an interview with the DON she indicated that there is an RN scheduled and delegated to act on behalf of the Licensee for all matters after hours. She indicated that the RN made a note of the incident on a specified day in April, 2016 and left a voice message to the DON.

A progress note dated on a specified day in April 2016 indicated that RPN #106 observed resident #041 to touch resident's #045 inappropriately in a sexual manner. During an interview on June 3, 2016 RPN #106 indicated that the resident #041 was removed from the area. In addition, RPN #106 indicated to Inspector #548 that she did inform the Director of Care of the sexual touching by resident #041 to resident #045 on the same day, by phone.

Progress notes date for a specified day in April 2016 indicate that resident #041 was found (witnessed public sexual incident) by the PSW trying to kiss resident #047 in the television lounge. The progress note reads: that resident #041 was removed from the resident #047 and resident #047 was removed from the area.

On June 3, 2016 during an interview with the DSWPS she indicated that the MOHLTC was not notified of the incident between resident #041 and resident #047.

Resident #041 has a history of sexual touching and kissing residents as indicated with resident's #045, #046, #047 and #48.

A home's document dated for a specified day in August 2015 specifies that resident #041 that there were observable public displays of kissing and touching of co-resident "private parts" who is not capable to make their own decisions.

The home's Multidisciplinary Assessment Committee weekly meeting minutes were reviewed for a specified days in March and April, 2016. The resident's #041 name is recorded and the minutes indicated that behaviours are being charted, the resident is exhibiting "disruptive, removing clothing and inappropriate behaviours and wandering" into (other) resident rooms.

On June 3, 2016 during an interview RPN #124 indicated the multidisciplinary committee discussed the resident's inappropriate sexual behaviours on a weekly basis.

On June 3, 2016 the DSWPS indicated visitors were complaining to staff of the observable public displays of inappropriate sexual behaviour from resident #041 to co-residents.

The home's policies titled: Elder Abuse, Quality Management 2015/, Zero Tolerance Policy on Abuse- Quality Management 2015/ZTPA and, MOHLTC-Reportable Matters, revision date September 4, 2015 - Administration 2015/MRM and Abuse and Neglect of a Resident- Actual or Suspected- Nursing 2015/ANRS, revision date September 2,2015 were reviewed. The Zero Tolerance Policy on Abuse indicates that staff, volunteers and any other person who witnesses or suspects the abuse of a resident or who receive complaints of abuse should report the matter immediately to the Executive director (ED) (or delegate) and any person may report the witnessed or suspected abuse to the any of the following: the Executive Director (or delegate) and the toll-free Long-Term Care ACTION line. In addition, it reads: When an investigation indicates that a resident has, or is likely to have suffered abuse, the ED shall notify the MOH Regional Office- by telephone, within 24 hours of having determined that abuse has taken place or is likely to have taken place. Policy: MOHLTC-Reportable Matters-Administration 2015/MRM, revision date: September 4, 2015, page 114 indicated to ensure that the incident is investigated and a report is submitted to the MHHLTC Director within 10 days of becoming aware of the incident (see attached) Table re: Reporting matters for immediate contact and full report within 10 days. The attached table, Appendix A, page 1 titled: Table 1: LTCHA Subsection 24 (1)- Reporting Certain Matters to the Director specifies how the Licensee is to immediately initiate and submit the on-line CIS form for the abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

The policy titled: Abuse and Neglect of a Resident- Actual or Suspected- Nursing 2015/ANRS, revision date September 2,2015, page RM 109, indicated that the MOHLTC is to be notified immediately according to protocols established for reporting of abuse and critical incidents.

From record review and staff interviews the Licensee was aware of incidents of resident's #041 inappropriate sexual behaviour and did not notify the MOHLTC. In addition, the home's policies on Abuse specify differing reporting requirements and do not contain an explanation of the duty to report under section 24. [s. 24. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Sleep patterns and preferences.

Resident #002 was admitted to the home on a specified day in February 2015. The plan of care was provided to the home at the time of admission indicating that the resident is a poor sleeper, doesn't sleep through the night gets up to read, then will sleep again, may nap, goes to bed at own time, bed times fluctuate.

During an interview on on a specified day in May 2016 resident #002 indicated to Inspector #549 that he/she would like to stay up later some nights. Resident #002 indicated that he/she has not mentioned to staff that he/she would like to stay up later when they assist him/her to bed earlier. The resident indicated that he/she does not want to be a bother.

PSW #105 who is a private part time care provider to resident #002 indicated during an interview on a specified day in May, 2016 that resident #002 bed times fluctuates. PSW #105 indicated that he/she is not always with the resident at bed time however, when she is she will ask resident #002 when he/she would like to go to bed. PSW#105 indicated that resident #002 will tell her if he/she wants to stay up later.

On a specified day in May 2016 during an interview PSW #115 indicated to Inspector #549 that she is not aware that resident #002 would like to stay up later some nights.

On May 27, 2016 the RAI Co-ordinator and Inspector #549 reviewed resident #002's current plan of care last reviewed on a specified day in May, 2016 and was unable to locate any documentation indicating what resident #002's sleep patterns and preferences are. The RAI Co-ordinator indicated to Inspector #549 that sleep patterns and preferences are not documented in the residents' plan of care.

During an interview on June 1, 2016 with the DON it was indicated to Inspector #549 that sleep patterns and preferences are not documented in the residents' plan of care.

In summary, the plan of care is not based on, at a minimum, interdisciplinary assessment of the following with respect to the residents: Sleep patterns and preferences. [s. 26. (3) 21.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

In accordance with O. Reg. 79.10 s. 68. (2) (d) the home is required to have a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

Resident #002 was assessed by the Registered Dietitian as being a moderate nutritional risk on a specified day in February, 2016 and a high nutritional risk on specified day in May 2016.

Inspector #549 reviewed resident #002’s written plan of care last revised on a specified day in May 2016. The written plan of care indicated that staff are to monitor the resident’s nutritional status, serve the diet as ordered and monitor intake and record. The plan of care also indicated that the resident had an unplanned/unexpected weight loss related to poor food intake and acute illness.

During an interview on May 27, 2016, the DFNS indicated to Inspector #549 that the home’s food and fluid intake monitoring and evaluating system includes daily documentation of food and fluid intake for each resident on the food intake record in the home’s electronic documentation system Point Click Care (PCC).

During an interview on May 27, 2016 the DFNS and the DON indicated that it is the responsibility of the PSWs to input the resident’s food intake into PCC for their assigned

residents daily.

Inspector #549 reviewed resident #002's food intake record for the month of May 2016. During the month there is no documentation of food intake record for breakfast or lunch meal service for 14 days.

The DFNS and DOC indicated that the home's expectation is that all residents will have their daily food intake amount documented on the food intake record in PCC daily. The expected documentation will also include if the resident refuses, is sleeping, in hospital or on a leave of absence.

In summary resident #002 was assessed as being a high nutritional risk and on fourteen separate days the food intake for resident #002 was not documented on the food intake record in PCC for the breakfast or lunch meal service. [s. 30. (2)]

2. The licensee has failed to ensure that any actions taken with respect to a resident under the skin and wound program, including interventions and the resident's responses to interventions are documented.

A review of resident #018's current care plan found that the resident had an open lesion related to malnutrition and poor skin turgor. It was documented in resident #018's progress note that this wound was discovered on a specified day in February, 2016.

A review of a physician's order for wound care dated on a specified day in April 2016, documented to bleach spray to clean the wound daily, followed by non-sticky dressing.

A review of a documented nursing order for wound care dated May 3, 2016, found that the wound was to be cleansed with a specific wound treatment, changed two times weekly and as needed.

On June 1, 2016 during an interview with Inspector #593 RPN #116 reported that for wound treatments, they usually complete a progress note in the electronic records however, if they did not have time, a written note would be left in the nursing communication book. RPN #116 reported that, if the treatment was not documented, it does not necessarily mean that the treatment was not completed.

A review of resident #018's progress notes found dressing changes to the wound area for specified dates in May, March and February 2016.

A review of the nursing communication book for March, April and May 2016, found documented dressing changes for resident #018 on specified dates in March, 2016 and April 2016.

On June 2, 2016 during an interview with Inspector #593, RN #113 who manages the skin and wound program, reported that they do not direct the nursing staff in each area with what they should do however, what they do and what they expect is that an order is to be entered in the Medication Administration Record (MAR) however, usually this is the responsibility of the full-time registered nursing staff in each home area.

A review of resident #018's MAR, found no entered orders or documentation related to the physician's order dated for a specified date in April 2016 nor a nursing order dated for a specified date in May 2016.

On June 2, 106 during an interview with Inspector #593, June 2, 2016, the DON reported that it was the expectation of the home that any wound treatments would be entered as an order so that the order is documented on the MAR and there would be a record of treatment. [s. 30. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

During an interview with Inspector #593 on a specified day in May 2016 resident #023 reported that they were given a shower however, they would prefer to receive a bath which they have reported to staff, however the response is that baths take too long. Resident #023 further reported that their bath days were scheduled twice a week with only one day in between and the resident indicated they would prefer if the bath days were spaced an extra day apart. Resident reported that a choice was not provided for bath days when first admitted to the home, the resident indicated that he/she indicated thier preference to staff but was informed the staff did not have the time to accommodate the request.

A review of resident #023's current care plan found that the resident was totally dependent on staff to provide a bath twice weekly and as needed.

A review of resident #023's health care record, found no documentation related to the residents preference for bathing or preferred bath days, including any assessments completed upon admission on a specified day in August 2015.

A review of the home area's bathing schedule found that resident #023 was scheduled for twice weekly bath in the mornings. The bath schedule did not specify whether the resident received a bath or a shower.

On May 30, 2016 during an interview with Inspector #593 PSW #117 who is a regular care provider for resident #023, reported that resident #023 receives a shower and reported that resident #023 has received a shower since admission.

On May 30, 2016 during an interview with Inspector #593, RPN #116 reported that when a resident was admitted to the home, a questionnaire is completed with the resident which included questions about bathing preferences. The RPN was unable to locate this document for resident #023. RPN #116 reported that regarding the bathing schedule, for newly admitted residents, they fit them into the schedule where they can and then they try to accommodate the resident's requests later. RPN #116 did confirm that the bath days had not been readdressed with resident #023 since admission in August 2015. [s. 3. (1) 11. i.] (593) [s. 33. (1)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident’s plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #018 exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A review of resident #018's current care plan found that the resident had an open lesion: unspecified related to malnutrition and poor skin turgor. It was documented in resident #018's progress notes that this wound was discovered on a specified day in February,2016.

During an interview with Inspector #593, June 1, 2016, RPN #116 reported that for wound treatments, they usually complete a progress note in the electronic records however, if they did not have time, a written note would be left in the nursing communication book. For skin and wound assessments, RPN #116 referred to RN #113 as they were responsible for this.

During an interview with Inspector #593, June 2, 2016, skin and wound champion RN #113 who manages the skin and wound program, reported that they do not assess every wound. RN #113 reported that they will assess wounds only if they are more complex or not healing in a fashionable amount of time. RN #113 further reported that there is an on-line tool that is used to assess wounds called the "Hillel Wound Assessment Tool" however they do not use this tool to assess wounds as usually this is the responsibility of the full-time registered nursing staff in each home area.

A review of resident #018's health care record found no completed "Hillel Wound Assessment Tools".

During an interview with Inspector #593, June 2, 2016, the DON reported that the "Hillel Wound Assessment Tool" should be completed for any change in wound status or treatment and that the expectation of the home is that the assessment tools should be completed at least monthly so that they know whether they are making progress or the wound is getting worse. [s. 50. (2) (b) (i)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to immediately notify the resident’s Power of Attorney of a witnessed incident of abuse.

The health record, relevant documentation and policies were reviewed.

1. As outlined in WN #1.

The home's policy titled: Zero Tolerance Policy on Abuse specifies that the resident's family members, substitute decision-makers or other specified in the plan of care, are to be informed when abuse of that resident has or is suspected to have occurred. [s. 97. (1) (b)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse.

The health record, relevant documentation and home policies were reviewed.

1. As outlined in WN #1.

On June 3, 2016 during an interview with the DSWPS indicated the home is hesitant to contact police for matters of a "sexual nature".

On June 21, 2016 during an interview the DON agreed the incident warranted notification to the police [s. 98.]

WN #15: 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).

Findings/Faits saillants :

1. The licensee failed to ensure to report a description of the individuals involved in the incident, including the names of residents.

1. As outlined in WN #1. A critical incident report was submitted not identifying the co-resident involved in the incident.

On June 3, 2016 the co-resident was identified by the DSWPS as resident #047. [s. 104. (1) 2.]

Issued on this 30th day of June, 2016

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	RUZICA SUBOTIC-HOWELL (548), GILLIAN CHAMBERLIN (593), RENA BOWEN (549)
Inspection No. / No de l'inspection :	2016_287548_0014
Log No. / Registre no:	013493-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 29, 2016
Licensee / Titulaire de permis :	THE OTTAWA JEWISH HOME FOR THE AGED 10 Nadolny Sachs Private, Ottawa-Carleton, ON, K2A-4G7
LTC Home / Foyer de SLD :	HILLEL LODGE 10 NADOLNY SACHS PRIVATE, OTTAWA, ON, K2A-4G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	STEPHEN SCHNEIDERMAN

To THE OTTAWA JEWISH HOME FOR THE AGED, 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 :

LTCHA, 2007 S.O. 2007,c8.,s. 19 (1). Every Licensee of a long-term care home shall protect residents from abuse.

The Licensee shall prepare, submit and implement a plan to include:
1. Reporting requirements- the person who had reasonable ground to suspect abuse of a resident that resulted in harm or risk of harm immediately report the suspicion to the MOHLTC.

2. Notification regarding incidents- that the appropriate police force is immediately notified on any alleged, suspected or witnessed incident of abuse that the licensee suspects may constitute criminal offense

3. Licensee must investigate, respond and act- that every alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee is aware of is immediately investigated

4. Policy to promote zero tolerance of abuse - Revisions to the Licensee's Zero Tolerance of Abuse and Neglect of residents' policy to include:
I. What clearly constitutes sexual abuse as per O. Reg 79/10 s. 2(1) (b);
II. Reporting requirements- an explanation of the duty to make mandatory reports;
III. Include procedures and interventions to assist and support residents who have been abused or neglected, or allegedly abuse or neglected;
IV. Describe measures and strategies to prevent abuse;
V. Describe training and retraining requirements for all staff;
VI. Set out the consequences for those who abuse or neglect residents;
VII. Specify procedures and interventions to deal with persons who have

abused or neglected or allegedly abused or neglected residents and specific measures to prevent abuse and neglect.

5) Retrain all staff on what constitutes sexual abuse and of their obligations to immediately report every alleged, suspected or witnessed incident of abuse

6) Develop a monitoring process to ensure all staff are retrained as planned and have the knowledge and skills required to report every alleged, suspected or witnessed incidents of abuse of a resident as required.

This plan will indicate who will be responsible for ensuring the completion of the tasks and the timeline for its completion. The plan should be submitted in writing by fax to Inspector Ruzica Subotic-Howell at 613-569-9670, no later than July 22, 2016.

Grounds / Motifs :

1. The Licensee failed to protect residents #045, #046, #047 and #048 from sexual abuse by resident #041.

Sexual abuse is defined by the LTCHA, 2007 as "any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member; ("mauvais traitement d'ordre sexuel")"

Resident #041 was identified by the home as having sexual behaviors towards co-residents.

Resident #041's progress notes and health care record were reviewed. The DON investigative notes were reviewed. The home's policies: Elder Abuse, Quality Management 2015/, Zero Tolerance Policy on Abuse and MOHLTC-Reportable Matters, revision date September 4, 2015 reference code: Administration 2015/MRM to promote zero tolerance of abuse and neglect of residents were reviewed. There is no definition of what constitutes sexual abuse. A component of the policy includes a memorandum dated February 12, 2015 from the MOHLTC that explicitly cites the definitions of abuse and the actions required by the home for mandatory and critical incident reporting requirements. The home's policies specify that the executive director or designate will notify

the police to investigate an alleged sexual abuse. The home's education and training of all staff to promote zero tolerance of abuse and neglect of residents was reviewed. There is no education on what constitutes resident to resident sexual abuse.

At the time of the inspection resident #041 no longer resides in the home.

The resident's care plan dated for a specified day in May, 2015 states: resident required "monitoring of his whereabouts hourly, to redirect and remove the resident from the immediate problem". The DON indicated the Substitute Decision-Maker (SDM) was aware of the resident's "inappropriate sexual behaviour" and how the resident wanted to initiate a sexual relationship with resident #048. The DON indicated the SDM discussed resident's #041 behaviour at the resident care conference on a specified day in July, 2016 and agreed the resident be moved to another unit to diminish contact with resident #048.

On a specified day in August 2015 it is recorded on one of the home's documents that resident #041 sought out a relationship of a sexual nature with an incapable resident #048. It reads: resident #041 is having a sexual relationship with an incapable resident (resident #048). In addition, it is recorded that resident #041 is seeking out a sexual relationship with resident #048 and resident #048 wants the same relationship based on observations exhibited by resident #048; smiling, happy, loves attention. The document indicated that the conduct is in public and visitors, other residents and staff have considered the behaviour as not acceptable in public areas. Resident #041 was eventually moved to another unit. From staff interviews with the DSWPS and RPN #113 on June 3, 2016 both indicated resident #041 sought out a relationship of a sexual nature with resident #048.

The home identified the possible risk of resident #041 seeking out other residents prior to the resident's transfer to another unit. The resident #041 was also known to make gestures to staff members as recorded in the progress note entry dated for a specified day in March, 2016 where the staff member writes that resident #041 made sexual advances to the staff member. The staff member redirected the resident.

For a specified period of time in March 2106 to April 2016 the resident #041 is found to be wandering into other resident rooms and around the unit. In addition,

there are three recorded instances where the resident is found without pants/clothes on and each time is redirected by staff.

On the first day of transfer to the new unit, a progress note entry indicated that resident #041 was found to be kissing a unidentified resident on the cheek in that resident's room. The following day it is recorded in the progress notes the resident is “wandering into resident room looking for residents”. A progress note entry on a specified date in April 2016 by a RN indicated that the resident “likes talking with resident and kissing them on the cheek and staff remind resident inappropriate to do that”. On a specified day in April 2016 a progress note entry by a registered practical nurse indicated that the resident was found in resident's #046 room with clothing removed, sitting on the bed attempting to have resident #046 engaged in a sexually inappropriate manner. Resident #041 was removed from the room.

On a specified day in April, 2106 the BSO nurse recommends behaviour monitoring re: "sexual behaviour". The resident is seen again by BSO several days later and the medication regime is reviewed. During an interview on June 1, 2016 the DON indicated that behavioural monitoring and one-to-one care was implemented related to the resident's #041 sexual behaviours.

The home was aware of the resident's #041 behaviours and discussed the “inappropriate sexual behaviours" at the multidisciplinary committee meetings held weekly from specified dates in March 2016 to April 2016 as recorded in the meeting minutes. During an interview on June 3, 2016 RPN #124 indicated that the resident's behaviours were being discussed at the meetings.

A progress notes dated on a specified day in April, 2016 indicated that RPN #106 observed resident #041 to touch resident's #045 inappropriately in a sexual manner. During an interview on June 3, 2016 RPN #106 indicated that the resident #041 was removed from the area. In addition, RPN #106 indicated to Inspector #548 that she did inform the Director of Care of the sexual touching by resident #041 to resident #045 on the same day, by phone.

Progress notes dated on a specified day in April 2016 indicated that resident #041 was found by the PSW trying to kiss resident #047. The progress note reads: that resident #041 was removed from the resident #047 and resident #047 was removed from the area. RPN #124 indicated she became aware of the incident observed by the PSW on a specified day in April 2016 and the matter

was brought forward to the ethics committee to discuss. RPN #124 reported to the inspector that the resident's family were not informed of the incident.

On the same day a PSW #130 witnessed resident #041 to be in resident's #047 room standing beside resident's bed with clothing and continence product removed. The incident is described in the progress notes that resident #041 was found by a PSW in resident's #047 room at the bedside with resident's #041 genitalia at resident's #047 hand. Resident #047 was asleep. Resident #041 was subsequently removed from the room. Several days lapsed before this incident was reported to the MOHLTC.

The Critical Incident Report was submitted to the MOHLTC on a specified day in May 2016 that did not identify the co- resident involved. The co-resident was later identified as resident #047 on June 3, 2016 by DSWPS. The DON indicated that the resident is not aware that an incident transpired as the resident was sleeping. Furthermore, nor had the home informed the family in fear of upsetting the resident. The DON indicated that the PSW #130 who observed the incident involving resident #041 to resident's #047 on did not understand the "gravity of the situation" and did not inform the registered practical nurse immediately, who in turn was not aware to call the MOHLTC after-hours pager but, had left a voice message for her.

The DON indicated that she was not certain if the incident warranted a critical incident report and had called the MOHLTC for direction. A voice message was left on a specified day in April, 2016 seeking direction on whether the incident was reportable to the MOHLTC. In two separate interviews on June 3, 2016 RPN #106 and DSWPS both indicated that staff are not instructed to notify police (for alleged sexual abuse); the DSWPS indicated the home is hesitant to call the police for matters of a "sexual nature". RPN #106 and #124 indicated the police were not notified of the incidents observed between resident #041 to resident's #045 and #047.The DON agreed during an interview that the behaviour exhibited by resident #041 to resident #47 was reportable to police, as supported in the home's policy.

On June 21, 2016 the inspector reviewed the definition of sexual abuse as per O.Reg 70/10 2 (1) (b) sexual abuse, the DON confirmed that the behaviours from resident #041 were of a sexual nature. Furthermore, the DON indicated that all four resident's #045, #046, #047 and #048 are not capable to consent to touching or behavior of a sexual nature from another resident.

Both RPN #106 and RPN #124 confirmed that although they were aware of the incidents they had not notified the Substitute Decision-Maker (SDM), the police nor the MOHLTC for the incidents involving resident #041 to resident's #045, #046, #047 and #048. During the inspection, the DON indicated that incidents of a sexual nature are not reported to the police however, agreed during the inspection that the incidents where of a sexual nature involving residents #045, #046, #047, #048 warranted reporting to the MOHLTC and the police.

In addition, the licensee failed to comply with LTCHA 2007 s. 20. Policy to promote zero tolerance (refer to WN #7) as the policy does not define sexual abuse in a manner that is compliant with O. Reg 79/10 s. 2(1) (b).

Furthermore, the licensee failed to comply with LTCHA 2007 s. 24(1) by not reporting an incident of alleged resident to resident sexual abuse to the Director (refer to WN #08).

Additionally, the licensee failed to notify the resident's substitute decision-maker immediately upon becoming aware of any alleged, suspected, witnessed incident of abuse, O.Reg 79/10, s. 97 (refer to WN #13).

Likewise, the licensee failed to ensure with O.Reg 79/10, s. 98 the appropriate police force is immediately notified of any suspected or witnessed incident of abuse that the license suspects may constitute a criminal offense (refer to WN #14).

Also, the licensee failed to comply with O. Reg 79/10, s. 104 to provide a description of the individuals involved in the incident, including the names of all the residents (refer to WN #15).

In this matter, the Licensee failed to protect resident's #045, #046, #047 and #048 from sexual abuse by resident #041. A compliance order is warranted as the scope was identified as widespread with serious allegation of sexual abuse involving several residents and previous issuance of non-compliance related to s. 20 (2) and s. 24 (1) in February 26, 2015.

(548)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
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 29th day of June, 2016

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Ruzica Subotic-Howell

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