Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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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
Oct 23, 2014	2014_360111_0026	O-000989-14	Resident Quality Inspection

Licensee/Titulaire de permis

HALIBURTON HIGHLANDS HEALTH SERVICES CORPORATION
7199 Gelert Road Box 115 HALIBURTON ON K0M 1S0

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

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

LYNDA BROWN (111), MELANIE SARRAZIN (592), SUSAN WENDT (546)

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): October 6-10, 14-16, 2014

Two critical incidents (log#000950 & 000597) were inspected concurrently during the RQI.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC),Food Service Manager, Director of Activity, Maintenance Supervisor, Family Council Co-chair, Resident Council President, Residents, Families, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), laundry attendant, maintenance, and activity aide.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Dining Observation
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.

20 WN(s)
3 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #45 was protected from sexual abuse by other resident's in the home.

Under O.Reg. 79/10, "sexual abuse" means (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.

2.Related to log #000597:

A critical incident report (CIR) was received on a specified date for a resident to resident sexual abuse incident that occurred two days earlier. The CIR indicated that Resident #44 was witnessed by staff inappropriately touching Resident #45 outside. A second CIR was submitted on the same day for a second incident of resident to resident sexual abuse that occurred two days after the first incident. The CIR indicated Resident #44 was found inappropriately touching Resident #45. Resident #45 confirmed being touched inappropriately by Resident #44 but denied any pain or injury.

The progress notes for Resident #44 indicated:
-the resident was relocated to another unit after the second incident and the resident has some cognitive impairment.
-the day of the first incident (before breakfast), the resident was found by a housekeeper in Resident #45 room "watching the resident" and was immediately removed. Later, Resident #44 was found by the RPN outside inappropriately touching Resident #45. The RPN immediately intervened, removed Resident #44 and informed resident/staff that Resident #44 is restricted from going outside unsupervised.
-two days later, an RPN entered the dining room and observed Resident #44 sitting next to Resident #45 touching Resident #45 inappropriately.As the RPN approached the

residents, Resident #44 immediately stopped the inappropriate touching. Resident #44 was relocated to sit in front of the nursing station. The ADOC met with Resident #44 later in the morning and the resident denied the incident.

Review of the progress notes for Resident #45 indicated:
-Resident #45 is independently mobile, cognitively impaired, continuously wanders throughout the unit and into other resident rooms, and was the recipient of 3 separate incidents of sexual abuse by two different residents (Resident #6 & #44).
-there was no documentation regarding either of the incidents that occurred on the first day or an assessment of Resident #45 for any injuries after the first incident of sexual abuse.
-the POA was not notified of the first incident of suspected sexual abuse until the following day.
-there was no indication of a physical assessment of the resident for injury after the second incident of suspected sexual abuse.
-approximately two months later (before supper), the resident was sitting in the lounge watching TV and Resident #6 was observed inappropriately touching the Resident #45 while Resident #45 was attempting to stop the inappropriate touching. Resident #6 was immediately removed from the area.

3.Related to log #000950:

Review of CIR for a resident to resident sexual abuse that occurred on a specified date. The CIR indicated that Resident #6 was witnessed sexually abusing Resident #45 in the main lounge.

Review of the health care record for Resident #6 indicated the resident had a prior incident of resident to resident sexual abuse towards another cognitively impaired female resident, and was placed on restrictions.

4.Therefore, licensee failed to protect Resident #44 from 3 separate incidents of sexual abuse as evidenced by:
-the licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with as Resident #45 was not assessed for injury after the first two incidents as issued under WN#7 [LTCHA, 2007, s.20(1)].
-the licensee failed to ensure that the resident's SDM and any other person specified by the resident was notified within 12 hours upon becoming aware of an incident of resident to resident sexual abuse as the SDM of Resident #45 was not notified until the following

day regarding the incident that occurred, as issued under WN#16[O.Reg. 79/10, s.97(1)9(b)].
-the licensee failed to ensure that the appropriate police force was immediately notified of a suspected or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence as the police were not notified of the first incident that occurred between Resident #44 & #45 until two days later(after the second incident occurred), as issued under WN#17[O.Reg. 79/10, s.98].
-the licensee failed to ensure that when a person had reasonable grounds to suspect abuse of a resident by another resident that resulted in risk of harm, was immediately reported to the Director,as the Director was not notified of the sexual abuse incident that occurred until the following day, as issued under WN #8[LTCHA, 2007, s.24(1)].
-the licensee failed to ensure that the demonstrated responsive behaviours for Resident #44 had the behaviour triggers identified, that strategies were developed and implemented related to monitoring of the resident after the first incident; and for Resident #45, on how to protect the resident from recurrence of sexually abusive behaviour of other residents, where possible, and the homes policy on responsive behaviours did not meet the requirements under the regulations, as issued under WN #2 [LTCHA, 2007, s.6(2)] & WN#11[O.Reg.79/10, s.53(1),(4)(a)(b)].
-the licensee failed to ensure that the homes written policy to promote zero tolerance of abuse and neglect of residents contained procedures and interventions to deal with persons who have abused or neglected or allegedly abuse or neglected "residents", and identified measures and strategies to "prevent abuse" as the policy only provided procedures after the incidents occur, and the policy only indicated actual and suspected abuse, not "alleged" as issued under WN#15[O.Reg. 79/10, s.96(b)(c)].
-the licensee failed to ensure that staff received annual training on the home's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities as the home was unable to provide any evidence that staff received annual re-training on the prevention of abuse and neglect of residents as issued under WN#7 [LTCHA, 2007, s.20(1)].
-Non-compliance was issued for LTCHA, s.19(1) on August 26, 2013 under inspection 2013_031194_0031. [s. 19. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care related to use of restraints was based on an assessment of the resident and the resident's needs and preferences.

During stage 1 of the RQI, observation of Resident #32 (outside), indicated the resident was in a tilted mobility aide, with two trunk restraints in place. The resident was unable to remove any of the physical restraints due to physical limitations.

Interview of PSW #108 and RPN#109 indicated the resident was using a tilt mobility aide and trunk restraints due to previous falls and sliding but one of trunk restraints was only to be used during mealtimes.

Review of the health record for Resident #32 indicated one of the trunk restraints was ordered by the physician but no order for the tilt mobility aide or the other trunk restraint. The progress notes (for the six month period following the physicians order) indicated there was no documented evidence regarding assessments related to the initial application of the restraints or quarterly reassessments related to the use of any of the restraints used.

Review of the current care plan for Resident #32 indicated the use of one of the trunk restraints and the use of the tilt mobility aide but no indication of the second trunk restraint to be used outside of mealtimes.

Therefore, the plan of care for Resident #32 related to restraints was not based on the resident's assessed needs as there was no documented evidence of an initial assessment or reassessments related to the use of the physical restraints. [s. 6. (2)]

2. Related to log#000597:

The licensee failed to ensure that the plan of care related to responsive behaviours was based on an assessment of the resident and the resident's care needs.

Review of the plan of care for Resident #45 for responsive behaviours indicated the resident wandered and will exit seek related to restlessness and cognitive impairment. The interventions included: provide assistance with locating room, allow resident to wander on unit, engage resident is group activities, familiarize resident with nursing home environment and activity programs on regular basis.

There were no interventions developed and implemented for Resident #45 who was the recipient of ongoing inappropriate sexual touching by Resident #44 and #6 on 3 occasions and was at risk due to wandering and cognitive impairment, where possible.

Review of the care plan for Resident #44 related to responsive behaviours indicated the resident had inappropriate sexual behaviour (verbal/physical)towards other residents and/or staff. Interventions included:
-avoid type of conversation that could encourage or initiate inappropriate behaviour;
-constant supervision in recreation programs, encourage attendance at recreational programs;
-determine cause, what triggered/lead up to behaviour and previous sexual history and document;
-display an accepting, non-judgemental manner to encourage resident to discuss concerns about sexuality; help resident meet needs for touch/affection (ie. pet therapy, hold hands);provide privacy;
-document summary of each episode;
-protect other residents if unable to protect themselves, remove resident from public area when behaviours are disruptive/unacceptable; not to go to lower level, tv lounge or library, other residents rooms, hallways (other than those leading to own room);
-areas able to visit: nursing station (main lounge), activity staff lead activities, dining room for meals, off property, his own room; monitor every 30 minutes while awake; if resident does not abide by restrictions, notify charge nurse or manager.

Review of the progress notes indicated the strategies to manage Resident #44 responsive behaviour of inappropriate sexual touching were not implemented until the day after the first incident of resident to resident sexual abuse occurred (after the ADOC became aware of the incident) and the monitoring of the resident while awake was occurring every hour after the first incident and only changed to every 30 minutes until

after the second incident occurred 2 days later. There was no indication of the use of yellow wander guard on doorway, and stop sign on the resident's door that were put in place to prevent other residents from entering the room. [s. 6. (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 to ensure the plan of care related to restraints is based on the resident's assessed needs and preferences, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint plan of care included alternatives to restraining that were considered and tried but were not effective in addressing the risk.

During stage 1 of the RQI, observation of Resident #32 (outside), indicated the resident was in a tilted mobility aide, with two trunk restraints in place. The resident was unable to remove any of the physical restraints due to physical limitations.

Interview of PSW #108 and RPN#109 indicated Resident#32 was using a tilt mobility aide and trunk restraint due to previous falls and sliding but the second trunk restraint was only to be used during mealtimes.

Interview of the ADOC indicated the process for completion of alternatives to restraints is to be completed prior to application of the restraint and documented in the residents' health record.

Review of the health record/progress notes for Resident #32 had no documented evidence of alternatives tried prior to the application for any of the restraints. [s. 31. (2) 2.]

2. The licensee has failed to ensure that the restraint plan of care included an order by the physician or a registered nurse in the extended class.

Review of the physicians orders for Resident #32 indicated a current restraint order for one of the trunk restraints but no indication of an order for the tilt mobility aide or second trunk restraint.[s. 31.(2)4.]

3. The licensee has failed to ensure that the restraint plan of care included the consent by the resident or the Substitute Decision Maker(SDM).

Review of the health care record for Resident #32 indicated no documented evidence of consent for any of the restraints that were in use. [s. 31. (2) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any physical restraining of restraints includes alternatives tried, physician order, and consent by the resident or SDM, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair.

During stage one of the Resident Quality Inspection (RQI), the base of the transfer pole for Resident #4, #6 and #13(located in the residents' bathroom) had rust, leaving unprotected metal.

Interview with Maintenance lead indicated that maintenance was responsible for the good state of repairs of assistive aides in use in the home, the lead was not aware of the 3 transfer poles in poor state of repair, indicated that there was no policy but nursing would usually notify maintenance of maintenance concerns. [s. 90. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented to ensure that all equipment, devices, and assistive aids and positioning aids in the home are kept in good repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that is accessible to residents cannot open more than 15 centimetres(cm).

The following resident rooms had slider windows in place that opened completely (greater than 15 cm): 112, 113, 114, 116, 119, 122, 123, 137, 138,143A, 212A, 214A, 237A, 238, 245A and 242B.

Interview of the maintenance lead indicated that he was not aware of the windows being opened beyond 15 cm. The maintenance lead indicated all the windows have a stopper mechanism to prevent the windows from opening greater than 15 cm but the mechanism was disengaged which allowed these windows to open completely. [s. 16.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system was accessible and could be used by the residents.

Observation of the bedside of Resident #3, #30 & #31 indicated the call bells were not functioning. The call bell in the bathroom for Resident #3 was wrapped around the wall attachment rendering the call bell inaccessible.

Interview of maintenance lead indicated he was not aware of the non-functioning call bells for Resident #3, #30 & #36. The maintenance lead indicated the call bells are randomly checked monthly but that nursing staff would usually record non-functioning call bells in the maintenance log (which is kept at each nursing station)and the log is checked daily.

Review of maintenance logs on the upper and lower units had no documented evidence of non-functioning call bells for those identified residents. [s. 17. (1) (a)]

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 that the licensee's written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Review of the home's policy "Abuse and Neglect of a Resident-Actual or suspected" (VII-G-10.000) (revised February 2014) indicated under procedures:
-when the staff member (or volunteer) becomes aware of potential or actual abuse, the following steps must be taken: safe guard the resident immediately, notify the charge nurse.

-the charge nurse will assess the resident for injuries and provide medical intervention if indicated, notify the RN, and initiate the nursing checklist.The checklist includes: notify police, update MOHLTC, interview and request written account of all possible witnesses, notify physician, notify family, if assault, a minimum documentation and assessment of resident status each shift for 72 hours.
-the RN will immediately notify the DOC/Administrator.
-upon hire and annually thereafter, all staff and volunteers will receive in-service education on the topic of abuse and neglect and the reporting of abuse and neglect. [s. 20. (1)]

2. Related to Log # 000597:

Review of the progress notes of Resident #44 indicated on a specified date and time, the resident was found outside inappropriately touching Resident #45. There was no indication Resident#45 was assessed for injury or monitored for the 72 hours. Review of the home's investigation indicated the RN was not notified of the incident and no checklist was completed to ensure all steps were completed. The RN was not notified until the following day,and then reported the incident to the physician, the family and ADOC. The ADOC at that time notified the MOHLTC and the Administrator but did not contact the police.
-Two days later, the resident was observed outside dining room sitting next to Resident #45 and inappropriately touching the resident. The resident was then moved to another unit immediately with restrictions put in place. Police were notified of both incidents, and the MOHLTC was notified of second incident. There was no documented evidence the resident was assessed for injury or the nursing checklist completed. There was no documentation for the resident the following day to indicate assessment of status for each shift for 72 hours post incident.
-Five days later, the physician was in to assess Resident #44 and ordered a PASE assessment.

Review of the progress notes of Resident #45 indicated:
-There was no documented evidence in the progress notes for Resident #45 for the first incident or an assessment of the resident for injuries.
-There was no documented evidence of an assessment of Resident #45 by the physician when the physician came in to assess Resident #44.[s. 20. (1)]

3. Request for staff training records on abuse and neglect from both the DOC & ADOC was not provided and the DOC indicated they were "unable to locate them". [s. 20. (1)]

4. Related to log #000950:

Review of CIR for a resident to resident sexual abuse that occurred indicated that Resident #6 was witnessed inappropriately touching Resident #45 in the main lounge.

Interview of the DOC indicated that she was not familiar with the "nursing checklist" that was to be completed as per the homes policy and that the checklist was not completed.

There was no documented evidence the nursing checklist was completed as per the homes policy. [s. 20. (1)]

5. Furthermore, the licensee failed to ensure that the policy "to promote zero tolerance of abuse and neglect of resident" included a program that complies with the regulations, for preventing abuse and neglect, as the homes policy did not address "alleged" incidents of abuse or neglect. The policy did not include what actions to take when abuse of a resident was by "another resident",
-or long term actions to put in place to prevent a recurrence. [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 ensure that when a person had reasonable grounds to suspect abuse of a resident by another resident, that resulted in risk of harm was immediately reported to the Director.

Related to Log # 000597:
A critical incident report (CIR) was received on a specified date for a resident to resident abuse incident that occurred 3 days earlier. The CIR indicated that Resident #44 was witnessed by an RPN inappropriately touching Resident #45 while outside.

Interview of ADOC indicated the first incident she was not made aware of the first incident that occurred the following day (later in the evening) via email and then came to the home and contacted the Director using the after hours contact. [s. 24.(1)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a PASD which is used to assist the resident with routine activity of living was included in the resident's plan of care.

Observation and interview of Resident #32 during stage 1 of the RQI, indicated the resident had a trunk restraint in place while in a mobility aide. The resident demonstrated the ability to remove and reapply the trunk restraint to the inspector multiple times rendering it a PASD.

Interview of PSW #108 indicated the resident applies the PASD and "insists on using it".

Review of the care plan (current) for Resident #32 had no indication regarding the use of the PASD while in the mobility aide at resident request. [s. 33. (3)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's received assistance to dress and was dressed appropriately in accordance with their preferences and appropriate clean footwear.

Observation of Resident #17. #18,#31, #35, #37, #41, #42, #43 during stage 1 of the RQI indicated the residents were up in wheel chairs wearing socks and no shoes or slippers. All of the residents had either shoes and/or slippers available in their room.

Review of the current care plans for the all the residents identified, indicated the residents required total assistance for dressing, were to be appropriately dressed, and to ensure clothing and footwear is clean and appropriate.

Interview of PSW #108 indicated some of the resident's would remove the footwear but "was not sure why they were all not wearing footwear" despite providing care to some of the observed residents. [s. 40.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other, and that written strategies, included techniques and interventions to prevent, minimize or respond to the responsive behaviour. The licensee also failed to ensure that written strategies, included techniques and interventions, to prevent, minimize or respond to the responsive behaviour.

Review of the home's policy "Responsive Behaviours" (VII-F-30.00) (updated February 2014) indicated:
-all members of the interdisciplinary team will work together to: identify possible triggers for the responsive behaviours, develop and implement strategies individualized to the

resident into the care plan, evaluate the effectiveness of the plan and revise if needed
-The RN/RPN will refer to available resources in the health care community such as: Behavioural Support Team (BSO), Behavioural Intervention Response Team (BIRT), or Psycho-Geriatric Resource Team (Geriatric Outreach).
-The Physician will assess and evaluate the medical plan of care, including the use of anti-psychotics; in consultation with interdisciplinary team refer to Geriatric Outreach team if required.
-the home may establish a Responsive Behaviour Team which may include PIECES resource staff.

Interview of the ADOC indicated the home usually uses the DOS behavioural monitoring record but does not have a BSO, BIRT or Responsive Behaviour Team or utilizes them from the community. The ADOC indicated all Registered Staff are trained in PIECES and one RN is designated as the lead. Interview of two RPN's indicated they were unaware the home had a lead person for PIECES.

The use of the DOS assessment tool was not identified in the policy, and the policy does not offer any written approaches to care, screening protocols, assessment, reassessment and identification of behaviour triggers that may result in responsive behaviors. The policy does not identify written strategies (techniques and interventions) to prevent, minimize or respond to the responsive behaviours. The policy does not address the resident monitoring and internal reporting protocols and of the identified resources, only one was actually available.(546) [s. 53. (1) 1.]

2. Related to log#000597:

The licensee has failed to ensure that the behaviour triggers were identified for the resident demonstrating responsive behaviours of inappropriate sexual touching where possible.

Review of the progress notes of Resident #44 indicated:
- on a specified date, the resident was found outside inappropriately touching Resident #45. Both residents were removed and Resident #44 was restricted from going outside.
-Two days later, the resident was witnessed outside the dining room inappropriately touching Resident #45. The resident was moved to another unit and placed on restrictions.
- Seven days later two cognitively impaired female residents (known for wandering) were observed coming out of the resident's room. STOP sign and yellow wanderguard placed

on the residents doorway. Resident informed to call staff if cognitively impaired residents entered the room.
-Three days later, the resident was observed removing the yellow wander guard from doorway and entering hallway where cognitively impaired female residents were wandering. Resident was reminded to remain in room as per restrictions and resident became upset and uncooperative with restrictions.The resident was then placed on every 30 minute checks.
-Two days later, a PSW reported that while provided am care, the resident made inappropriate gestures towards the staff member and attempted to inappropriately touch the staff member (but was able to move away). Two staff required to perform all care.
-approximately a month later, the resident had "attempted to grab a female resident" [no longer in the home] that was passing by his room but was redirected away from the resident.
-Approximately two months later,the resident was suspected of inappropriately touching Resident #14 at the nursing station when staff intervened.

Review of the care plan for Resident #44 related to responsive behaviours indicated: Inappropriate sexual behaviour (verbal/physical) resident touches other residents and or staff inappropriately, need for affection, need for attention, and sensory deprivation.

The resident's responsive behaviour of inappropriate sexual touching did not identify the triggers which include: "other female residents and [specific area of the female]" on the care plan. [s. 53. (4) (a)]

3. The licensee has failed to ensure that the behavioural triggers were identified for Resident #14 in response to the resident's responsive behaviours, and strategies were developed and implemented to respond to the resident's responsive behaviours.

Review of Resident #14 health care record indicated the resident was documented at the time of admission, as being "pleasantly confused, and as a wanderer but not an exit seeker".

A review of Resident #14’s health record and care plan related to responsive behaviours indicated the resident had a progressive decline in physical functioning and cognition. The resident demonstrated verbal/physical aggression, resistance to treatment and personal care, screaming, and wandering related to cognitive impairment. Interventions included: be cognizant of not invading the resident's personal space, document each episode, approach slowly and from the front, be sure to have the residents attention

before speaking or touching, if strategies are not working, stop and re-approach in 10 minutes, if refuses care, leave and return in 10 minutes, try to redirect undesirable behaviour, document care being refused, inform resident ahead of time care to be provided, discuss with resident implications with not complying with therapeutic regime, distract resident with an task or activity, provide directional cures, provide assistance with locating own room, allow resident to wander on unit.

Review of the progress notes for Resident #14 indicated the resident was physically aggressive (would throw dishes on the floor and at staff in dining room); physically aggressive towards other resident's (attempted to punch Resident #20 in the face, entered another resident's room and then hit the resident on the head (Resident #44),and attempted to hit Resident #21 while walking in the hall). A month after the first incident (towards Resident #20), the documentation indicated "notify the attending physician at next rounds and a behavior monitoring record is initiated for a period of seven (7) days". After the second incident (towards Resident #44) indicated "this resident’s physical aggression towards other residents and staff is escalating and recommends to continue to monitor closely, and track on behaviour record". There were several entries of pacing and restlessness, and rummaging/hoarding (other residents purses/utensils for weapons). A month later, the physician assessed the resident and documented the following: "aggression at meals with utensils (stabbing staff) and resistance at bath time; the attending nurses report this is gradually worsening and that no precipitating causes have been identified. The resident had been on the anti-psychotic medication since admission but dose was weaned down. The physician documented that nurses have implemented all non-pharmacological measures and ordered an increase in the anti-psychotic medication". A month later, struck another resident in the face with an object after lunch.

There was no assessment or indication of the triggers for this resident’s responsive behaviors identified as pacing, restlessness, rummaging, hoarding, striking other residents and staff, throwing objects, clearing objects from tables. There was no referral for additional behavioural support. There was no indication who the aggressive behaviour was directed towards, no strategies developed in managing the responsive behaviors identified as pacing, restlessness, rummaging, hoarding, striking other residents and staff, throwing objects, and clearing objects from tables. [s. 53. (4) (b)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that any concerns or complaints received from the Resident's Council was provided a written response within 10 days.

Upon review of the Residents' Council meeting minutes from September 9, 2013 to October 14, 2014, indicated there were no written responses provided by the licensee to the Residents' Council in regards to "food concerns" identified for the following months: September 2013, October 2013, December 2013, February 2014, March 2014, May 2014, September 2014.
There were no Diner's Club Meeting minutes (where food concerns are addressed) for May and June, 2014 as the Dietary Manager had cancelled the scheduled meetings. The Council "requested that a concern form be filed as the past several months the Dietary Manager had cancelled and not held a Diner's Club meeting". The Council reported "feeling as though they were not being heard and that no one cared".

Interview with the Food Services Manager(FSM) confirmed that "there were a few meetings which had been missed". During the interview, the FSM acknowledged that responses to concerns or issues were "usually provided by the next meeting" verbally and was not aware of the Duty to Respond legislation, which must be completed in writing, within 10 days of receipt of a concern, issue or recommendation. [s. 57. (2)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. Review of the Licensee Confirmation Checklist Admission Process completed by the DOC indicated an explanation of fire and evacuation procedures were not posted in the home.

Observation on both upper and lower units and interview of DOC also confirmed these items were not posted. [s. 79. (3) (i)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that Residents’ Council advice is sought in the development and carrying out of the satisfaction survey, and in acting on the survey's results.

Review of the LTCH Confirmation Checklist for Quality Improvement completed by the DOC/Administrator(CEO)on October 6, 2014, Inspector #111 noted that the licensee had confirmed a "NO" answer, in writing to Questions 9, 10 and 11 which referred to: seeking the advice of the Resident's Council in the development of the satisfaction survey, in the carrying out of the survey, and in acting on the survey's results.

On October 10, 2014, an interview with the President of Residents’ Council confirmed that the licensee did not involve the Residents’ Council in any part of the satisfactory survey.

During an interview on October 15, 2014, with the Program Manager, reported that Residents’ Council had been consulted for the last survey (completed in 2013)and that it would be in the Residents’ Council meeting minutes. Review of Residents’ Council meeting minutes, had no evidence to support that the licensee had consulted Residents’ Council in the development of the satisfaction survey, in the carrying out of the survey and in acting on the survey's results. The survey results from 2013 were also not made available to Residents’ Council. [s. 85. (3)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the homes written policy to promote zero tolerance of abuse and neglect of residents contained procedures and interventions to deal with persons "who have abused or neglected or allegedly abuse or neglected residents" and identified measure and strategies "to prevent abuse and neglect".

Review of the home's policy " Abuse and Neglect of a Resident-Actual or Suspected" (VII-G-10.00) only contained procedures and interventions to deal with "staff or volunteer persons" who have abused or neglected or allegedly abused or neglected residents. There was no procedures and interventions to deal with "residents" who abused or allegedly abused. The policy did not include measures and strategies to prevent abuse and neglect of residents, instead only provided actions taken "after" incidents occur. [s. 96. (b)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of an incident of resident to resident sexual abuse.

Related to Log # 000597:
A critical incident report (CIR) was received on a specified date for a resident to resident sexual abuse incident that occurred two days prior. The CIR indicated that Resident #44 was witnessed by staff inappropriately touching Resident #45 while outside.

Interview of ADOC indicated the RPN intervened and took appropriate action but did not report the incident to SDM. [s. 97. (1) (b)]

WN #17: 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 police were immediately notified of of any alleged, suspected or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence.

Related to Log # 000597:
A critical incident report (CIR) was received on a specified date for a resident to resident sexual abuse incident that occurred two days prior. The CIR indicated that Resident #44 was witnessed by staff inappropriately touching Resident #45 while outside.

Interview of ADOC indicated the first incident was not reported to the police until after the second incident that occurred when Resident #44 was witnessed inappropriately touching Resident #45 a second time two days later. [s. 98.]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

Interview of RN #S111 indicated Resident #46 self-administered medications.
Observation and interview of Resident #46 provided three inhalations which were all kept in the drawer resident's bedside table that was not locked. RN #S111 indicated no awareness of any policies related to resident self administration and storage of medications.
Review of the Physician orders (current) had no instructions related to "self administration".[s.131.(5)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (1) Every licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of,
(a) all expired drugs; O. Reg. 79/10, s. 136 (1).
(b) all drugs with illegible labels; O. Reg. 79/10, s. 136 (1).
(c) all drugs that are in containers that do not meet the requirements for marking containers specified under subsection 156 (3) of the Drug and Pharmacies Regulation Act; and O. Reg. 79/10, s. 136 (1).
(d) a resident's drugs where,
(i) the prescriber attending the resident orders that the use of the drug be discontinued,
(ii) the resident dies, subject to obtaining the written approval of the person who has signed the medical certificate of death under the Vital Statistics Act or the resident's attending physician, or
(iii) the resident is discharged and the drugs prescribed for the resident are not sent with the resident under section 128. O. Reg. 79/10, s. 136 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written policy was developed in the home that provides for the ongoing identification, destruction and disposal of all expired drugs

On a specified date, 3 bottles of nasal spray, 5 Bottles of natural tears, 2 bottle of liquid medication were found in the medication cart on the second floor. All of the medications had been opened but did not indicate a date of opening to determine date of expiry. On the same day, observation of the Government stock room, indicated the following medications were observed to be expired: 1 bottle of liquid medication (expiry date May 2013); 4 bottles of laxative (expiry date of January 2014 and April 2014) and 1 bottle of Tylenol 500mg tablets (expiry date of September 2014).

Interview with DOC indicated that expired drugs should be removed from the shelves. DOC was not able to provide a policy for expired drugs. DOC also indicated that all eye drops and liquid medication should be labeled with a sticker of the date of opening and the date that the medication should be discarded once this one is open.

Review of the "National Pharmacy Policy" recommended expiry dates of four weeks after inhalations or eye drops but there was no indication of procedures to follow regarding liquid medication.

Therefore the home failed to ensure that a written policy was developed for the destruction and the disposal of all expired drugs. [s. 136. (1)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 225. Posting of information

Specifically failed to comply with the following:

s. 225. (1) For the purposes of clause 79 (3) (q) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 79 of the Act includes the following:
1. The fundamental principle set out in section 1 of the Act. O. Reg. 79/10, s. 225 (1).
2. The home's licence or approval, including any conditions or amendments, other than conditions that are imposed under the regulations or the conditions under subsection 101 (3) of the Act. O. Reg. 79/10, s. 225 (1).
3. The most recent audited report provided for in clause 243 (1) (a). O. Reg. 79/10, s. 225 (1).
4. The Ministry's toll-free telephone number for making complaints about homes and its hours of service. O. Reg. 79/10, s. 225 (1).
5. Together with the explanation required under clause 79 (3) (d) of the Act, the name and contact information of the Director to whom a mandatory report shall be made under section 24 of the Act. O. Reg. 79/10, s. 225 (1).

Findings/Faits saillants :

1. Review of the Licensee Confirmation Checklist Admission Process completed by the DOC indicated the home's license or approval, including any conditions or amendments , copy of the home's service accountability agreement, and the most recent audited reconciliation report were not posted in the home. [s. 225. (1) 2.]

2. Observation on both upper and lower units confirmed these items were not posted. [s. 225. (1) 3.]

Issued on this 5th day of December, 2014

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111), MELANIE SARRAZIN (592), SUSAN WENDT (546)
Inspection No. / No de l'inspection :	2014_360111_0026
Log No. / Registre no:	O-000989-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 23, 2014
Licensee / Titulaire de permis :	HALIBURTON HIGHLANDS HEALTH SERVICES CORPORATION 7199 Gelert Road, Box 115, HALIBURTON, ON, K0M-1S0
LTC Home / Foyer de SLD :	HYLAND CREST 6 McPherson Street, P.O. Box 30, Minden, ON, K0M-2K0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Varouj Eskedjian

To HALIBURTON HIGHLANDS HEALTH SERVICES CORPORATION, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a corrective action plan that includes the following:
-review and revise the plan of care for Resident #45, to ensure that the risks are identified, and strategies are developed and implemented to manage the risk of inappropriate touching where possible,
-review and revise the plan of care for Resident #44, to ensure that all triggers are identified & strategies are developed and implemented related to responsive behaviours of inappropriate touching where possible,
-retrain all staff involved in direct care on the home's policy of prevention of abuse and neglect and reporting requirements to ensure that resident's are assessed for injury, the Substitute Decision Makers's (SDM) or any other persons designated by the resident are notified within 12 hours, and to ensure police and the Director are immediately notified of incidents of resident to resident sexual abuse,
-review and revise the home's policy "Prevention of Abuse and Neglect of Residents" to ensure that all alleged, suspected, and witnessed incidents are included, contain procedures and interventions to deal with persons who have abused or neglected or allegedly abuse or neglected "residents", and identify measures and strategies to "prevent abuse" (as the policy only provided procedures after the incidents occur),
-review and revise the home's policy "Responsive Behaviours" to ensure that procedures and interventions are developed and implemented to meet the needs of resident's with responsive behaviours, including written approaches to care, screening protocols, assessments, reassessments, and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other, and that written strategies, include techniques and interventions to prevent, minimize or respond to the responsive behaviour.

This plan is to be submitted to Lynda Brown via email at: lynda.brown2@ontario.ca by November 4, 2014.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that Resident #45 was protected from sexual abuse by other resident's in the home.

Under O.Reg. 79/10, "sexual abuse" means (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.

2.Related to log #000597:

A critical incident report (CIR) was received on a specified date for a resident to resident sexual abuse incident that occurred two days earlier. The CIR indicated that Resident #44 was witnessed by staff inappropriately touching Resident #45 outside. A second CIR was submitted on the same day for a second incident of resident to resident sexual abuse that occurred two days after the first incident. The CIR indicated Resident #44 was found inappropriately touching Resident #45. Resident #45 confirmed being touched inappropriately by Resident #44 but denied any pain or injury.

The progress notes for Resident #44 indicated:
-the resident was relocated to another unit after the second incident and the resident has some cognitive impairment.
-the day of the first incident (before breakfast), the resident was found by a housekeeper in Resident #45 room "watching the resident" and was immediately removed. Later, Resident #44 was found by the RPN outside inappropriately touching Resident #45. The RPN immediately intervened, removed Resident #44 and informed resident/staff that Resident #44 is restricted from going outside unsupervised.
-two days later, an RPN entered the dining room and observed Resident #44 sitting next to Resident #45 touching Resident #45 inappropriately.As the RPN approached the residents, Resident #44 immediately stopped the inappropriate touching. Resident #44 was relocated to sit in front of the nursing station. The ADOC met with Resident #44 later in the morning and the resident denied the incident.

Review of the progress notes for Resident #45 indicated:
-Resident #45 is independently mobile, cognitively impaired, continuously wanders throughout the unit and into other resident rooms, and was the recipient of 3 separate incidents of sexual abuse by two different residents (Resident #6 & #44).
-there was no documentation regarding either of the incidents that occurred on the first day or an assessment of Resident #45 for any injuries after the first incident of sexual abuse.
-the POA was not notified of the first incident of suspected sexual abuse until the following day.
-there was no indication of a physical assessment of the resident for injury after

the second incident of suspected sexual abuse.
-approximately two months later (before supper), the resident was sitting in the lounge watching TV and Resident #6 was observed inappropriately touching the Resident #45 while Resident #45 was attempting to stop the inappropriate touching. Resident #6 was immediately removed from the area.

3.Related to log #000950:

Review of CIR for a resident to resident sexual abuse that occurred on a specified date. The CIR indicated that Resident #6 was witnessed sexually abusing Resident #45 in the main lounge.

Review of the health care record for Resident #6 indicated the resident had a prior incident of resident to resident sexual abuse towards another cognitively impaired female resident, and was placed on restrictions.

4.Therefore, licensee failed to protect Resident #44 from 3 separate incidents of sexual abuse as evidenced by:
-the licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with as Resident #45 was not assessed for injury after the first two incidents as issued under WN#7 [LTCHA, 2007, s.20(1)].
-the licensee failed to ensure that the resident's SDM and any other person specified by the resident was notified within 12 hours upon becoming aware of an incident of resident to resident sexual abuse as the SDM of Resident #45 was not notified until the following day regarding the incident that occurred, as issued under WN#16[O.Reg. 79/10, s.97(1)9(b)].
-the licensee failed to ensure that the appropriate police force was immediately notified of a suspected or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence as the police were not notified of the first incident that occurred between Resident #44 & #45 until two days later(after the second incident occurred), as issued under WN#17[O.Reg. 79/10, s.98].
-the licensee failed to ensure that when a person had reasonable grounds to suspect abuse of a resident by another resident that resulted in risk of harm, was immediately reported to the Director,as the Director was not notified of the sexual abuse incident that occurred until the following day, as issued under WN #8[LTCHA, 2007, s.24(1)].
-the licensee failed to ensure that the demonstrated responsive behaviours for

Resident #44 had the behaviour triggers identified, that strategies were developed and implemented related to monitoring of the resident after the first incident; and for Resident #45, on how to protect the resident from recurrence of sexually abusive behaviour of other residents, where possible, and the homes policy on responsive behaviours did not meet the requirements under the regulations, as issued under WN #2 [LTCHA, 2007, s.6(2)] & WN#11[O.Reg.79/10, s.53(1),(4)(a)(b)].
-the licensee failed to ensure that the homes written policy to promote zero tolerance of abuse and neglect of residents contained procedures and interventions to deal with persons who have abused or neglected or allegedly abuse or neglected "residents", and identified measures and strategies to "prevent abuse" as the policy only provided procedures after the incidents occur, and the policy only indicated actual and suspected abuse, not "alleged" as issued under WN#15[O.Reg. 79/10, s.96(b)(c)].
-the licensee failed to ensure that staff received annual training on the home's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities as the home was unable to provide any evidence that staff received annual re-training on the prevention of abuse and neglect of residents as issued under WN#7 [LTCHA, 2007, s.20(1)].
-Non-compliance was issued for LTCHA, s.19(1) on August 26, 2013 under inspection 2013_031194_0031. [s. 19. (1)] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 23rd day of October, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

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