Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 28, 2018	2018_742527_0013	034889-16, 022679-17, 023836-17, 025059-17, 001193-18, 001880-18, 002348-18, 002642-18, 003097-18, 008454-18	Critical Incident System

Licensee/Titulaire de permis

2063412 Ontario Limited as General Partner of 2063412 Investment LP
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Long-Term Care Home/Foyer de soins de longue durée

Creedan Valley Care Community
143 Mary Street CREEMORE ON L0M 1G0

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

KATHLEEN MILLAR (527), AMANDA COULTER (694), SHARON PERRY (155)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 4, 5, 6, 7, 8, 11, 12, 13, 15, 18, 19, 21 and 22, 2018.

During the course of this inspection, the following Critical Incident System (CIS) inspections were conducted:

Log #034889-16, related to alleged verbal and emotional abuse;
Log #022679-17, related to a fall;
Log #023836-17, related to an acute respiratory infection (ARI) outbreak;
Log #025059-17, related to an alleged abuse;
Log #001193-18, related to an alleged abuse;
Log #001880-18, related to an alleged abuse;
Log #002348-18, related to an alleged abuse;
Log #002642-18, related to a missing controlled substance;
Log #003097-18, related to an acute respiratory outbreak; and
Log #008454-18, related to an acute respiratory outbreak.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), the Resident Relations Coordinator, the Food Services Supervisors, the Programs Manager, the Administrative Manager, the Resident Assessment Instrument (RAI) Coordinator, the Nurse Practitioner (NP), the Behavioural Support Ontario (BSO) Registered Nurse (RN), BSO Registered Practical Nurse (RPN) and BSO Personal Support Worker (PSW), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Care Support Assistants (CSAs), Registered Dietitian (RD), Physiotherapist (PT), physiotherapy aide (PTA), maintenance staff, environmental services aides, dietary aides, activities staff, office clerks, residents and family members.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services, reviewed relevant documents, including but not limited to, clinical records, policies and procedures, internal investigation notes, training records and meeting minutes.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

- **10 WN(s)**
- **4 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that all residents were protected from abuse by anyone and free from neglect by the licensee or staff.

The critical incident reports submitted to the Director on specific dates in early 2018, indicated that there were incidents of alleged sexual abuse that occurred on these dates, by resident #001 towards residents #002, #003 and #004. Resident #001 had a history of inappropriate sexual behaviours towards staff and when they inappropriately touched resident #002, this was the first time resident #001 had inappropriately touched residents in the home.

The clinical record and the investigation notes were reviewed for resident #001 and #002, which indicated that on a specific date and times, resident #001 had inappropriately touched resident #002, two to three times. There were no staff members present at the time of the incident; however resident #002 was able to accurately describe the resident and the incident.

On a specific date and time, resident #001 was found by the physiotherapy assistant in an area of the home. Resident #001 had inappropriately touched resident #003. The home had documented in the critical incident system report that one of the actions they implemented was one to one monitoring of resident #001. Based on the clinical record review and a review of the home's one to one information, one to one was not implemented at this time.

Subsequently, at a later date in 2018, resident #001 was found at the nursing station. Resident #001 had inappropriately touched resident #004. The home implemented one to one monitoring for resident #001, after this incident and for resident #004 they implemented support and assessments in order to monitor for any changes.

Resident #001 had three incidents of sexually abusing residents within a two week period.

The DOC was interviewed and confirmed that the home made a referral to the Behavioural Support Services Team (BSST) and the Psycho-Geriatrician. The BSST did not consult with the home, related to resident #001's sexual responsive behaviours until approximately four weeks since the referral was initiated. The BSST recommended trial behavioural strategies. Dementia Observation Scale (DOS) monitoring was initiated after the first incident and it was in place during the second and third incidents; however the documentation related to resident #001's sexually inappropriate behaviours were inconsistently documented and there was no analysis to identify trends or patterns, which would assist in determining triggers and/or interventions to be implemented to manage

the resident's responsive behaviours.

Resident #001 was assessed by the Psycho-Geriatrician and made recommendations to manage the resident's sexually inappropriate behaviours.

One to one staff that were interviewed during the course of this inspection, which included staff member #105, #017, #117, #130 and #133, were not aware of all the responsive behaviour strategies that were implemented when the resident was exhibiting sexually inappropriate behaviours.

Resident #001 had on one to one monitoring and the resident was observed numerous occasions during this inspection and was not being monitored by the one to one staff member assigned and was observed seated in the lounge close to residents. In addition, resident #001 was seated in the dining room at meals and was able, at arm's reach, to touch certain residents at another dining room table.

The DOC was interviewed and acknowledged each incident of sexual abuse by resident #001 towards residents #002, #003 and #004. The DOC indicated that as a result of the second incident with resident #003, the home had planned to implement one to one monitoring related to resident #001's high risk sexual behaviours; however they had problems trying to staff one to one and acknowledged that it was not implemented until several days after the third incident. The DOC acknowledged the licensee's obligation to protect all residents from abuse. The DOC acknowledged the inconsistencies in the implementation of the strategies to manage the resident's sexual responsive behaviours and the inconsistencies in the staff documentation.

The licensee failed to ensure that all residents were protected from abuse by anyone and free from neglect by the licensee or staff.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #001193-18; log #001880-18; and log #002348-18.

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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

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

Findings/Faits saillants :

1. The licensee failed to ensure that, (a) the matters referred to in subsection (1) were developed and implemented in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices; (b) that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The Responsive Behaviour annual program evaluation for 2017, was reviewed and there were no date(s) identified as it related to when the changes and improvements were implemented.

The licensee's policy titled "Responsive Behaviours - Management", directed staff to keep a written record of the evaluation and analysis and changes/improvements were promptly implemented. There was no direction related to ensuring that the written record included the date the changes were implemented.

The DOC was interviewed and acknowledged that they were expected to identify the date(s) on the annual program evaluation and this was not done.

The licensee failed to ensure that the written record of the 2017 annual program evaluation for the Responsive Behaviour Program included the date that the changes were implemented.

This area of non-compliance was identified during Critical Incident System (CIS) Inspections log #001193-18; log #001880-18; and log #002348-18.

2. The licensee failed to ensure that, for each resident demonstrating responsive behaviours that, (b) strategies were developed and implemented to respond to these behaviours, where possible.

Resident #001 had a history of responsive behaviours related to resisting care and sexually inappropriate behaviours. The sexual behaviours exhibited by resident #001 on three specific dates, early 2018, involved three different residents. The three residents were sexually abused by resident #001 and the incidents were not witnessed by anyone.

The responsive behaviour plan of care was reviewed and one to one monitoring was implemented on a specific date in 2018. The responsive behaviour plan of care directed staff to monitor behaviour episodes and attempt to determine the underlying cause. Staff were to consider the location, time of day, persons involved, situations and document behaviour and potential causes. In addition, the plan of care directed staff to ensure that resident #001 was not in areas with other residents, whenever possible.

The clinical record was reviewed, which identified the one to one monitoring was not implemented until three days after the third sexual abuse incident of three residents.

During observations of resident #001, on specific dates and times 2018, the resident was observed not being monitored by the one to one staff member and was consistently seated within close proximity of certain residents. The clinical record also revealed that

staff did not consistently document the behavioural episodes on the Dementia Observation Scale (DOS); the Antecedent-Behaviour-Consequences (A-B-C) Chart, which elaborated on the causes, the sexual behaviour and the outcomes; and the registered staff did not consistently document the location of the sexual behaviour, the time of day, the persons involved, the situations and the potential causes for the sexual behaviours in the progress notes.

The licensee's policy titled "Responsive Behaviours – Management", directed staff to document planned interventions for addressing specific responsive behaviours and to provide treatment and interventions on the plan of care.

Staff member #107 was only able to identify one or two strategies for the resident, but otherwise didn't know anything else. The staff member was asked if they had access to the responsive behaviour plan of care and they said no.

Staff member #117 was interviewed and was asked if they were aware of the strategies they were expected to implement if the resident was exhibiting sexual responsive behaviours, and they said not really, only what they tell me. The staff member indicated that they watch the resident closely, but only able to identify a couple of strategies. The staff member was asked if they had access to the responsive behaviour plan of care and they said no and they weren't sure what the plan of care was.

RN #114 was interviewed and indicated that there was a plan in place for the resident's sexual behaviours. The RN said that these interventions were new and wasn't aware of what specific strategies were developed and implemented to manage the resident's sexual behaviours. The RN was also unable to identify the causes for the resident's behaviours and indicated that they document in the progress notes what the one to one tells them and was unable to identify what specifically the registered staff were expected to document. The RN acknowledged that the one to one was sometimes non-clinical staff and did not have access to the responsive behaviour plan of care.

The DOC was interviewed and acknowledged that staff were expected to develop and implement the strategies to manage the resident's sexual behaviours and this was not occurring consistently.

The licensee failed to ensure that, for resident #001, who was demonstrating responsive behaviours, that actions were taken to respond to the needs of the residents, including assessments, reassessments and interventions and that the residents responses to

interventions were documented.

This area of non-compliance was identified during Critical Incident System (CIS) Inspections log #001193-18; log #001880-18; and log #002348-18.

3. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, (c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions were documented.

A) Resident #001 had a history of responsive behaviours related to resisting care and sexually inappropriate behaviours. The sexual behaviours exhibited by resident #001 on specific dates in early 2018, involved three residents. The three residents were sexually abused by resident #001.

The clinical record was reviewed, which revealed that the Dementia Observation System (DOS) was initiated on as specific date in 2018, after the first incident of sexually inappropriate behaviours by resident #001. The DOS charting was reviewed for a five month period in 2018, which identified inconsistent charting of the resident's behaviours and responses to the interventions.

The A-B-C charting documentation of the resident's sexually inappropriate behaviours over a four week period in 2018 was reviewed. This documentation, which was a tool used to track every instance of the resident's sexual behaviours, was not implemented until four months after the first incident. The A-B-C charting identified inconsistencies in the documentation, what interventions were implemented and the resident's response to the interventions.

Review of the Behavioural Support System Team (BSST) notes on a specific date in 2018, identified that RN #134 attended the home to go over the assessments that the behaviour support specialist requested the home staff to complete. The assessments were not completed by the staff, therefore no documentation related to these assessments were located on the resident's clinical record.

The licensee's policy titled "Responsive Behaviours - Management", directed registered staff to conduct and document behavioural assessments and the resident's responses to the interventions when experiencing responsive behaviours

The DOC was interviewed and acknowledged that the staff were inconsistently documenting and this was an ongoing issue with staff. The DOC also stated that registered staff did not complete the Physical, Intellectual, Emotional, Capabilities, Environment and Social (PIECES) and/or Understanding, Flagging, Interaction, Reflection and Reporting, Support, Team (U-First) assessments, which was expected and did not document the assessments requested by the behavioural support specialist.

The licensee failed to ensure that, for resident #001, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions were documented.

This area of non-compliance was identified during Critical Incident System (CIS) Inspections log #001193-18, log #001880-18, and log #002348-18.

B) According to the Critical Incident System (CIS), resident #010 hit resident #009 on the head on a specific date in 2017. No staff witnessed the incident; however another resident's daughter reported that resident #010 asked resident #009 to move so that they could go around them in their wheelchair, when resident #009 did not move, the visitor said that resident #010 hit resident #009 on the top of the head. Both residents were assessed and resident #009 had an injury. There was no previous history of altercations between the two residents and/or physically responsive behaviours from resident #010.

The clinical record was reviewed, which confirmed the information documented in the CIS; however there were no referrals to the BSO as a result of this new behaviour for resident #010.

Resident #010 was interviewed and recalled the incident differently that what was in the report.

The licensee's policy titled "Responsive Behaviours - Management", directed registered staff to complete an electronic Responsive Behaviour Referral to the BSO Lead / Designate when there was a new responsive behaviour.

The DOC was interviewed and acknowledged that there was no referral to the BSO as a result of resident #010's new behaviour of physical abuse, when there should have been one completed.

This area of non-compliance was identified during Critical Incident System (CIS)

Inspections log #025059-17.

The licensee failed to ensure that, for resident #001 and #010, who were demonstrating responsive behaviours, that actions were taken to respond to the needs of the residents, including assessments, reassessments and interventions and that the residents responses to interventions were documented.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 (a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; (b) that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes are implemented; to ensure that, for each resident demonstrating responsive behaviours that, (b) strategies are developed and implemented to respond to these behaviours, where possible; and to ensure that, for each resident demonstrating responsive behaviours, (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, to be implemented voluntarily.

WN #3: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other, and (b) in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

Resident #001 was experiencing sexual responsive behaviours. The resident had sexually abused three residents on specific dates in 2018. Resident #001's sexual responsive behaviours continued and they were placed on one to one monitoring. The DOC also made a referral to the BSST for assessment. The PSW member of the BSST attended the home to initiate observations and the resident was subsequently assessed

by the BSST.

The resident was observed by LTCH Inspector #527 on specific dates in 2018. The resident had one to one staff. Resident was making inappropriate sexual comments to staff during the observations. The resident was interviewed and did not recall any incidents.

The clinical record was reviewed, which identified the assessments, external consultations and one to one monitoring of the resident's responsive behaviours. The PsychoGeriatrician made recommendations to implement specific strategies in the responsive behaviour plan of care and determine if effective in managing the resident's sexual responsive behaviours.

RPN #105 was interviewed and was providing one to one care for resident #001. The RPN was unable to identify what the triggers were for the resident's behaviours and was only able to identify a couple of the interventions to manage the resident's sexual behaviours. The RPN said that they had not been involved in any huddles related to the resident's responsive behaviours and wasn't sure of what assessments were completed.

Interviewed staff member #117, who had provided one to one monitoring of resident #001 on approximately six shifts. The staff member said that they weren't aware of what caused the resident's responsive behaviours and knew some of what they had to do for the resident because the nurse told them. The staff member did not have access to the responsive behaviour plan of care, only what information was placed on the clipboard. They were non-clinical staff and were not aware of the aspects of care for resident #001.

Interviewed staff member #130, who had provided one to one monitoring of resident #001 on many shifts. The staff member said that they don't do assessments of the resident and didn't know what the plan of care was. They said that they do what the nurses tell them to do for the resident.

Interviewed RN #114, who was the charge nurse. The RN told the LTCH Inspector #527, that the resident was seen by the PsychoGeriatrician and the BSST and there was a plan in place, but was only able to identify three interventions that were implemented to manage the resident's sexual behaviours. The only assessments they were aware of was the Dementia Observation Scale (DOS) and the A-B-C Chart. The RN said that they thought that the BSST had done assessments and they were not shared with them or the team.

Interviewed RN #129, who also acted as a charge nurse. The RN said that the BSST completed assessments and they do the analysis of the assessments and make changes to the plan of care for the resident's behaviours.

The RNs, RPN and other staff members that provided one to one care for resident #001, were unaware of the trial period for the interventions recommended by the PsychoGeriatrician and indicated that no one had asked them if they felt the interventions were effective or not and/or if any revisions needed to be made to the resident's plan of care.

The licensee failed to ensure that the staff and others involved in the different aspects of care for resident #001, collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other, and (b) in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #001193-18; log #001880-18; and log #002348-18.

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) Resident #004 was sexually abused by resident #001 on a specific date in 2018. There was no physical injury identified by the registered staff when resident #004 was assessed immediately after the incident; however the resident had a change in behaviour. As a result of the incident, one of the actions taken was to conduct skin assessments for the resident for 72 hours post incident and this was not completed.

The clinical record was reviewed and there were only three out of nine (3/9) assessments completed for this resident.

The Director of Care (DOC) was interviewed and acknowledged that registered staff were expected to complete head to toe/skin assessments for resident #004 for 72 hours after the incident in 2018 and this was not done.

This area of non-compliance was identified during a Critical Incident System (CIS)

Inspection, log #002348-18.

B) Resident #001 had a history of responsive behaviours related to resisting care and sexually inappropriate behaviours. The sexual behaviours exhibited by resident #001 on three specific dates in early 2018, involved three residents.

As a result of these incidents the home implemented one to one care in order to monitor resident #001.

The resident was observed by LTCH Inspector #527 on a specific date and time unsupervised. The one to one staff member was at the nursing station completing their documentation on the computer and they were unable to see resident #001.

Resident #001 was also observed on four other dates and times. The assigned one to one staff member was not monitoring the resident continuously. The one to one staff member was observed assisting other residents and there were intervals when the one to one staff member was in the kitchen, the resident was not visible to them.

The licensee's policy titled "Considerations for Implementing 1:1 Staffing", directed the assigned one to one staff to provide continuous one to one monitoring of the resident.

The clinical record review identified that resident #001 had eloped from the home on a specific date in 2018 when they were on one to one monitoring. The resident was outside the building smoking with their oxygen on during morning report. There was no one to one monitoring the resident.

CSA #122 said that they were watching the resident all the time and someone covers for them when on break. The CSA stated that they were told that at lunch they were allowed to help in the dining room serving meals and cleaning the tables.

RPN #105 said they continuously monitor the resident and when they go on their breaks, another staff member takes over the one to one. The RPN said that they were expected to always be able to observe the resident and ensure they were not sitting close to certain residents. The RPN acknowledged that if the resident was in the dining room and staff were documenting at the nursing station and/or assisting with the meal service, that the one to one staff member would not be able to continuously monitor resident #001.

The DOC was interviewed and said that staff were expected to provide continuous

monitoring of resident #001 and the DOC acknowledged that if the one to one staff member was at the nursing station doing their documentation while the resident was in the front dining room, that they would not be able to monitor.

This area of non-compliance was identified during Critical Incident System (CIS) Inspections log #001193-18; log #001880-18; and log #002348-18.

The licensee failed to ensure that the care set out in the plan of care for resident #001 and #004 was provided to the residents as specified in the plan.

3. The licensee failed to ensure that the staff and others who provide direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

Resident #001 had a history of responsive behaviours related to resisting care and sexually inappropriate behaviours.

Staff member #117, #130, #141, CSA #126 and #140, were not aware of all the interventions required to manage the resident's sexual behaviours and each of the staff acknowledged that they did not have access to the plan of care. The staff members were not familiar with the plan of care terminology. The staff members also acknowledged that they were dependent on the nurses to tell them what they need to do for resident #001 and if there were any changes to what they had to do for the resident.

RN #114, #129 and RPN #105 stated that the non-clinical staff members and CSA's did not have access to the plan of care and were dependent on the nursing staff to communicate the interventions over and above what was documented on the clipboard they use. The nursing staff also acknowledged that there was inconsistencies in the communication to the staff performing the one to one duties and it was difficult to know what was told to the staff members from one shift to the next.

The licensee failed to ensure that the staff and others who provide direct care to resident #001, were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

4. The licensee failed to ensure that the resident was reassessed and the plan of care was reviewed and revised (b) when the resident's care needs changed.

The clinical record was reviewed and there was a referral to the PsychoGeriatrician for consultation related to resident #001's sexually inappropriate behaviours. The PsychoGeriatrician attended the home and made recommendations.

The responsive behaviour plan of care was reviewed and the plan of care was not revised to include the recommended changes by the PsychoGeriatrician.

The licensee's policy titled "Responsive Behaviours - Management", directed registered staff to provide interventions and coach frontline team members about the interventions on the care plan.

Staff member #107, #117, and CSA #126 were interviewed and they were not aware of all the interventions on the plan of care and did not have access to the plan. They were not aware of the recommendations by the physician, when the resident's care needs changed and the revised interventions to manage the resident's inappropriate sexual behaviours.

The DOC was interviewed and confirmed the PsychoGeriatrician had consulted and made medication changes and recommendations on new strategies to implement to manage the resident's sexual behaviours. The DOC acknowledged the responsive behaviour plan of care was not revised when the care needs changed, to include all the recommendations made by the physician.

The licensee failed to ensure that resident #001 was reassessed and the plan of care was reviewed and revised when the resident's care needs changed.

This area of non-compliance was identified during Critical Incident System (CIS) Inspections log #001193-18; log #001880-18; and log #002348-18.

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 the staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other; to ensure that the care set out in the plan of care is provided to the resident as specified in the plan; to ensure that the staff and others who provide direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it; and to ensure that the resident was reassessed and the plan of care was reviewed and revised (b) when the resident's care needs changed, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The following licensee policies and procedures were not complied with:

A) The licensee's policy titled "Responsive Behaviours - Management, directed ", directed registered staff to conduct and document an assessment of the resident

experiencing responsive behaviours to include: (i) evaluating the effectiveness of a planned intervention on the care plan addressing specific responsive behaviours; and (ii) complete an electronic Responsive Behaviour Referral to the internal Behaviour Support Ontario (BSO) Lead / Designate when there was a new, worsening, or change in responsive behaviours.

(i) The clinical record was reviewed for resident #001, specifically the responsive behaviour plan of care. There was no documentation to reflect that the responsive behaviour interventions to address resident #001's inappropriate sexual behaviours towards female residents were evaluated to determine their effectiveness. There was no documentation of the evaluation by the home staff or the BSST.

RN #114 and #129 were interviewed and neither of the RNs were able to identify if the interventions were evaluated for effectiveness. Both RNs said that the BSO evaluated the responsive behaviour interventions and they talk to the DOC, who would then tell us if any changes needed to be made to the plan of care.

The DOC was interviewed and indicated that when the BSST was in the home they would review the documentation, assessments and discuss the interventions to determine if effective or not, then the care plan would be revised. The DOC was unsure if the interventions recommended by the physician on specific dates in 2018, were evaluated to determine if they were effective or not.

(ii) The clinical record review also indicated that they had experienced new behaviours on a specific date in early 2018, when the resident had exhibited sexually inappropriate behaviours towards resident #002. In addition, resident #001's inappropriate sexual behaviours worsened, when the resident exhibited inappropriate sexual behaviours towards residents #003 and #004. The referral to the Behaviour Services Support Team (BSST) was not made until three days after the third incident and the BSST did not complete the responsive behaviour assessment until the following month.

The DOC was interviewed and acknowledged that they made the referral to the BSST and Waypoint, after the third incident of sexually inappropriate behaviours by resident #001.

The registered staff failed to ensure that an electronic Responsive Behaviour Referral to the BSO lead/designate when there was a new and/or worsening change in responsive behaviours and when the responsive behaviour posed a risk to others.

The licensee failed to ensure that the Responsive Behaviours - Management policy and procedures were complied with.

B) The licensee's policy titled "Consideration for Implementing 1:1 Staffing", directed staff assigned to one to one staffing to: be aware and follow the plan of care in place for the resident and provide continuous one to one monitoring of the resident and do not leave the resident alone unless the plan of care had changed.

The resident was observed on six specific dates and times 2018. The resident was seated in the dining room and was unsupervised.

The DOC was interviewed and acknowledged that the one to one staff were expected to constantly monitor the resident in the dining room at meal times. The DOC acknowledged that the registered staff were expected to monitor the one to one to ensure they were aware of the interventions needed for resident #001 and to ensure they were complied with.

The staff providing one to one for resident #001, were not aware and following the responsive plan of care and did not provide continuous one to one monitoring of the resident, as directed in the Consideration for Implementing 1:1 Staffing policy and procedures.

C) The licensee's documentation policy titled "Documentation - Interdisciplinary Guidelines", directed staff to document in the paper chart for those documents not housed in the computerized record, such as flow sheets. Staff were expected according to the guidelines to document the event, date/time of entry, signature, and the discipline/category of the team member after the signature.

The clinical record review revealed that there were numerous inconsistencies from January to June 2018, in the documentation on the Dementia Observation Scale (DOS) and A-B-C (Anecdotal, Behaviour and Consequence/Outcome) charting by clinical and non-clinical staff who were providing one to one monitoring/care of resident #001. There was missing documentation of the events, missing dates/times, no initials, no master list of signatures that could be matched to initials, there was correction fluid used on the documents when errors were made, errors were scribbled out and staff were doodling all over the flow sheets.

The DOC was interviewed and acknowledged that clinical and non-clinical staff were not compliant with their documentation guidelines.

The staff providing one to one monitoring for resident #001, did not document as expected and according to the licensee's documentation guidelines.

This area of non-compliance was identified during Critical Incident System (CIS) Inspections log #001193-18; log #001880-18; and log #002348-18.

D) Resident #009 was injured by resident #010 on a specific date in 2017. Resident #009 was assessed by registered staff and as a result of the incident, one of the actions taken was to conduct head injury for the resident for 72 hours post incident and this was not completed.

The clinical record was reviewed and the investigation notes from the incident revealed the action to be taken was head injury routine (HIR) for resident #009 and to be completed by registered staff for 72 hours after the resident was physically abused. LTCH Inspector #527, was not able to locate any HIR assessments on resident #009's clinical record.

The DOC was interviewed and acknowledged that registered staff were expected to complete head injury routine for resident #009 for 72 hours after the incident and this was not done.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #025059-17.

The licensee failed to ensure that the responsive behaviours policies and procedures; the guidelines for implementing one to one staffing; the documentation guidelines and the head injury routine procedures were complied with.

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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participate in the implementation of the program.

On a specific date and times in 2018, PSW #112, #131 and #132 were observed feeding two residents each and supervising other residents at their tables in the dining room. The PSWs did not perform hand hygiene in between feeding residents, after cleaning dirty

dishes off the dinging room table and/or before feeding and/or assisting another resident with their meal. It wasn't until the PSWs completed feeding all the residents at their tables and cleaning the dirty dishes off, were they observed performing hand hygiene.

The licensee's policy titled "Hand Hygiene", directed staff to perform hand hygiene before and after performing a task involving close resident contact, as well as before handling food or drink, and between tasks on residents to prevent cross-contamination.

PSW #112 and #131 were interviewed and acknowledged that they did not perform hand hygiene and should have after they cleaned the dirty dishes of their tables and before starting to feed or assist another resident with their meal.

The DOC was interviewed and acknowledged that staff were expected to comply with the hand hygiene practices as outlined in their policies and procedures.

The licensee failed to ensure that all staff participate in the implementation of the program.

This area of non-compliance was identified during Critical Incident System (CIS) Inspections, log #023836-17; log #003097-18; and log #008454-18.

2. The licensee did not ensure that on every shift symptoms indicating the presence of infection in residents were monitored in accordance with prevailing practices and that the symptoms were recorded.

The licensee experienced an acute respiratory illness (ARI) outbreak during specific dates in 2017 and specific dates in 2018.

The original copies of the ARI Outbreak line list were reviewed. The line list identified that specific residents had exhibited two or more symptoms of an infection.

The residents affected with symptoms of an ARI increased up to twenty nine with the last resident being identified as symptomatic for an ARI on a specific date in 2017.

During this time, staff members were also exhibiting symptoms of an ARI, with the last staff member being symptomatic in 2017.

RN #114 indicated that they conduct surveillance when they need to and was unable to

locate their surveillance form. The RN said the ADOC and DOC do most of the surveillance and tracking of infections in their home. The RN had worked during the home's last two ARI outbreaks and was unaware that they were expected monitor and track infections on every shift, and said that they don't discuss or review the line list at shift report.

RN #122 was on duty during an ARI outbreak in 2017, when two additional residents and three to five staff members became symptomatic. The RN did not recall contacting the ADOC, DOC, the oncall Manager and/or Public Health related to the additional resident (s) and staff members who became symptomatic prior to the 2017 outbreak being declared. The RN said that the registered staff track some infections and informed the inspector that they forgot to add a resident to their infection control tracking form when the resident was experiencing symptoms of an infection. The RN was unable to locate the surveillance form for tracking residents with signs and symptoms of health care associate infections, such as ARI or Gastroenteritis. The RN said that usually it was the ADOC and DOC who do the Public Health (PH) surveillance forms and said that they usually don't communicate resident's with infections during change of shift, unless there was a reason, such as a resident was ordered a new antibiotic.

The DOC was unable to provide copies of the surveillance forms the staff used for tracking infections.

The licensee did not ensure that on every shift symptoms indicating the presence of infection in residents were monitored in accordance with prevailing practices and that the symptoms were recorded.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #023836-17; log #003097-18; and log #008454-18.

3. The licensee failed to ensure that the following immunization and screening measures were in place: 4. Staff was screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

LTCH Inspector #155 identified when conducting employee file reviews, that three CSA's had only One-Step Tuberculosis (TB) testing on their files and was unable to locate the second step testing for TB.

The licensee's policy titled "Recommendations for Tuberculosis (TC) Screening in Long Term Care Communities", recommended that all team members must have a two-step TB skin test before starting to work.

CSA #122 was interviewed and said that they were asked to get a two-step TB test done, but they were told they could start to work and then get the second TB test after they started to work.

The DOC was interviewed and acknowledged that a two-step TB skin test was required of all new employees prior to starting to work in the home. The DOC confirmed that the two-step TB skin testing for CSA #122, #136 and #140, were not completed prior to working in the home.

The licensee failed to ensure that new staff were screened for tuberculosis in accordance with evidence-based practices and in accordance with their policies and procedures.

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 all staff participate in the implementation of the program; to ensure that on every shift, (a) symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices; and to ensure that the following immunization and screening measures were in place: 4. Staff was screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that, without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy was complied with.

On a specific date in early 2018, resident #001 was found by the Physiotherapy Assistant inappropriately touching resident #003. Staff separated the residents and an investigation by the home was completed. Resident #003 was not able to consent to sexual touching and was moderately cognitively impaired.

The clinical record for resident #003 was reviewed and there was no documentation in the progress notes of the incident or documentation on the plan of care.

The licensee's policy titled "Prevention of Abuse & Neglect of a Resident", directed staff to document the current resident status on the resident's record, complete a critical incident report and update the care plan as appropriate, ensuring that direct care staff were made aware of the current resident status.

RN #114, #129 and RPN #105 were interviewed and acknowledged that when there was an incident of alleged abuse and/or responsive behaviours, that these incidents were expected to be documented in the progress notes in Point Click Care (PCC). RN #120 and RPN #105 reviewed the progress notes for resident #003 and acknowledged that there were no progress notes of the incident; however it was documented in resident #001's progress note in PCC.

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

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) The CIS report was submitted to the Director on a specific date in 2018, related to resident #001 sexually abusing resident #002; however the licensee did not report the results of the investigation and the actions taken to the Director.

Another CIS report was submitted to the Director on a specific date in 2018, related to resident #001 sexually abusing resident #004; however the licensee did not report the results of the investigation and the actions taken to the Director.

The DOC was interviewed and acknowledged that they did not report the results of their investigation of these two incidents to the Director.

This area of non-compliance was identified during the Critical Incident System (CIS) Inspections related to, log #001193-18, log #001880-18 and log #002348-18.

B) The CIS report was submitted to the Director on a specific date in 2017, related to resident #010 physically abusing resident #009; however the licensee did not report the results of the investigation and the actions taken to the Director.

The DOC was interviewed and acknowledged that they did not report the results of their investigation of this incident to the Director.

This area of non-compliance was identified during the Critical Incident System (CIS) Inspection related to log #025059-17.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure, (e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented was promptly prepared.

The 2017 annual program evaluation for the Prevention of Abuse and Neglect program was reviewed and there was no date(s) identified as it related to when the changes and improvements were implemented.

The licensee's policy titled "Prevention of Abuse & Neglect of a Resident", directed the staff to keep a written record of each evaluation, which included the date(s) the changes were implemented.

The DOC was interviewed and confirmed that they were expected to identify the date(s) on the annual program evaluation, when the prevention of abuse & neglect changes / improvements were implemented and this was not done.

The licensee failed to ensure that the written record of the 2017 annual program evaluation for the Prevention of Abuse and Neglect program included the date that the changes and improvements were implemented.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all medication incidents were documented, reviewed and analyzed, corrective action was taken and a written record was kept.

Resident #022 was ordered a specific type of medication management. The Nurse Practitioner (NP) assessed the resident and had a discussion with the resident and family on the day of admission about transitioning to a different route for medication administration and they were agreeable to this; however if it was not effective, treatment would return to the original medication.

According to the medication administration records that were date and time stamped, four medications were removed from the resident at a specific date and time in 2018. The DOC and pharmacist subsequently completed the controlled substance destruction and the four medications were discovered missing at that time.

A review of the home's investigation notes contained only handwritten notes and they were not dated or signed.

The DOC was interviewed and explained that the handwritten notes were related to interviews the Administrator, DOC, a representative from corporate office and a union representative wrote when they met with each registered staff of the home. The investigation notes did not include a summary of the incident, analysis, steps taken to prevent further incidents or outcome of the home's investigation.

LTCH Inspector #694 interviewed RN #121, who was one of two registered staff working and co-signed for disposing the four medications into the destruction bin. According to the staff member, the destruction bin, when they discarded the medications looked normal.

The DOC acknowledged the medication incident report was not completed regarding the missing medications. The DOC and pharmacist completed medication destruction together and they discovered the missing medications.

LTCH Inspector #694 reviewed the incident reports for both months in 2018 and the monthly summary report of medication incidents, which did not include the missing medications. The DOC acknowledged the incident was not reviewed by the Pharmacy Advisory Committee, which was where all medication incidents were reviewed, analyzed and plans to prevent further incidents would occur.

The licensee failed to ensure that all medication incidents were documented, reviewed, analyzed, corrective action was taken and a written record of this was kept.

This area of non-compliance was identified during a Critical Incident Inspection, log #002642-18.

2. The licensee failed to ensure that a quarterly review was completed to reduce and prevent further incidents, changes and improvements identified in the review were implemented and a written record was kept.

Resident #022 was ordered a specific type of medication. The Nurse Practitioner (NP) assessed the resident and had a discussion with the resident and family on the day of admission about transitioning to different route of medication and they were agreeable; however if this was not effective, treatment would return to the original medication.

Four medications were removed from the resident at a specific date and time. The DOC

and pharmacist subsequently completed the controlled substance destruction and the four medications were discovered missing at that time.

The incident forms for two months in 2018 were reviewed and the monthly summary report of medication incidents, did not include the missing medications.

The DOC was interviewed and acknowledged that a medication incident report was not completed regarding the missing medications and therefore was missed when medication incidents were discussed at the quarterly Pharmacy Advisory Committee meeting. The DOC was unable to provide any documentation about the medication incident, the home's investigation or any corrective actions taken.

The licensee failed to ensure that a quarterly review of all medication incidents had occurred in the home in order to reduce and prevent further incidents, any changes or improvements identified in the review were implemented and a written record of this was kept.

This area of non-compliance was identified during a Critical Incident Inspection, log #002642-18.

WN #10: 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. (2) The drug destruction and disposal policy must also provide for the following:
1. That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that their policy regarding drugs for destruction or disposal, including controlled substances, shall be stored in a double-locked storage area in the home was followed.

The licensee's policy titled "Drug Destruction and Disposal, regarding monitored medication directed staff to retain the medications in the double-locked wooden box in the locked medication room. Only the DOC would hold the keys to the wooden box, however the box was only accessed by the DOC and the pharmacist or physician.

RN #121 was interviewed, they were one of two registered staff working and co-signed disposing medications into the destruction bin on a specific date in 2018. According to the RN, the destruction bin looked normal.

The DOC was interviewed and they acknowledged that the registered staff and the police discovered the destruction box for controlled substances was tampered with. The bottom lock was unlocked, the key would not work and the box was also not secured to the wall of the cupboard, the way it was installed.

The licensee failed to ensure that they followed their policy regarding drug destruction and disposal. That any controlled substance that was to be destroyed would be stored in a double-locked storage area within the home until destruction occurred.

This area of non-compliance was identified during a Critical Incident Inspection, log #002642-18.

Issued on this 14th day of September, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KATHLEEN MILLAR (527), AMANDA COULTER (694), SHARON PERRY (155)
Inspection No. / No de l'inspection :	2018_742527_0013
Log No. / No de registre :	034889-16, 022679-17, 023836-17, 025059-17, 001193-18, 001880-18, 002348-18, 002642-18, 003097-18, 008454-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 28, 2018
Licensee / Titulaire de permis :	2063412 Ontario Limited as General Partner of 2063412 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Creedan Valley Care Community 143 Mary Street, CREEMORE, ON, L0M-1G0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Paula Rentner

To 2063412 Ontario Limited as General Partner of 2063412 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s.19 (1) of the LTCHA.

Specifically the licensee must:

a) Ensure residents #002, #003, #004 and any other residents are protected from sexual abuse by resident #001.

b) Develop and implement a written, weekly audit to be conducted over the next three months to ensure monitoring and documentation as per the plan of care for resident #001.

Grounds / Motifs :

1. The licensee failed to ensure that all residents were protected from abuse by anyone and free from neglect by the licensee or staff.

The critical incident reports submitted to the Director on specific dates in early 2018, indicated that there were incidents of alleged sexual abuse that occurred on these dates, by resident #001 towards residents #002, #003 and #004.

The clinical record and the investigation notes were reviewed for resident #001 and #002, which indicated that on a specific date and times, resident #001 had inappropriately touched resident #002, two to three times. Resident #002 was able to accurately describe the resident and the incident.

On a specific date and time, resident #001 had inappropriately touched resident #003. The home had documented in the critical incident system report that one of the actions they implemented was one to one monitoring of resident #001.

Based on the clinical record review and a review of the home's one to one information, one to one was not implemented at this time.

At a later date in 2018, resident #001 was found at the nursing station. Resident #001 had inappropriately touched resident #004. The home implemented one to one monitoring for resident #001, after this incident.

Resident #001 had three incidents of sexually abusing residents within a two week period.

The DOC was interviewed and confirmed that the home made a referral to the Behavioural Support Services Team (BSST) and the Psycho-Geriatrician. The BSST did not consult with the home, until approximately four weeks after the referral was initiated. The BSST recommended trial behavioural strategies; however the documentation related to resident #001's sexually inappropriate behaviours were inconsistently documented and there was no analysis to identify trends or patterns, which would assist in determining triggers and/or interventions to be implemented to manage the resident's responsive behaviours.

Resident #001 was assessed by the Psycho-Geriatrician who made recommendations to manage the resident's sexually inappropriate behaviours.

One to one staff member #105, #017, #117, #130 and #133, were not aware of all the responsive behaviour strategies that were implemented when the resident was exhibiting sexually inappropriate behaviours.

Resident #001 had on one to one monitoring and the resident was observed numerous occasions during this inspection and was not being monitored by the one to one staff member assigned.

The DOC indicated that as a result of the second incident with resident #003, the home had planned to implement one to one monitoring related to resident #001's high risk sexual behaviours; however it was not implemented until several days after the third incident. The DOC acknowledged the inconsistencies in the implementation of the strategies to manage the resident's sexual responsive behaviours.

The licensee failed to ensure that all residents were protected from abuse by

anyone and free from neglect by the licensee or staff.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #001193-18; log #001880-18; and log #002348-18.

The severity of this issue was determined to be a level 2 as there was potential for harm to residents. The scope of the issue was a level 3 as it related to three of three residents reviewed. The home had a level 4 history of on-going non-compliance with this section of the Act that included:
- Written notification (WN) and a Voluntary Plan of Correction (VPC) issued September 11, 2015, (2015_334565_0019) and August 15, 2017, (2017_1231171_007)
(527)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 07, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(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).

Order / Ordre :

The licensee must be compliant with s.53 (4) (b).

Specifically the licensee must:

a) Ensure that staff providing one to one monitoring and staff that provide direct care to resident #001, implement the responsive behaviour plan of care and document the strategies implemented and the effectiveness of the responsive behaviour strategies.

b) Ensure that staff providing one to one monitoring and staff that provide direct care to resident #001, receive training on the resident's responsive behaviour plan of care; one to one monitoring and documentation expectations. This includes written documentation of the staff trained and the training content provided to direct care providers.

Grounds / Motifs :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, (c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Resident #001 had a history of responsive behaviours related to resisting care

and sexually inappropriate behaviours. The sexual behaviours exhibited by resident #001 on specific dates in early 2018, involved three residents. The three residents were sexually abused by resident #001.

The clinical record was reviewed, which revealed that the Dementia Observation System (DOS) was initiated on as specific date in 2018, after the first incident of sexually inappropriate behaviours by resident #001. The DOS charting was reviewed for a five month period in 2018, which identified inconsistent charting of the resident's behaviours and responses to the interventions.

The A-B-C charting documentation of the resident's sexually inappropriate behaviours over a four week period in 2018 was reviewed. This documentation, was not implemented until four months after the first incident. The A-B-C charting identified inconsistencies in the documentation, what interventions were implemented and the resident's response to the interventions.

Review of the Behavioural Support System Team (BSST) notes on a specific date in 2018, identified that RN #134 attended the home to go over the assessments that the behaviour support specialist requested the home staff to complete. The assessments were not completed by the staff, therefore no documentation related to these assessments were located on the resident's clinical record.

The licensee's policy titled "Responsive Behaviours - Management", directed registered staff to conduct and document behavioural assessments and the resident's responses to the interventions when experiencing responsive behaviours

The DOC was interviewed and acknowledged that the staff were inconsistently documenting and this was an ongoing issue. The DOC also stated that registered staff did not complete the Physical, Intellectual, Emotional, Capabilities, Environment and Social (PIECES) and/or Understanding, Flagging, Interaction, Reflection and Reporting, Support, Team (U-First) assessments, which was expected and did not document the assessments requested by the behavioural support specialist.

The licensee failed to ensure that, for resident #001, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were

documented.

This area of non-compliance was identified during Critical Incident System (CIS) Inspections log #001193-18, log #001880-18, and log #002348-18.

The licensee failed to ensure that, for resident #001, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

This area of non-compliance was identified during Critical Incident System (CIS) Inspections log #001193-18, log #001880-18, and log #002348-18.

The severity of this issue was determined to be a level 2 as there was potential for harm to residents. The scope of the issue was a level 3 as it related to four of five residents reviewed. The home had a level 2 history of on-going non-compliance with this section of the Act that included:
- A Written Notification (WN) and Compliance Order (C) issued January 16, 2017 (2017_414110_0002) related to Responsive Behaviours (s. 54 (b).
- Written Notification (WN) and Voluntary Plan of Correction (VPC) January 16, 2017 (2017_414110_0002) related to Responsive Behaviours (s. 55).
- Written Notification (WN) and Voluntary Plan of Correction (VPC) issued September 11, 2015, (2015_334565_0019) related to Responsive Behaviours (s. 54 (b).

(527)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 07, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 28th day of August, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector /
Nom de l'inspecteur : Kathleen Millar

Service Area Office /
Bureau régional de services : Central West Service Area Office