Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District
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Telephone: (800) 663-3775

Original Public Report

Report Issue Date: July 16, 2024
Inspection Number: 2024-1137-0002
Inspection Type: Critical Incident
Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.
Long Term Care Home and City: Secord Trails Community, Ingersoll

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):
June 10, 11, 12, 13, 14, and 17, 2024

The following intake(s) were inspected:

- Intake #00111916 [2628-000009-24] related to prevention of sexual abuse.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the

licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 115 (5) 2. ii.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
ii. names of any staff members or other persons who were present at or discovered the incident, and

The licensee failed to make a report in writing to the Director within 10 days of becoming aware of the incident, including names of any staff members or other persons who were present at or discovered the incident.

Rationale and Summary
A Critical Incident (CI) documented the names of the home staff responding to the incident as "RPN, RN and PSW staff". The names of the individual staff members who were present or discovered the incident were missing from the report.

The Director of Care verified the reporting requirement included the names of the staff and updated the CI for the "Name of home staff responding to incident" to include the names of the staff.

Sources: CI report and staff interview.
[563]

Date Remedy Implemented: June 17, 2024

WRITTEN NOTIFICATION: Responsive Behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(b) strategies are developed and implemented to respond to these behaviours, where possible;

The licensee failed to ensure that for a resident demonstrating responsive behaviours, strategies were developed and implemented to respond to those behaviours where possible.

Rationale and Summary

The Point of Care (POC) behaviour documentation and Resident Assessment Instrument Minimum Data Set (RAI-MDS) completed for the resident identified multiple episodes of behaviours.

Personal Support Workers (PSW) documented "Alert" progress notes from POC that identified threatening behaviours with no other documentation as part of the progress notes to identify what specific behaviour was exhibited.

A PSW stated the resident exhibited behaviours during care, and required an intervention that was proven effective in the resident accepting care. The care plan had no strategies developed to respond to the behaviour when they were demonstrating responsive behaviours. Staff and the resident were at risk for harm

and/or injury.

The Director of Care (DOC) verified the resident was identified with behaviours with no specific strategies developed to respond to those responsive behaviours. The DOC verified there was risk when the registered staff were not alerted to consider sending a BSO referral for assessment, and to review of the care plan to ensure the interventions were effective and current.

For the resident demonstrating behaviours, strategies were not developed to respond to these behaviours putting the resident and their care givers at risk for harm and injury.

Sources: clinical record review, policies and staff interviews.
[563]

COMPLIANCE ORDER CO #001 Reporting Certain Matters to Director

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:

The Licensee has failed to comply with FLTCA, 2021, s. 28 (1) 2

Specifically, the licensee must:

a) Ensure all registered nursing staff receive training/education related to FLTCA s. 28 (1) 2 where "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: 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." Specifically, any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by another resident, grounds to suspect that sexual abuse may occur, and of risk of harm.

b) A documented record must be maintained of this training, including the date the training was provided, content covered as part of the training, who provided the training, and who attended the training.

c) Complete a documented assessment of those residents using the Lichtenberg Tool for Assessing Sexual Capacity to Consent and using the Mini Mental State Exam (MMSE).

d) Complete a documented assessment of those residents using the "Decision Tree for Assessing Competency to Participate in an Intimate Relationship".

e) Upon observation of the residents with expressive behaviours, staff are to intervene immediately, unless residents have been assessed and deemed capable to consent.

f) For any incident of alleged non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards residents that resulted in harm, or a risk of harm must be reported to the Director of the Ministry of Long-Term Care.

Grounds

A) The licensee failed to ensure that the abuse of a resident by a resident was immediately reported to the Director.

Rationale and Summary
A Critical Incident (CI) report was submitted to Director of Ministry of Long-Term Care (MLTC) related to alleged abuse of a resident by a resident.

The Director of Care (DOC) acknowledged the home did not immediately report the incident of resident to resident abuse to Director of the MLTC. Late reporting to the Director did not impact the residents.

B) The licensee failed to ensure that the suspected sexual abuse of multiple residents by resident #001 was immediately reported to the Director.

Rationale and Summary
There was another CI report related to abuse of a resident by a resident. However, review of the progress notes also identified there was reasonable grounds to suspect the resident was abusing other residents and the DOC verified those incidents were not reported to the Director of the MLTC.

The DOC explained the incidents that occurred and were not reported to the MLTC through the CI reporting system and should have been. The DOC stated the home concentrated on the follow up involving the two residents only.

The residents' capacity to consent to an intimate relationship was not assessed, and staff did not report the incidents that resulted in risk of harm, placing vulnerable residents at potential risk of abuse.

There was an increased risk to residents when the home failed to report the suspicion of abuse of a resident by a resident that resulted in risk of harm to the resident. Reporting to the MLTC would have served to protect the residents.

Sources: residents' clinical records, and staff interviews.
[563]

This order must be complied with by August 23, 2024

COMPLIANCE ORDER CO #002 Training

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 82 (7) 1.
Training
s. 82 (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The Licensee has failed to comply with FLTCA, 2021, s. 82 (7) 1.
Specifically, the licensee must:
a) Review the home's policy related to Sexual Expression & Intimacy and all evidence based clinical assessment tools used by the home. Ensure a description and explanation of the Cognitive Performance Scale scores to determine a resident's cognition and ability to consent is included as part of the policy related to Sexual Expression & Intimacy. Ensure at least one member of the nursing management team, one member of the registered nursing staff and one member of the Personal Support Workers participate in the review. A documented record of the

review and/or revision as required, the date of the review, the changes made if any, and who participated must be maintained.
b) Ensure the policy related to Sexual Expression & Intimacy is included as part of the abuse and neglect annual education/training for all staff.
c) Ensure all nursing team members have access to the resources available to determine a resident's cognition and ability to consent to sexual intimacy.

Grounds
The licensee failed to ensure that all staff who provide direct care to residents received abuse recognition and prevention training annually as a condition of continuing to have contact with residents.

Fixing Long-Term Care Act 2021, s. 82 (1) where, "Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section."

Ontario Regulation 246/22, s. 261 (2) where, "The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 82 (7) of the Act" subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 82 (7) of the Act."

Rationale and Summary
There was a Critical Incident (CI) report related to abuse of a resident by a resident. At that time, education was provided to the registered nursing staff present at the time of the incident.

The Sexual Expression & Intimacy policy directed the Executive Director or designate to ensure team members participated in education about sexual expression and intimacy, their roles and responsibilities, and how to access current

resources, and ensure immediate reporting to health authorities using the required document for any suspected, actual, or alleged incidents of sexual abuse. The Director of Care or designate was to ensure the utilization of evidence based clinical assessment tools to distinguish between capable consenting sexual expression and responsive behaviours related to sexual expression.

Ontario Regulation 246/22, s. 2 (1), sexual abuse means 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.

The DOC stated there was education on hire related to abuse, but not the policy related to sexual expression and intimacy. The DOC verified this was the first time staff had received education related to sexuality and the capacity to consent. The DOC stated the prevention of nonconsensual sexual touching and the resident's capacity to consent were not a part of the training provided on hire or annually. The annual abuse education did not provide for sexual abuse recognition, did not train staff to use the tool used by the home to assess capacity or how to interpret CPS scores to determine capacity.

The Executive Director/Administrator was to ensure team members participated in education about sexual expression and intimacy. Residents were at risk for sexual abuse when the nursing staff were not trained on the tools for assessing sexual capacity to consent or how to interpret CPS scores to determine capacity. Staff need to be able to recognize sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident, and when staff do not have the training to assess a residents' capacity to consent, residents were at risk for abuse and exploitation.

Sources: policy and assessment review; and staff interviews.

[563]

This order must be complied with by August 23, 2024

COMPLIANCE ORDER CO #003 Altercations and Other Interactions Between Residents

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 59
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The Licensee has failed to comply with O. Reg. 246/22, s. 59.
Specifically, the licensee must:
a) Review the home's policies related to responsive behaviour management and all associated tools and assessments and revise as needed. Ensure at least one member of the nursing management team, one member of the registered nursing staff and one member of the Personal Support Worker participate in the review. A

documented record of the review and/or revision, the date of the review, the changes made if any, and who participated must be maintained.
b) Complete a documented interdisciplinary assessment of those residents based on the requirements outlined in the home's responsive behaviour program/policies.
c) Ensure the care plan related to responsive behaviour management for those residents identifies potentially harmful interactions between and among residents, including identifying factors based on an interdisciplinary assessment or through observation that could potentially trigger such altercations, and identifying and documenting interventions to prevent sexually inappropriate interactions.

Grounds
The Licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations, and identifying and implementing interventions.

Rationale and Summary
There was a Critical Incident (CI) report related to abuse of a resident by a resident. The Sexual Expression & Intimacy policy explained a procedure the staff were to follow where the nurse upon becoming aware of a resident observation of unwanted sexual expression, or there was evidence of distress or injury noted and/or inappropriate for the surrounding environment, they were to immediately intervene to ensure the safety of resident(s), assess the resident(s) using the designated tool to assess capacity to consent.

The Director of Care (DOC) verified the staff use the CPS to interpret the cognitive status of a resident and if the staff were in doubt would they need to separate and figure out what next steps needed to be taken. The DOC acknowledged a plan of

care for all residents to identify their capacity to consent to sexual interactions based on an assessment would help to alleviate doubt and protect residents from sexual abuse.

The home had a resource titled, "Decision Tree for Assessing Competency to Participate in an Intimate Relationship" that stated, "Use the decision tree below after completing the full assessment" and the DOC verified the full assessment was the MMSE. The DOC stated the identified residents did not have the ability to avoid exploitation, had no awareness of risk, did not have the appreciation for the consequences related to a sexual interaction with another resident, could not state the level of intimacy they were comfortable with, and they did not have the ability to set limits, or have their wishes respected. Both residents were unable to consent.

The "Lichtenberg Tool for Assessing Sexual Capacity to Consent" and a "Decision Tree for Assessing Competency to Participate in an Intimate Relationship" was not completed for those residents. The residents' capacity to consent to an intimate relationship was not assessed putting potentially vulnerable residents at risk of abuse.

The DOC stated the decision tree would need to be completed and was not for the residents, therefore the home could not use the outcome of the decision tree and the information provided to identify risk and to implement interventions. The decision tool identified risk and it was the home's duty to protect the residents based on an assessment and the residents' capacity to consent.

The Assistant DOC (ADOC) was overseeing the Responsive Behaviour program and verified they updated care plans related to responsive behaviour interventions based on documentation in the progress notes, POC and the Dementia Observational System (DOS). The care plans for the residents should identify specific

interventions to minimize the risk of altercations. The ADOC verified that the potential issues should be specifically identified so that care providers could recognize those potential issues and intervene appropriately. The ADOC also verified the care plan did not identify what triggered the inappropriate behaviour and the interventions did not provide clear direction to staff who must respond to the behaviour.

The Director of Care verified to minimize the risk of altercations and potentially harmful interactions between and among residents, the care plan should have identifying factors and potential triggers related to the inappropriate behaviours for the residents with specific interventions identified to keep residents safe. The DOC stated assessments were not completed at the time of the incident and the care plans were not updated based on the observed behaviours, altercations and potentially harmful interactions between and among residents.

Sources: clinical record review, investigation notes/education records, policies and staff interviews.
[563] [000814]

This order must be complied with by August 23, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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