Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 29, 2019	2019_505103_0017	008817-19, 008911-19, 011077-19, 011357-19, 012097-19, 012198-19, 012656-19, 012933-19, 013258-19, 013357-19	Complaint

Licensee/Titulaire de permis

Providence Care Centre
752 King Street West KINGSTON ON K7L 4X3

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

Providence Manor
275 Sydenham Street KINGSTON ON K7K 1G7

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 20, 21, 24, 25, 27, July 2-5, 8-11, 2019.

Log #008817-19 and Log #011357-19-complaints related to alleged incidents of resident abuse,
Log #008911-19 (CIS #C553-000017-19), Log #011077-19 (CIS #C553-000026-19), Log #012097-19 (CIS #C533-000032-19), Log #012198-19 (CIS #C553-000031-19), Log #012656-19 (CIS #C553-000034-19), Log #012933-19 (CIS #C553-000035-19), Log #013258-19 (CIS #C553-000019-19), Log #013357-19 (CIS #C553-000038-19)-alleged incidents of resident abuse.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), an Activity Aide, the Social Worker, the Education Coordinator, Assistant Director of Care (ADOC), Director of Care (DOC), and the Administrator.

During the course of the inspection, the inspector reviewed resident health care records, the above named critical incidents submitted by the home, made resident observations and reviewed the home's abuse policy, "Abuse and Neglect Free Environment, CARE-RC-1" revised on March 19, 2019 and abuse education/training records.

The following Inspection Protocols were used during this inspection:
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

This inspector reviewed the licensee's abuse policy, "Abuse and Neglect Free Environment, CARE-RC-1" revised on March 19, 2019.

The policy indicated:
- all personnel must promptly report any incidents of resident abuse to their immediate supervisor/manager,
-notification to the MOHLTC must occur immediately whenever there are reasonable grounds to suspect resident abuse has occurred,

-the police are immediately notified when there is a suspicion the incident may constitute a criminal offence,
-the Substitute Decision Maker (SDM) or any other person specified by the resident will be immediately notified of an alleged, suspected or witnessed incident of resident abuse or neglect that resulted in a physical injury or pain to the resident, or that caused distress to the resident that could be detrimental to the resident's health or well-being,
-the SDM will be notified within twelve hours upon Providence Manor becoming aware of any other alleged, suspected or witnessed incidents of resident abuse or neglect.

O. Regulations 79/10, s. 2 (1) defines verbal abuse as any form of verbal communication of a threatening nature that is made by anyone other than a resident.

On an identified date, a verbal altercation was overheard between a visitor and resident #003. RN #105 was interviewed and stated the staff reported the visitor had been making threats of harm toward resident #003. RN #105 stated they assessed resident #003 and the visitor had left the home. RN #105 stated they believed the incident constituted verbal abuse of a resident, but failed to report the incident to the Ministry of Long-Term Care (MLTC) immediately. RN #105 indicated they sent an email to the DOC to alert them of the incident upon their arrival to work the following morning.

DOC #104 was interviewed and stated they became aware of the incident of verbal abuse the following morning and notified both the MLTC and the police at that time.

On another identified date, a verbal altercation was witnessed by staff involving a visitor and resident #004. Activity Aide #118 witnessed the incident and stated the visitor had made a verbal threat of physical harm to resident #004. Activity Aide #118 stated staff members immediately intervened to separate the visitor from resident #004.

ADOC #103 was interviewed and stated RN #119 became aware of the incident the following day and reported the incident to them. ADOC #103 stated during the home's investigation, they discovered RN #115 had been made aware of the alleged verbal abuse at the time of the incident, but failed to immediately report the incident. ADOC #103 stated upon being made aware of the incident, a critical incident, #C553-000019-19 was submitted to the MLTC to report the alleged verbal abuse of resident #004 and the police were notified. Additionally, the substitute decision maker for resident #004 was notified of the incident for the first time approximately twenty-four hours after the incident occurred.

On another identified date, the licensee submitted CIS #C553-000038-19 to report an incident of resident verbal abuse involving resident #004. The critical incident indicated a verbal altercation was witnessed by staff involving a visitor and resident #004. DOC #104 stated staff members witnessed the visitor making verbal statements that included a verbal threat of harm toward resident #004. The incident was reported by the staff members to RN #115 at the time of the incident, but the RN failed to immediately report the incident. DOC #104 indicated they became aware of the incident the next day during morning report and notified the MLTC and the police of the incident at that time.

O. Regulation 79/10, s. 2 (1) defines sexual abuse as any non-consensual touching of a sexual nature directed towards a resident by a person other than the licensee or staff member.

The licensee submitted a critical incident, #C553-000031-19, on an identified date to report a witnessed incident of resident to resident sexual abuse involving residents #004 and #005. PSW #114 witnessed the incident and was interviewed. PSW #114 stated they saw resident #004 touching resident #005 in an inappropriate sexual manner. Both residents were reported to have been sitting in the area of the nursing station and according to PSW #114, resident #005 appeared to be asleep. PSW #114 indicated they called for another PSW to assist them and both residents were separated. PSW #114 stated they then reported the incident to RN #102.

RN #102 was interviewed and stated they recalled being notified of the alleged incident of sexual abuse involving residents #004 and #005. RN #102 indicated they were aware this incident required immediately reporting, however RN #102 stated they became busy and forgot to report the incident until the following day.

DOC #104 indicated the MLTC and the police were notified of the alleged incident of sexual abuse for the first time by means of the critical incident that was submitted the following day. The substitute decision makers for residents #004 and #005 were notified of the incident for the first time approximately twenty-four hours following the incident.

O. Regulations 79/10, s. 2 (1) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

On an identified date, RPN #112 was advised by a PSW of an alleged incident of physical abuse involving residents #001 and #002. RPN #112 was interviewed and stated resident #001 reported another resident had entered their room and struck them.

During RPN #112's assessment of resident #001, they noted discolouration on an identified area of resident #001. Additionally, RPN #112 stated resident #001 indicated they were upset and fearful resident #002 would return and hurt them again. RPN #112 stated they notified RN #111 of the alleged incident of abuse and took actions to safeguard the resident.

RN #111 was interviewed and stated they assessed both resident #001 and #002 for injuries and noted resident #001 had a small laceration on an identified area. RN #111 stated the SDM was not notified at that time because of the lateness of the incident, the injury was minor and the resident did not require transfer to a hospital. RN #111 stated they directed the staff to call both SDM's in the morning.

The licensee has failed to ensure the written policy to promote zero tolerance of abuse of residents was complied with in regards to the notifications to the MLTC, the police and the SDM's of the alleged, suspected and witnessed incidents of resident abuse. [s. 20. (1)]

2. The licensee has failed to ensure, at a minimum, the policy to promote zero tolerance of abuse and neglect of residents provided that abuse and neglect are not to be tolerated and contained an explanation of the duty under section 24 to make mandatory reports.

This inspector reviewed the licensee's abuse policy, "Abuse and Neglect Free Environment, CARE-RC-1" revised on March 19, 2019 and was unable to find the statements within the policy that stated abuse and neglect are not to be tolerated or the explanation under s. 24 of the LTCHA of the duty to make mandatory reports.

Discussion was held with both DOC #104 and the Administrator who confirmed the statements were not outlined in the current version of the license's abuse policy. DOC #104 indicated the information was contained within related policies but not within the home's abuse policy. [s. 20. (2)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #001's substitute decision maker (SDM) was given the opportunity to participate fully in the development of resident #001's plan of care.

Resident #001's medication record and progress notes were reviewed. They indicated on an identified date, RN #109 obtained a telephone order to discontinue an identified medication and to initiate another identified medication.

RN #109 was interviewed and stated resident #001 had been assessed by geriatric psychiatry and their recommendations had been received in regards to resident #001's medications. RN #109 stated they contacted the on-call Medical Resident and received a telephone order to make the medication changes as outlined in the recommendations. RN #109 indicated they did not contact resident #001's SDM in regards to the medication changes and they did not have any discussion with the on-call Medical Resident in regards to obtaining SDM consent for the medication changes.

On an identified date, resident #001 had been noted by staff to have a decline in their ability to transfer and ambulate and a physiotherapy consult was initiated. Additionally, resident #001's Medical Resident discovered the changes that had been made to resident #001's medications. Following discussion with resident #001's SDM, orders were written at that time to resume the medication regime for resident #001 that had previously been in place.

DOC #104 was interviewed and indicated it is the home's expectation that all medication changes are discussed with the SDM's prior to any changes being made to ensure they have a full understanding of the changes and to participate in the development of the resident plan of care. [s. 6. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure resident #001's SDM is given the opportunity to participate fully in the development and implementation of resident #001's plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. A person who had reasonable grounds to suspect incidents of abuse had occurred involving residents #003, #004 and #005, failed to immediately report the suspicion and the information upon which it was based to the Director.

As outlined in WN #1, on an identified date, a verbal altercation was overheard between a visitor and resident #003. RN #105 was notified of the incident at the time of the alleged verbal abuse but failed to immediately notify the MLTC.

As outlined in WN #1, on another identified date, a verbal altercation was witnessed by staff involving a visitor and resident #004. RN #115 had been made aware of the alleged verbal abuse at the time of the incident, but failed to immediately report the incident to the MLTC.

As outlined in WN #1, on an identified date, staff witnessed an incident of verbal abuse involving a visitor and resident #004. The incident was reported to RN #115 at the time of the incident, but RN #115 failed to immediately report the incident to the MLTC. [s. 24. (1)]

2. As outlined in WN #1, on an identified date, PSW #114 witnessed an alleged incident of resident to resident sexual abuse involving residents #004 and #005. PSW #114 indicated they reported the incident to RN #102 after safe guarding the resident. RN #102 failed to report the incident to the MLTC until the following day. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure the written policy to promote zero tolerance of abuse and neglect of residents identified training and retraining requirements for all staff including training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care.

This inspector reviewed the licensee's abuse policy, "Abuse and Neglect Free Environment, CARE-RC-1" revised on March 19, 2019. Discussion was held with both DOC #104 and the Administrator who confirmed the training and retraining requirements were not outlined in the current version of the abuse policy as required by the legislation. [s. 96. (e)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure resident #001's substitute decision maker was immediately notified of an alleged incident of resident abuse that resulted in a physical injury and that caused distress to resident #001.

As outlined in WN #1, on an identified date, RPN #112 was advised by a PSW of an alleged incident of physical abuse involving residents #001 and #002 that resulted in an injury to resident #001. RN #111 was made aware of the alleged incident of abuse at the time of the incident, but failed to immediately notify the SDM's for residents #001 and #002 until the following morning. [s. 97. (1) (a)]

2. The licensee has failed to ensure the substitute decision maker was notified within twelve hours of witnessed incidents of resident abuse involving residents #004 and #005.

As outlined above in WN #1, PSW #114 witnessed resident #004 touching resident #005 in a sexual manner on an identified date. The substitute decision makers for residents #004 and #005 were notified of the incident approximately twenty-four hours following the incident.

As outlined in WN #1, Activity Aide #118 witnessed a visitor making a verbal threat of harm toward resident #004 on an identified date. The substitute decision maker for resident #004 was notified of the incident for the first time approximately twenty-four hours after the incident. [s. 97. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to ensure the appropriate police force were immediately notified of incidents of resident abuse that may have constituted a criminal offence.

As outlined in WN #1, a verbal altercation involving a visitor and resident #003 occurred on an identified date. The police were notified of the incident of alleged verbal abuse for the first time the following morning.

As outlined in WN #1, an alleged incident of verbal abuse occurred on an identified date between a visitor to the home and resident #004. The alleged verbal abuse was reported to the police for the first time the following day.

As outlined in WN #1, PSW #114 witnessed resident #004 touching resident #005 in a sexual manner on an identified date.The incident was reported to the police for the first time the following day.

As outlined in WN #1, an alleged incident of verbal abuse occurred on an identified date between a visitor to the home and resident #004. The alleged verbal abuse was reported to the police for the first time the following day. [s. 98.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the date and time of an alleged incident of abuse was included in making a report to the Director.

As outlined in WN #1, an alleged incident of verbal abuse involving a visitor and resident #003 occurred on an identified date. A critical incident, #C553-000017-19 was submitted to the MLTC the following day and indicated the alleged verbal abuse occurred on the incorrect date.

An alleged incident of physical abuse involving resident #006 and #007 occurred on an identified date. A critical incident, #C553-000025-19 was submitted to the MLTC and indicated the alleged physical abuse occurred on an incorrect identified date. [s. 104. (1) 1.]

Issued on this 31st day of July, 2019

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARLENE MURPHY (103)
Inspection No. / No de l'inspection :	2019_505103_0017
Log No. / No de registre :	008817-19, 008911-19, 011077-19, 011357-19, 012097-19, 012198-19, 012656-19, 012933-19, 013258-19, 013357-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 29, 2019
Licensee / Titulaire de permis :	Providence Care Centre 752 King Street West, KINGSTON, ON, K7L-4X3
LTC Home / Foyer de SLD :	Providence Manor 275 Sydenham Street, KINGSTON, ON, K7K-1G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kyle Cotton

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Providence Care Centre, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 20 (1) of the LTCHA.

Specifically, the licensee must:

1) Provide training and education on the licensee's abuse policy, "Abuse and Neglect Free Environment, CARE-RC-1" revised March 19, 2019 with an emphasis on mandatory reporting to MLTC, police and SDM's, and use of the decision trees to support decision making to: RN #105, RN #115, RN #102, and RN #111. Ensure there is written documentation to support the completion of this training and education.

2) Ensure all remaining staff receive annual abuse training/education for 2019 prior to September 30, 2019 ensuring mandatory reporting is included. Ensure there is written documentation to support the completion of this training and education.

3) Develop and implement a written strategy in regards to actions that will be taken when staff fail to comply with the licensee's abuse policy. Identify the person(s) who will be responsible for auditing, monitoring compliance and taking corrective action.

4) Communicate the written strategy to all staff.

Grounds / Motifs :

1. The licensee has failed to ensure the written policy to promote zero tolerance

of abuse and neglect of residents was complied with.

This inspector reviewed the licensee's abuse policy, "Abuse and Neglect Free Environment, CARE-RC-1" revised on March 19, 2019.

The policy indicated:
- all personnel must promptly report any incidents of resident abuse to their immediate supervisor/manager,
-notification to the MOHLTC must occur immediately whenever there are reasonable grounds to suspect resident abuse has occurred,
-the police are immediately notified when there is a suspicion the incident may constitute a criminal offence,
-the Substitute Decision Maker (SDM) or any other person specified by the resident will be immediately notified of an alleged, suspected or witnessed incident of resident abuse or neglect that resulted in a physical injury or pain to the resident, or that caused distress to the resident that could be detrimental to the resident's health or well-being,
-the SDM will be notified within twelve hours upon Providence Manor becoming aware of any other alleged, suspected or witnessed incidents of resident abuse or neglect.

O. Regulations 79/10, s. 2 (1) defines verbal abuse as any form of verbal communication of a threatening nature that is made by anyone other than a resident.

On an identified date, a verbal altercation was overheard between a visitor and resident #003. RN #105 was interviewed and stated the staff reported the visitor had been making threats of harm toward resident #003. RN #105 stated they assessed resident #003 and the visitor had left the home. RN #105 stated they believed the incident constituted verbal abuse of a resident, but failed to report the incident to the Ministry of Long-Term Care (MLTC) immediately. RN#105 indicated they sent an email to the DOC to alert them of the incident upon their arrival to work the following morning.

DOC #104 was interviewed and stated they became aware of the incident of verbal abuse the following morning and notified both the MLTC and the police at that time.

On another identified date, a verbal altercation was witnessed by staff involving a visitor and resident #004. Activity Aide #118 witnessed the incident and stated the visitor had made a verbal threat of physical harm to resident #004. Activity Aide #118 stated staff members immediately intervened to separate the visitor from resident #004.

ADOC #103 was interviewed and stated RN #119 became aware of the incident the following day and reported the incident to them. ADOC #103 stated during the home's investigation, they discovered RN #115 had been made aware of the alleged verbal abuse at the time of the incident, but failed to immediately report the incident. ADOC #103 stated upon being made aware of the incident, a critical incident, #C553-000019-19 was submitted to the MLTC to report the alleged verbal abuse of resident #004 and the police were notified. Additionally, the substitute decision maker for resident #004 was notified of the incident for the first time approximately twenty-four hours after the incident occurred.

On another identified date, the licensee submitted CIS #C553-000038-19 to report an incident of resident verbal abuse involving resident #004. The critical incident indicated a verbal altercation was witnessed by staff involving a visitor and resident #004. DOC #104 stated staff members witnessed the visitor making verbal statements that included a verbal threat of harm toward resident #004. The incident was reported by the staff members to RN #115 at the time of the incident, but the RN failed to immediately report the incident. DOC #104 indicated they became aware of the incident the next day during morning report and notified the MLTC and the police of the incident at that time.

O. Regulation 79/10, s. 2 (1) defines sexual abuse as any non-consensual touching of a sexual nature directed towards a resident by a person other than the licensee or staff member.

The licensee submitted a critical incident, #C553-000031-19, on an identified date to report a witnessed incident of resident to resident sexual abuse involving residents #004 and #005. PSW #114 witnessed the incident and was interviewed. PSW #114 stated they saw resident #004 touching resident #005 in an inappropriate sexual manner. Both residents were reported to have been sitting in the area of the nursing station and according to PSW #114, resident

#005 appeared to be asleep. PSW #114 indicated they called for another PSW to assist them and both residents were separated. PSW #114 stated they then reported the incident to RN #102.

RN #102 was interviewed and stated they recalled being notified of the alleged incident of sexual abuse involving residents #004 and #005. RN #102 indicated they were aware this incident required immediately reporting, however RN #102 stated they became busy and forgot to report the incident until the following day.

DOC #104 indicated the MLTC and the police were notified of the alleged incident of sexual abuse for the first time by means of the critical incident that was submitted the following day. The substitute decision makers for residents #004 and #005 were notified of the incident for the first time approximately twenty-four hours following the incident.

O. Regulations 79/10, s. 2 (1) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

On an identified date, RPN #112 was advised by a PSW of an alleged incident of physical abuse involving residents #001 and #002. RPN #112 was interviewed and stated resident #001 reported another resident had entered their room and struck them. During RPN #112's assessment of resident #001, they noted discolouration on an identified area of resident #001. Additionally, RPN #112 stated resident #001 indicated they were upset and fearful resident #002 would return and hurt them again. RPN #112 stated they notified RN #111 of the alleged incident of abuse and took actions to safeguard the resident.

RN #111 was interviewed and stated they assessed both resident #001 and #002 for injuries and noted resident #001 had a small laceration on an identified area. RN #111 stated the SDM was not notified at that time because of the lateness of the incident, the injury was minor and the resident did not require transfer to a hospital. RN #111 stated they directed the staff to call both SDM's in the morning.

The licensee has failed to ensure the written policy to promote zero tolerance of abuse of residents was complied with in regards to the notifications to the MLTC, the police and the SDM's of the alleged, suspected and witnessed incidents of

resident abuse. [s. 20. (1)]

The decision to issue this non-compliance as a Compliance Order (CO) was based on the following:
The severity of these non-compliances was determined to be minimal harm and minimal risk to residents #001, #003, #004 and #005.
The scope of the non-compliance was determined to be widespread as it related to 5/8 incidents of abuse related reports reviewed.
The licensee had a compliance history of ongoing non-compliance with this section of the Act as follows:
Written Notification (WN) and Voluntary Plan of Correction (VPC) issued February 23, 2017 (2017_520622_0001), and
WN and VPC issued November 22, 2017 (2017_520622_0041),
Additionally, the licensee had a compliance history of ongoing non-compliance with the following related sections:
LTCHA, s. 24 and O. Reg s. 98 -WN and VPC issued July 17, 2017 (2017_505103_0026),
LTCHA, s. 24 and O. Reg. s. 98-WN and VPC issued October 6, 2017 (2017_520622_0032),
LTCHA, s. 24 and O. Reg. s. 98-WN and VPC issued November 22, 2017 (2017_520622_0041),
LTCHA, s. 24 and O. Reg. s. 98-WN and CO issued October 12, 2018 (2018_505103_0024),
LTCHA, s. 24-WN issued January 2, 2019 (2018_505103_0035).

(103)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 04, 2019

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

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 29th day of July, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DARLENE MURPHY

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