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 # / Registre no	Type of Inspection / Genre d'inspection
Sep 28, Nov 16, 2016	2016_321501_0019	028951-16, 029182-16	Complaint

Licensee/Titulaire de permis

ATK CARE INC.
1386 INDIAN GROVE MISSISSAUGA ON L5H 2S6

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

RIVER GLEN HAVEN NURSING HOME
160 High Street P.O. Box 368 Sutton West ON L0E 1R0

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

SUSAN SEMEREDY (501), GORDANA KRSTEVSKA (600)

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): September 28, 29, 30, October 3, 4, 5, 6, 7, 11 and 12, 2016.

Intakes inspected included:
#028951-16 complaint related to duty to protect
#028907-16 CIS related to duty to protect
#029182-16 complaint related to reporting and complaints, safe and secure home
#029370-16 CIS related to duty to protect
#029245-16 CIS related to duty to protect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Recreation Director, Environmental Services Manager, Psychogeriatrian Consultant/Educator, Behaviour Support Ontario provider, pharmacy consultant, physician, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), housekeeper, substitute decision makers (SDMs), and residents.

During the course of the inspection, the inspectors conducted observations in home and resident areas, observation of care delivery processes, and review of the home's policies and procedures, residents' health records and staff personnel files.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #901	2016_321501_0019	501

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to protect resident #002 and six other residents from abuse.

On an identified date, an anonymous call was received by the Ministry of Health and Long Term Care (MOHLTC) ACTION Line indicating a resident was touching residents of the opposite sex in an inappropriate manner.

On an identified date, Registered Nurse (RN) #103 called the MOHLTC ACTION Line and made a report indicating resident #001 was abusing other residents. Resident #001 had been in the home since an identified date, and had allegedly been inappropriately touching residents of the opposite sex since one month following his/her admission.

A search of the CIS (Critical Incident System) revealed the only CIS submitted for this incident was on the same date RN #103 called. The CIS revealed that there have been at least 27 separate incidents of abuse of at least five residents by resident #001 since an identified month. The report indicated resident #001 was inappropriately touching residents of the opposite sex. At least one of the residents expressed fear according to the CIS.

Staff members #100 and #101 told the inspector that there were a total of seven residents identified so far. Both staff told the inspector that this behaviour had been going on for quite a while. One staff member told the inspector that management was not doing anything to stop the abuse and both indicated resident #001 sought out unsupervised residents when he/she believed that the staff were distracted by activities on the care unit.

The Administrator told the inspector that they had not taken resident #001 seriously and confirmed they have not notified the police at the time of the interview. The Administrator

also agreed with the inspector that this constitutes abuse and told the inspector that he/she was planning to contact the police. There were no interventions in place to protect the affected residents from resident #001 until after the Registered Nurse (RN) called the MOHLTC ACTION Line on an identified date.

Based on the scope of seven residents and the severity of the action of resident #001 and the inaction by the licensee, an immediate order was served. [s. 19. (1)]

2. The licensee has failed to protect seven residents from an identified type of abuse.

One type of abuse as outlined in section 2.(1) of the Regulation (O.Reg.79/10) means any non-consensual touching, behaviour or remarks of an identified nature or identified exploitation directed towards a resident by a person other than a license or staff member.

Review of a Critical Incident Report submitted on an identified date, revealed resident #001 was discovered by a staff member to be standing beside resident #005's wheelchair and was behaving inappropriately.

Review of resident #001's progress notes revealed this was not the first time he/she had touched other residents of the opposite sex. Other incidents included were documented as having occurred on identified dates and times:

1. Resident #001 found in resident #008's room, in bed with resident.
2. Resident #001 was following residents of the opposite sex down the hallway and was noted to guide three identified co-residents into his/her room.
3. Resident #001 found in hallway behaving inappropriately with another unidentified resident.
4. PSW reported finding resident #001 with identified co-resident in room behaving inappropriately.
5. Resident #001 moved down to another floor this evening. Shortly after arriving, resident was found in the lounge behaving inappropriately with resident #004.
6. PSW witnessed resident #001 grab onto resident #002's hand. Shortly after resident #001 grabbed onto resident #004's hand and was walking up the hallway looking into rooms.
7. Resident #001 continues to act inappropriately with resident #007.
8. Resident #001 was walking up and down the hall, resident acted inappropriately with resident #006 and was grabbing resident #004.

9. Resident #001 was acting inappropriately with resident #002 who stated "I am scared."
10. Resident #001 acted inappropriately with another resident which scared that resident and made him/her anxious.
11. Resident #001 trying to get into resident #007's room and was acting inappropriately with resident #004.
12. Resident #001 trying to act inappropriately with resident #004 and was trying to act inappropriately with other residents of the opposite sex on the home area.
13. Resident #001 was sitting on the couch in the lounge beside an unidentified co-resident, acting inappropriately.
14. Staff reported that resident #001 was observed adjusting his/her clothes while leaving the front lounge. Staff entered the front lounge while resident #001 exited and observed resident #004 sitting on the couch partially unclothed.
15. Resident #001 was sitting with resident #007 on the couch. Resident #001 was trying to act inappropriately with resident #007.
16. Previous shift RN reported to writer that resident #001 was acting inappropriately with resident #004 in the front lounge.
17. Resident #001 observed acting inappropriately with resident #007.
18. PSW reported that resident #001 acted inappropriately with resident #004.
19. Resident #001 went into resident #004's room and was acting inappropriately.
20. Resident #001 was seen by PSW in resident #003's room acting inappropriately.
21. Resident #001 observed by writer to be in resident #002's room acting inappropriately.
22. Resident #001 was observed wandering into resident #002 and #007's rooms. Resident #001 was observed acting inappropriately with resident #002.
23. Resident #001 was found in the front lounge with resident #004 and was acting inappropriately. PSW reported resident #001 was trying to wheel another resident from a different floor to his/her room.
24. PSW reported to writer that resident #001 was witnessed acting inappropriately with resident #002. Resident #002 yelled at resident #001 to "get out."
25. Resident #001 was acting inappropriately with resident #006 in the lounge.
26. Resident #001 observed walking into resident #003's room and grabbing his/her hand. Resident #001 also observed acting inappropriately with resident #003.
27. Another resident reported to the staff that resident #001 acts inappropriately with resident #007 every night.
28. Resident #001 was standing in the hallway acting inappropriately with resident #004. Writer intervened and resident #001 yelled at writer and showed his/her fist against writer's face and made threatening comments. RN filled in a referral for BSO and left a message with the POA and also started the behavioural monitoring on resident.

29. Resident #001 acting inappropriately with resident #007 after dinner. Resident #001 was entering into other resident rooms and taking off yellow wander strips.
30. Resident #001 was trying to act inappropriately with resident #006 when he/she was sitting in the dining room. Another identified resident complained that resident #001 walks in his/her room very often and he/she does not like that.
31. Resident #001 witnessed by PSW to act inappropriately with resident #003.
32. Resident #001 was noted acting inappropriately with resident #003.
33. Resident #001 was walking in the halls, when another resident was also walking in the halls and a PSW noticed them engaged in inappropriate behaviour.
34. Resident #001 was noted in resident #002's room standing by his/her chair where he/she was sitting. Resident #001 was touching him/her inappropriately. Resident #002 was smiling and looking at resident #001.
35. Reported to writer by PSW that resident #001 was inappropriately touching an unidentified resident.
36. Resident #001 was standing at the door of resident #002 who was in front of him/her with an opened piece of clothing.
37. Resident #001was observed acting inappropriately with resident #002 in the front lobby while resident was already upset and looking for his/her spouse.
38. Resident #001 was entering into resident #002's room and when re-directed, came out of the room and pointed out resident #006 who was sitting in the wheelchair at the desk and asked writer "can I get him/her then?"
39. Resident #001 found by staff in resident #002's room while he/she was asleep in his/her chair acting inappropriately.

Most of the above progress notes indicated that resident #001 was successfully redirected and staff would continue to monitor.

Interview with housekeeper #101 revealed that on an identified date, he/she witnessed resident #001 looming over resident #005 in his/her wheelchair with a specific body area close to his/her face. Two PSWs were busy at the time so the housekeeper went to get RN #103 and while doing so, noticed that resident #001 was touching resident #005 inappropriately. The housekeeper redirected resident #001 who complied. The housekeeper indicated that resident #001 would sometimes become aggressive when redirected. The housekeeper then reported the incident to RN #103. The housekeeper also mentioned that he/she has reported many instances to registered staff when he/she has found resident #001 touching other residents because according to him/her and PSW #100, resident #001 seems to engage in this type of activity when he/she thinks the nursing staff are busy.

An interview with RN #103 who is a casual RN revealed he/she was first made aware of resident #001's behaviour of inappropriately touching residents of the opposite sex on an identified date, when the housekeeper reported the above mentioned incident. According to the RN, he/she spoke with the Administrator on the telephone who advised him/her to call the MOHLTC and inquire how the home could get funding for one-to-one supervision which he/she did. The RN told the inspector that he/she was surprised to read in resident #001's progress notes that this inappropriate behaviour had been going on for several months. Review of the progress notes and an Unusual Occurrence Report and interview with the RN revealed he/she also contacted both SDMs involved, contacted resident #001's physician, set up one-to-one supervision for resident #001 and assessed resident #005 who did not appear to suffer any ill effects from the encounter. The RN admitted that he/she was aware this was an allegation of abuse and needed to be reported to the MOHLTC but did not contact the police as he/she felt resident #001 could be managed by the home in the immediate future and it was up to management to make additional decisions upon their return the following day.

The inspector conducted record reviews, observations and interviews regarding the status of the seven residents which revealed the following:

Record review revealed resident #005 was admitted to the home on an identified date and a had an identified cognitive performance score (CPS) indicating severely impaired. According to a Minimum Data Set (MDS) assessment dated on an identified date, and interview with the SDM, there is a language barrier and the resident's speech is unintelligible. Observations and interviews with RN #103, PSWs #100 and #105 revealed the resident is wheelchair bound and unable to communicate. Interview with the SDM revealed he/she was informed of the incident that occurred on an identified date, on the same day by a RN. The SDM told the inspector he/she did not think resident #005 was capable of consenting to such activity and believed that residents who are not in their full state of mind should have people take responsibility to ensure the resident's dignity and safety. The SDM felt that the home should have done something sooner in regards to resident #001's behaviour as further conversations with the management revealed this was not the first time resident #001 had made such advances to residents of the opposite sex.

Record review revealed resident #002 was admitted to the home on an identified date, with identified medical conditions. A mini mental assessment was completed on an identified date, for resident #002 resulting in a score that indicated moderate cognitive

impairment. Review of the resident's plan of care and interview with RN #103 revealed resident #002 often appears sad and lonely. RN #103 told the inspector resident #002 may not be capable of consenting to an identified activity but may not resist. Review of the incidents regarding resident #001 and #002 revealed that sometimes resident #002 is fine with accepting the attention of resident #001 while other times, he/she is not. Interview with resident #002 revealed he/she was unsure whether he/she would welcome a relationship with a co-resident, stating "maybe yes, maybe no." Interview with resident #002's SDM revealed he/she was informed of an incident regarding resident #001 approximately six weeks prior, did not have any concerns and believed that resident #002 may be capable of consenting to this identified activity.

Record review revealed resident #006 was admitted to the home on an identified date with identified medical conditions. Resident #006's current CPS indicates resident is severely impaired. Resident was unable to carry on a conversation with the inspector but did make identified gestures and made these gestures with the inspector's hands. Observations and interviews revealed resident #006 is wheelchair bound. Interviews with RN #103 and #112 revealed they did not believe resident #006 would be capable to consent to anything. An interview with RPN #106 revealed resident #006 often makes certain noises which may provoke resident #001 to be inappropriate. An interview with resident's SDM revealed he/she does not believe resident #006 is capable to consent to such identified activity but loves to be shown affection. The SDM was aware there was a roaming resident that touches residents of the opposite sex but the home had not informed him/her that any incidents had occurred between this resident and their family member.

Record review revealed resident #003 was admitted to the home on an identified date with identified medical conditions. Resident #003's current CPS score indicates mild impairment. Observation, staff interviews and interview with resident's SDM revealed resident understands English but will only speak an identified language. Interview with resident #003's SDM indicated he/she was upset that the home did not contact him/her when the incident happened in an identified month but waited until the first week of the next month. Record review revealed incidents occurred between resident #001 and #003 in months previous to the the reported month. The SDM indicated he/she did not believe resident #003 was capable to consent to this identified activity as he/she has indicated that that part of his/her life is over.

Record review revealed resident #004 was admitted to the home on an identified date with identified medical conditions. Resident #004's current CPS score indicates severe

impairment. Record review, staff interviews, interview with resident's SDM and observation revealed resident has little memory. Interview with resident's SDM revealed resident #004 would not be able to consent to this identified activity. Resident's SDM was satisfied that the home was taking care of the situation as long as the resident had one-to-one monitoring to protect his/her parent and other residents.

Record review revealed resident #007 was admitted to the home on an identified date and has a current CPS that indicates moderate impairment and a Minimal Mental State Examination (MMSE) conducted on an identified date revealing mild cognitive impairment functioning. An interview with resident #007 revealed he/she was indecisive about having relations with another co-resident. Record review revealed resident #007 was observed having a consensual activity with resident #001 on an identified date, and when interviewed by the DOC regarding the incident, the resident indicated he/she was lonely. An interview with resident #007's SDM revealed he/she is uneasy with the situation because he/she is worried about safety and does not feel resident #007 knows what he/she is doing.

Record review revealed resident #008 was admitted to the home on an identified date, with identified medical conditions. Resident #008's current CPS indicates moderate impairment. According to staff members #104 and #110, resident #008 is very cognitively impaired and has been known to walk up to residents or staff and act inappropriately. Interview with resident #008's SDM revealed he/she was informed of the incident that occurred on an identified date, when resident #001 was found with resident #008. The SDM indicated resident #008's medical condition has progressed significantly and would be unable to defend him/herself and if somebody would attempt contact with him/her, he/she would not protest. The SDM indicated resident #008 would not be capable to consent to such activity.

Record review revealed resident #001 was admitted to the home on an identified date, with identified medical conditions. Resident #001's CPS indicates severe impairment and a MMSE completed on an identified date, revealed severely impaired cognitive functioning. Observation revealed that resident #001 is able to ambulate independently but is not able to carry on a conversation. Staff interviews and an interview with resident #001's SDM revealed resident was admitted to the home when his/her spouse was in the hospital for palliative care. According to the SDM and DOC, resident #001 has been grieving the passing of his/her spouse which occurred on an identified date.

Record review of resident #001's progress notes and interviews with PSWs #105 and

115 revealed resident #001 was displaying interest in residents of the opposite sex shortly after admission onto an identified floor. Interview with PSW #115 revealed even before resident #001 was observed with resident #008, he/she was watching and luring residents of the opposite sex to empty rooms but was able to be redirected. Record review revealed resident #001 was moved from one floor to another to the first floor to be with his/her spouse, and shortly after being transferred was found acting inappropriately with resident #004. There was no evidence to indicate either residents were assessed for capacity at the point of interaction.

Interviews with housekeeper #101 and PSW #100 revealed they have viewed resident #001's touching of residents as abuse because they believe the residents are not able to consent to the touching. According to these staff members, resident #001 waits until the nursing staff are busy and will then attempt to engage a resident who is often unable to consent due to dementia. These staff members have reported it several times to registered staff and believe management have let this go on too long. Interview with RN #103 who reported the incident on an identified date, revealed he/she knew it was abuse the first time it was reported to him/her, was shocked to learn it had happened several times previously and believed that management did nothing to protect vulnerable residents. Interview with RPN #106 and #110 revealed each time they witnessed or received a report from PSWs regarding resident #001 acting inappropriately with residents of the opposite sex, they have documented these activities and believe the ADOC and DOC should be monitoring these documentations every 24 hours. RPN #106 and #110 also indicated that they were never questioned regarding their multiple documentations regarding resident #001 and do not feel management did enough to protect the residents.

Interviews with the ADOC and DOC revealed they do not monitor the 24 hour report in the electronic documenting system as it is the RNs in charge that review these. The expectation is that the RNs will inform them if there are situations they cannot handle. Interview with the ADOC revealed he/she was aware of the first reported incident when resident #001 was found with resident #008 but did not conduct an investigation or do any follow up that was documented. Further interview with the ADOC revealed he/she did not report any of the incidents involving resident #001 and other residents to the MOHLTC because in speaking with the DOC and Administrator, it was not interpreted as abuse. Interview with the DOC confirmed that the home did not protect the above residents from abuse because he/she is now aware that consent needs to be given and in order to ensure consent, the home needs to do much more in terms of assessment. The DOC thought that monitoring and redirecting was enough but now realizes that this

was an ineffective measure to prevent future occurrences and protect residents.

The Administrator told the inspector on the first day of the inspection that the actions of resident #001 constituted abuse because it was not known that the residents of the opposite sex had given consent. The Administrator confirmed he/she was aware of the first incident regarding resident #001 and resident #008 on an identified date, the day the incident occurred and because he/she was on vacation, overlooked any follow up.

Based on the scope of seven residents and the severity of the action of resident #001 and the inaction by the licensee, an order is being served. [s. 19. (1)]

Additional Required Actions:

CO # - 901 was served on the licensee. CO # - 002 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. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there are written approaches to care developed to meet the
needs of the residents with responsive behaviours that include:
• screening protocols
• assessment
• reassessment, and
• identification of behavioural triggers that may result in responsive behaviours, whether cognitive,
physical, emotional, social, environmental or other.

On an identified date, the MOHLTC ACTION Line received a complaint related to an incident when a resident was found away from the home, walking alone. The resident

was taken back to the home by the Assistant Director of Care (ADOC).

Review of resident #003's chart revealed the resident was initially admitted to the secure home area on the second floor. Further review of the resident's chart failed to reveal that the resident had been assessed for the responsive behaviour of wandering when admitted to the home. The chart review also revealed the resident had been transferred to home area on the first floor because no exit seeking behaviour had been identified. However, it failed to reveal that the resident had been reassessed regarding his/her change in the responsive behaviour.

Review of resident #003's progress notes revealed on an identified date, while driving to work, the ADOC had observed the resident walking on a street without supervision. The ADOC took the resident back to the home. Review of the resident's progress notes for an identified month, prior the elopement, revealed the resident had been walking up and down from the front lounge to his/her room. The progress notes further revealed the night prior to resident #003's elopement, the night nurse documented that the resident had been agitated on several occasions walking here and there in the hallways throughout the night. However, the resident's plan of care had failed to reveal that the resident had been assessed for experiencing any responsive behaviour or there had been any written plan of care developed .

Interview with RPN #126 revealed that the staff observed the resident and documented in the observation record. The RPN stated that the resident was not assessed for the specific identified behaviors of wandering and agitation.

Interview with the DOC revealed the home had a policy for guiding the staff to manage responsive behaviours however there was no responsive behaviour program established in the home with written approaches to care, or developed to meet the needs of the residents with responsive behaviour that include assessment, reassessment and identification of behavioural triggers that may result in responsive behaviour, whether cognitive, physical, emotional, social, environmental or other. The DOC further confirmed they contracted an outside BSO team that would come to the home when a resident had been referred, to assess the resident, identify triggers and develop residents' written plan of care using their tools. Further the DOC confirmed after the resident had been admitted to the home, the staff observed the resident for seven days using a tool titled Behavioural Assessment with 30 different responsive behaviours to be chosen from with frequency. The staff provide general approaches to manage residents' responsive behaviour and if the staff were unable to manage the responsive behaviour anymore, they refer the

resident to the outside BSO team.

Interview with the Administrator confirmed the home used services from the outside BSO team to manage the responsive behaviour of the residents in the home and the home is working now with the two sister homes to establish a responsive behaviour program in the home to manage the residents' behaviour. [s. 53. (1) 1.]

2. On an identified date, the MOHLTC ACTION Line received an anonymous complaint related to concerns about residents in the home with responsive behaviours and nothing had been done about these behaviours.

Review of the complaint revealed resident #011 had been physically abusing residents at the home which resulted in the resident being taken to the hospital by the police, resident #003 had been wandering outside the home unattended, and resident #010 had been climbing outside the window because he/she wanted to go home.

Review of the home's policy titled Resident Care and Service Manual, subject Behavioural Management Program Assessment #RCSM G-45-05 reviewed August 16, 2016, revealed that residents with challenging and/or disruptive behaviour will have a behavioural assessment done by using accepted assessment tools to track the occurrence of behaviour and implement strategies to manage the challenging behaviour. The results of the test will assist with the identification of criteria for transfer/discharge to or from the Special Care Unit, assist with the evaluation of the impact of medication used and titrating them up or down, allow staff to focus on the behaviours that pose a risk and those that can be accommodated.

Review of the policy failed to reveal that there were written approaches to care including assessment, reassessment, and identification of behavioural triggers that may result in responsive behaviour. Further the review of the policy failed to reveal written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviour.

Interview with the ADOC, DOC and the Administrator confirmed the home had not established a responsive behaviour program in the home, but they are working on it with their two sister homes. [s. 53. (1) 1.]

3. The licensee has failed to ensure that the behaviour triggers had been identified for the resident demonstrating responsive behaviour.

On an identified date, the MOHLTC ACTION Line received an anonymous complaint related to a concern that there are residents in the home with responsive behaviours, residents that are physically abusive, and some that wander, but nothing had been done about the behaviours.

Review of resident #003's chart revealed the resident had been admitted to the secure home area on the second floor, but on an identified date, had been transferred to the home area on the first floor because the resident had not experienced exit seeking behaviour and elopement.

Review of resident #003's written plan of care prior to the elopement on an identified date, revealed no indication that the resident had been wandering and was at risk for exit seeking.

Review of resident #003's progress notes revealed on an identified date, while driving to work, the ADOC had observed the resident walking on a street without supervision. The ADOC had brought the resident back to the home. The resident had been provided with a wander guard and monitored by staff every 15 minutes. Review of the resident's progress notes prior to the elopement revealed the resident had been walking up and down from the front lounge to his/her room. The progress notes further revealed on an identified date, prior to resident #003’s elopement, the night shift documented the resident had been agitated on several occasions but failed to reveal what triggered the resident's behaviour. Review of the resident's progress notes and written plan of care failed to reveal that the behavioural triggers had been identified for resident #003 who experienced elopement behaviour.

Interview with RN #103 and RPN #116 revealed the staff had not identified the behavioural triggers for resident #003. They confirmed that resident had been wandering in the hallway from the home area to the main entry, but he/she had never left the building. RN #103 and RPN #116 confirmed they had not identified why resident #003 had left the home on an identified date.

Interview with the ADOC confirmed the home had not conducted an investigation or assessed the resident to identify the triggers for resident #003's responsive behaviour. [s. 53. (4) (a)]

4. The licensee has failed to ensure that the behaviour triggers had been identified for

the resident demonstrating responsive behaviour.

On an identified date, the MOHLTC ACTION Line received an anonymous complaint related to a concern that there are residents in the home with responsive behaviours, residents that are physically abusive, and some that wander, but nothing had been done about the behaviours.

Review of the complaint revealed resident #011 had been physically assaulting residents at the home so the resident had been taken to the hospital by the police.

Review of resident #011's chart revealed the resident had been sent to the hospital on an identified date, because of responsive behaviours that the home had not been able to manage. Resident #011 had been assessed by the emergency physician and sent back to the home. On another identified date, after resident #011 had been physically aggressive to other residents in the home, he/she was sent to the hospital again, this time by police and physician's order under Form 1. At the time of the inspection the resident was still in the hospital.

Review of progress notes from admission revealed resident #011 had various identified responsive behaviours including having been aggressive with other residents and staff. Progress notes revealed there were 26 physically aggressive behaviour incidents documented before resident was sent to the hospital. For all incidents the intervention provided to the resident had been to redirect the resident and remind him/her the behaviour was not appropriate. The progress note review failed to reveal that the interventions had been evaluated for effectiveness.

Review of the resident's MMSE from an identified date, indicated a significant decline in resident's cognitive status. Further review of the resident's chart failed to reveal triggers identified for resident’s responsive behaviour.

Review of the summary of resident #011's behaviour assessment record completed from an identified time period, failed to reveal that triggers were identified for the resident's behaviour and what interventions were in place to manage the behaviour.

Review of resident #011's written plan of care failed to reveal what triggers had been identified for the resident's behaviour.

Interview with RPN #104 confirmed staff had not identified the triggers for resident #011's

responsive behaviours. [s. 53. (4) (a)]

5. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions.

On an identified date, the MOHLTC ACTION Line received a complaint related to an incident when a resident had been found away from the home, walking alone. The resident was taken back to the home by the ADOC.

Review of resident #003's chart revealed the resident was initially admitted to the secure home area on the second floor. Further review of the resident's chart failed to reveal the resident had been assessed for responsive behaviour of wandering when admitted to the home. The chart review also revealed on an identified date, the resident had been transferred to the home area on the first floor because no exit seeking behaviour had been identified, however it failed to reveal that the resident had been reassessed regarding his/her change in the responsive behaviour.

Review of resident #003's progress notes revealed on an identified date, while driving to work, the ADOC had observed the resident walking on a street without supervision. The ADOC had brought the resident back in the home. Review of the resident progress notes prior to the elopement revealed the resident had been walking up and down from the front lounge to his/her room. The progress notes further revealed on an identified date, prior to resident #003's elopement, the night shift documented the resident had been agitated on several occasions walking here and there in the hallways. However, the progress notes had failed to reveal that the resident had been assessed for experiencing responsive behaviour.

Review of resident #003's written plan of care prior to the elopement, failed to identify that the resident had been experiencing wandering behaviour. Interview with RPN #116 revealed the resident had not been assessed on admission or reassessed when he/she had been transferred from the secure home area on the second floor to the first floor.

Interview with the DOC and ADOC confirmed the home expected staff to assess residents for responsive behaviours on admission and whenever there is a change in behaviour. Staff had not assessed resident #003 for his/her exit seeking behaviour on admission or reassessed this behavioiur after the resident was transferred to another home area. [s. 53. (4) (c)]

6. Review of a Critical Incident Report submitted on an identified date, revealed resident #001 was discovered by a staff member to be standing beside resident #005's wheelchair, pressing his/her body up against his/hers on identified date. Resident #001 was noted to be touching resident #005 inappropriately.

Review of resident #001's progress notes revealed this was not the first time he/she had touched other residents of the opposite sex. Other incidents included were documented as having occurred on identified dates and times:

1. Resident #001 found in resident #008's room, in bed with resident.
2. Resident #001 was following residents of the opposite sex down the hallway and was noted to guide three identified co-residents into his/her room.
3. Resident #001 found in hallway behaving inappropriately with another unidentified resident.
4. PSW reported finding resident #001 with identified co-resident in room behaving inappropriately.
5. Resident #001 moved down to another floor this evening. Shortly after arriving, resident was found in the lounge behaving inappropriately with resident #004.
6. PSW witnessed resident #001 grab onto resident #002's hand. Shortly after resident #001 grabbed onto resident #004's hand and was walking up the hallway looking into rooms.
7. Resident #001 continues to act inappropriately with resident #007.
8. Resident #001 was walking up and down the hall, resident acted inappropriately with resident #006 and was grabbing resident #004.
9. Resident #001 was acting inappropriately with resident #002 who stated "I am scared."
10. Resident #001 acted inappropriately with another resident which scared that resident and made him/her anxious.
11. Resident #001 trying to get into resident #007's room and was acting inappropriately with resident #004.
12. Resident #001 trying to act inappropriately with resident #004 and was trying to act inappropriately with other residents of the opposite sex on the home area.
13. Resident #001 was sitting on the couch in the lounge beside an unidentified co-resident, acting inappropriately.
14. Staff reported that resident #001 was observed adjusting his/her clothes while leaving the front lounge. Staff entered the front lounge while resident #001 exited and observed resident #004 sitting on the couch partially unclothed.
15. Resident #001 was sitting with resident #007 on the couch. Resident #001 was trying

to act inappropriately with resident #007.
16. Previous shift RN reported to writer that resident #001 was acting inappropriately with resident #004 in the front lounge.
17. Resident #001 observed acting inappropriately with resident #007.
18. PSW reported that resident #001 acted inappropriately with resident #004.
19. Resident #001 went into resident #004's room and was acting inappropriately.
20. Resident #001 was seen by PSW in resident #003's room acting inappropriately.
21. Resident #001 observed by writer to be in resident #002's room acting inappropriately.
22. Resident #001 was observed wandering into resident #002 and #007's rooms. Resident #001 was observed acting inappropriately with resident #002.
23. Resident #001 was found in the front lounge with resident #004 and was acting inappropriately. PSW reported resident #001 was trying to wheel another resident from a different floor to his/her room.
24. PSW reported to writer that resident #001 was witnessed acting inappropriately with resident #002. Resident #002 yelled at resident #001 to "get out."
25. Resident #001 was acting inappropriately with resident #006 in the lounge.
26. Resident #001 observed walking into resident #003's room and grabbing his/her hand. Resident #001 also observed acting inappropriately with resident #003.
27. Another resident reported to the staff that resident #001 acts inappropriately with resident #007 every night.
28. Resident #001 was standing in the hallway acting inappropriately with resident #004. Writer intervened and resident #001 yelled at writer and showed his/her fist against writer's face and made threatening comments. RN filled in a referral for BSO and left a message with the POA and also started behavioural monitoring on resident.
29. Resident #001 acting inappropriately with resident #007 after dinner. Resident #001 was entering into other resident rooms and taking off yellow wander strips.
30. Resident #001 was trying to act inappropriately with resident #006 when he/she was sitting in the dining room. Another identified resident complained that resident #001 walks in his/her room very often and he/she does not like that.
31. Resident #001 witnessed by PSW to act inappropriately with resident #003.
32. Resident #001 was noted acting inappropriately with resident #003.
33. Resident #001 was walking in the halls, when another resident was also walking in the halls and a PSW noticed them engaged in inappropriate behaviour.
34. Resident #001 was noted in resident #002's room standing by his/her chair where he/she was sitting. Resident #001 was touching him/her inappropriately. Resident #002 was smiling and looking at resident #001.
35. Reported to writer by PSW that resident #001 was inappropriately touching an

unidentified resident.
36. Resident #001 was standing at the door of resident #002 who was in front of him/her with an opened piece of clothing.
37. Resident #001was observed acting inappropriately with resident #002 in the front lobby while resident was already upset and looking for his/her spouse.
38. Resident #001 was entering into resident #002's room and when re-directed, came out of the room and pointed out resident #006 who was sitting in the wheelchair at the desk and asked writer "can I get him/her then?"
39. Resident #001 found by staff in resident #002's room while he/she was asleep in his/her chair acting inappropriately.

Most of the above progress notes indicated that resident #001 was successfully redirected and staff would continue to monitor.

Resident #001 was admitted to the home on an identified date, and even before admission a CCAC (Community Care Access Centre) Placement Services Behavioural Assessment Tool completed on an identified date, noted the resident had inappropriate behaviour. This behaviour was described as touching others inappropriately and indicated a neighbour reported to a family member that resident #001 grabbed at him/her inappropriately when he/she was helping him/her. It occurred only once and redirection proved effective. Interviews with the ADOC and DOC confirmed this was never assessed by the registered staff of the home and measures were not taken to monitor or mitigate the risks to other residents in resident #001's initial plan of care.

Interview with PSW #115 who witnessed the first reported inappropriate behaviour of resident #001 at the home on an identified date, revealed he/she thought something was odd because resident #008's door was closed. The PSW walked into the room during nourishment time and observed resident #008 partially unclothed while sitting beside resident #001. Resident #001's clothes were undone and he/she was inappropriately touching resident #008. The PSW redirected resident #001 out of the room while the resident acknowledged he/she had done something wrong. According to the PSW, resident #008 appeared to be asleep and when woken up, was unaware of what had happened. The PSW reported the incident to the RPN who then reported it to the RN in charge.

Further interview with PSW #115 revealed that before the above mentioned incident, resident #001 was observed going into nonverbal resident rooms to stand and watch. The PSW indicated resident #001 was also observed luring other identified residents into

unoccupied rooms and was redirected before anything happened. The PSW also described resident #001 as looking to see where staff were and then proceeding to go into other residents' rooms.

Review of progress notes revealed the RPN documented the above mentioned incident and stated that the RN made a call to the ADOC. Interview with the ADOC revealed the RN contacted him/her that day, explained the situation and asked for direction of what to do. Interview with the Administrator revealed the RN also called him/her that day to inform him/her of the situation. According to the Administrator, he/she informed the RN to call the MOHLTC and police and start an Unusual Occurrence Report. Interview with RN #128 revealed he/she did not recall the Administrator telling him/her to do anything else other than ensure the report was written and to continue to observe resident #001. Review of the DOC's binder of Unusual Occurrence Reports revealed a report was written to describe the occurrence which was signed by the RPN. There is no indication on the report that any further action was taken. Interviews with the ADOC, DOC and Administrator confirmed that they were aware of the incident and did not follow up with registered staff to ensure assessments were completed and interventions implemented to address resident #001's responsive behaviours.

Review of resident #001's progress notes revealed the physician made a note on an identified date, that there were concerns regarding the resident's behaviour and before considering medication, wanted the staff to implement behavioural monitoring. Review of the behaviour monitoring sheets from an identified time period, revealed resident #001 did not make any verbal or physical advances. The sheets did reveal resident #001 had other identified behaviours.

Review of resident #001's progress notes revealed there was no reason given for behaviour monitoring that started for another identified time period. The behaviour monitoring sheets revealed there was one day in which the resident made physical advances that happened several times during the day and was extremely disruptive. During this period there was also other responsive behaviours noted.

Review of resident #001's progress notes revealed that on an identified date, the resident was observed doing up an identified piece of clothing while leaving the front lounge and staff noted that resident #004 was sitting on the couch partially unclothed. According to the note, the RPN notified the ADOC and RN and behaviour monitoring was initiated. Review of the behaviour monitoring sheets for an identified period of time, revealed there was one day that resident #001 made verbal advances, two days that he/she made

physical advances and one day when he/she was observed walking down the hall with an identified piece of clothing undone. There were also other responsive behaviours noted.

Review of resident #001' progress notes revealed that on an identified date, the resident was standing in the hallway touching resident #004 inappropriately and when staff intervened resident #001 started yelling aggressively. The note indicated that the RN filled in a referral for Behavioural Support Ontario (BSO), left a message with the SDM and also started behaviour monitoring. Interview with RN #129 revealed he/she never completed the BSO referral because he/she did not hear back from resident #001's SDM to provide consent. Review of the behaviour monitoring sheets for another period of time, revealed resident #001 made verbal and physical advances. There were also several other responsive behaviours noted.

Review of the home's policy #RCSM G-45-05 titled "Behavioural Management Program Assessment" reviewed August 16, 2016, revealed that upon completion of the seven days of behavioural monitoring, when behaviours are evident, the RN will initiate a referral to the Behavioural Support Team.

Interview with RN #128 revealed he/she was not aware that RNs are responsible to assess the behaviour monitoring sheets and more often than not these sheets just get filed. The RN indicated that if he/she happens to see that such sheets have multiple behaviours then he/she will write this in the progress notes and inform the ADOC. Interview with RN #129 who documented that a BSO referral was going to be initiated for resident #001 pending SDM consent, admitted that the home's process to deal with responsive behaviours lacks cohesiveness as no one understands who is responsible for what. Interview with the DOC and ADOC revealed that this is an area the home needs to improve upon to ensure that someone is in charge of reviewing, assessing, and following up on reported responsive behaviours.

Review of resident #001's progress notes, assessments and written plan of care revealed there were no assessments of the behavioural monitoring sheets or interventions implemented during each of the above four time periods. Interview with the DOC confirmed there was no review of these sheets, assessments completed and interventions implemented to respond to resident #001's needs.

Based on the potential risk of harm, noncompliance regarding more than one resident with responsive behaviours and the home's lack of strategies to prevent, minimize and

respond to responsive behaviours, an order is being served. [s. 53. (4) (c)]

Additional Required Actions:

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

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. The licensee has failed to immediately report the suspicion of abuse and the information upon which it is based on to the Director.

Record review and staff interview revealed resident #011 was abusing other residents in at least 26 separate incidents during an identified time period. Resident #011 was sent to the hospital on two identified dates for continually being abusive.

Interview with RN #103 revealed resident #011 was abusive with other residents on an identified date, throughout the day, and was sent to the hospital accompanied by the police. One of the residents who was abused complained of pain and was sent to the hospital. RN #103 indicated that he/she did not report this incident to the MOHLTC as he/she was not aware that this was his/her responsibility.

Review of a critical incident report revealed resident #011's abusive behaviour was not reported until an identified date, after inspector #501 met with police detectives who were in the home to investigate the incident involving resident #001 on an identified date. Interview between inspector #501 and the DOC and Administrator confirmed the home had not reported this incident as they were not aware that the suspicion of resident to resident abuse needed to be immediately reported. [s. 24.]

2. Record review and staff interviews revealed resident #001 was abusing at least seven residents of the opposite sex in at least 39 separate incidents during an identified time period. Staff interviews revealed some were aware this constituted abuse whereas others were not. Interviews with the ADOC, DOC and Administrator confirmed they had not investigated these incidents to find out if consent had been obtained and therefore should have known that these incidents could be regarded as abuse. Not until an identified date, were there phone calls made to the MOHLTC regarding resident #001 touching resident #005 by RN #103 and an anonymous caller.

Based on the severity of harm related to abuse, the scope involving several residents and the home's lack of awareness of reporting requirements to the Director, an order is being served. [s. 24. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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. (6) When a resident is admitted to a long-term care home, the licensee shall, within the times provided for in the regulations, ensure that the resident is assessed and an initial plan of care developed based on that assessment and on the assessment, reassessments and information provided by the placement co-ordinator under section 44. 2007, c. 8, s. 6 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure when a resident is admitted to a long-term care home, within the times provided for in the regulations, ensure that the resident is assessed and an initial plan of care developed based on that assessment, reassessments and information provided by the placement co-ordinator under section 44.

On an identified date, the MOHLTC ACTION Line received a complaint related to an incident when a resident was found away from the home, walking alone. The resident was taken back to the home by the ADOC.

Review of resident #003's chart revealed the resident was initially admitted to the secure home area on the second floor, but on an identified date, had been transferred to the home area on the first floor because the resident had not experienced exit seeking behaviour.

Review of the placement co-ordinator reassessment record titled Behavioural Assessment Tool indicated resident #003 had wandering behaviour and will leave immediate environment if not prevented. Further record review revealed if the resident got bored or if he/she wanted to go out, he/she will just leave if not prevented.

Review of resident #003's progress notes revealed on an identified date, while driving to work, the ADOC had observed the resident walking on a street without supervision. The ADOC had brought the resident back to the home. Review of the resident progress notes prior to the elopement revealed the resident had been walking up and down from the front lounge to his/her room.

Review of resident #003's written plan of care prior to the elopement on an identified date, failed to reveal that the initial plan of care for resident #003 had been developed based on the assessment, reassessments and information provided by the placement co-ordinator.

Interview with RN#103 and RPN#116 revealed the staff had not developed the resident's plan of care based on the assessment, reassessments and information provided by the placement co-ordinator.

Interview with the DOC and ADOC confirmed the practice in the home was for staff to consider assessment, reassessment and other information provided by the placement coordinator when developing the resident's plan of care.

Interview with the Administrator confirmed staff were expected to have used the placement coordinator's information when developing the plan of resident #003's care. [s. 6. (6)]

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 when a resident is admitted to a long-term care home, within the times provided for in the regulations, ensure that the resident is assessed and an initial plan of care developed based on that assessment, reassessments and information provided by the placement co-ordinator under section 44, to be implemented voluntarily.

WN #5: 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act.

Review of the home's policy titled Resident Care and Service Manual, subject Behavioural Management Program Assessment #RCSM G-45-05 reviewed August 16, 2016, revealed that residents with challenging and/or disruptive behaviour will have a behavioural assessment done by using accepted assessment tools to track the occurrence of behaviour and implement strategies to manage the challenging behaviour. The results of the test will assist with the identification of criteria for transfer/discharge to or from the Special Care Unit, assist with the evaluation the impact of medication used and titrating them up or down, allow staff to focus on the behaviours that pose a risk and those that can be accommodated.

On an identified date, the MOHLTC ACTION Line received an anonymous complaint related to concerns that there are residents in the home with responsive behaviours who were being abusive and wandering, and nothing had been done about the behaviours. Review of the complaint revealed resident #011 had been abusing residents at the home and the resident had been taken to the hospital by the police.

Review of resident #011's chart revealed the resident was of an identified age admitted to the home on an identified date with an identified medical condition. The resident had been sent to the hospital on an identified date, because of responsive behaviours that the home had not been able to manage. Resident #011 had been assessed by the emergency physician and sent back to the home. On an identified date, after resident #011 had been physically abusive to other residents in the home, he/she was sent to the

hospital again. At the time of the inspection the resident was still in the hospital. Record review revealed resident #011 had abused an identified resident who was also sent to the hospital for the complaint of pain but no injuries were identified.

Review of resident progress notes from admission to an identified date, revealed the resident had been experiencing identified responsive behaviours. Progress notes revealed there were 26 abusive behaviours documented before resident was sent to the hospital. For all incidents the intervention provided to the resident had been to redirect the resident and remind him/her the behaviour was not appropriate. The progress note review failed to reveal that the interventions had been evaluated for effectiveness.

Review of the resident's MMSE from an identified date, indicated a significant decline in the resident's cognitive status. Further review of the resident's chart failed to reveal any triggers for the resident's responsive behaviour. Review of the summary of the resident's behaviour assessment record completed during an identified time period failed to reveal that triggers were identified for the resident's behaviour and what interventions were in place to manage the behaviour.

Review of the policy failed to reveal that there were written approaches to care including assessment, reassessment, and identification of behavioural triggers that may result in responsive behaviour. Further the review of the policy failed to reveal written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviour.

Interview with RPN # 104 indicated he/she had completed an MMSE for each resident after admission to establish a base and to follow the course of cognitive changes in the resident. The seven day observation period of resident responsive behaviours was completed when the staff had not be able to manage resident behaviour, so referrals would be sent outside to a Behavioural Support Ontario (BSO) team to come in and assess the resident. Further the RPN revealed there was a gap in the process of managing the responsive behaviours because there was no assessment or reassessment tool to assist them to identify the triggers of the responsive behaviour. The RPN confirmed the interventions they use were to redirect the resident and remind him/her the behaviour was not appropriate.

An interview with DOC confirmed the process in the home in regards to responsive behaviours is to refer the resident to the outside BSO team who assess, identify triggers, set up the plan of care and mentor the staff to implement the interventions. The home

does not have a tool for assessment, reassessment, and a tool to identify the triggers for responsive behaviour or written strategies.

An interview with the Administrator confirmed the home does not have a responsive behaviour program in place and the policies they were using were not complete and were not effective. Further the Administrator confirmed they are working with two sister homes to revise the policy and establish a responsive behaviour program for all three homes. [s. 8. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres (cm).

Review of a complaint submitted to the MOHLTC ACTION Line on an identified date revealed resident #010 attempted to climb out of the window on an identified floor.

Review of progress notes from an identified date, revealed resident #010 was admitted to the home on an identified date. The day after admission the resident had removed the screen off the window and climbed over so one leg had been outside the window. The staff had noted the resident when he/she had been trying to squeeze his/her upper part of the body through the window.

Observation of windows that open to the outdoors and are accessible to residents on the first floor hallway south windows, third floor hallway both windows, south and north, and windows in identified residents' rooms, revealed the windows opened more than 20 cm.

Interview with PSW #122 revealed he/she was doing rounds when he/she noted resident #010 sitting on the window with half of his/her lower body outside the window and bent forward trying to squeeze the rest of his/her body through the window. Further the PSW revealed the window had been left open by staff so resident removed the screen and tried to leave the home through the window.

Interview with the Environmental Services Manager (ESM) confirmed all the windows by default had been set to open about eight inches or 20.3 cm. After the incident the home had reset the two windows in the hallway on the second floor to 15 cm. The ESM further confirmed the windows in the residents rooms and the hallways of the other two floor are still able to open up to over 20 cm.

Interview with the Administrator confirmed the windows had been set by default to open 8 inches and after the inspection the ESM had reset all the windows that open to the outdoors and is accessible to residents to 15 cm. [s. 16.]

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 every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres, to be implemented voluntarily.

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. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident that the licensee knows of or that is reported is immediately investigated.

Record review and interviews with RN #128 and RPN #130 revealed resident #001 was found engaging resident #008 in activities that were not consented to. The RN notified the ADOC and Administrator and the RPN completed an Unusual Occurrence Report which was found in the DOC's binder. Interviews with the ADOC, DOC and Administrator revealed that such activity could be possible abuse as it was not known if the activities were consensual. The ADOC, DOC and Administrator confirmed they were aware of the incident but did not investigate. [s. 23. (1) (a)]

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 that every alleged, suspect or witnessed incident of abuse of a resident that the licensee knows of or that is reported is immediately investigated, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that includes mood and behaviour patterns, including wandering or potential behavioural triggers and variations in resident functioning at different times of the day.

On an identified date, the MOHLTC ACTION Line received an anonymous complaint related to a concern that there are residents in the home with responsive behaviours, but nothing had been done about these behaviours. Review of the complaint also revealed resident #010 had attempted to climb out of a window.

Review of resident #010's MDS assessment of an identified date, revealed the resident had memory problems and moderately impaired cognitive skills for daily decision making. The resident had been identified to have wandering responsive behaviours in the week prior to the MDS assessment and the behaviour had not been easy altered.

On three identified days, resident #010 had been observed by the inspector and noted to be not only wandering in the hallway and common areas but also pacing beside the door, ready to exit at any time.

Review of the progress notes from an identified time period revealed resident #010 had been wandering multiple times and experiencing agitated behaviour if redirected.

Review of the written plan of care did not include the responsive behaviours of wandering, and other identified responsive behaviours for resident #010.

Interview with RPN #126 indicated the practice in the home is to put in a referral for the BSO team to come and assess the resident and develop a plan of care. Further the RPN confirmed the wandering behaviour had not been addressed in the written plan of care because resident #010 had been recently admitted and had not been referred to the BSO team yet.

Interview with the DOC confirmed the staff were expected to initiate the resident's written plan of care and update with the BSO team when they come to assess the resident. [s. 26. (3) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the responsive behaviour was plan of care based on an interdisciplinary assessment of the resident that includes mood and behaviour patterns, including wandering or potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that criminal reference checks are conducted prior to hiring the staff member who is 18 years of age or older.

Review of staff members #132 and #133's personnel records revealed there were no criminal reference checks (CRCs) on file. For staff #131 there was a criminal reference check on file that did not include a vulnerable sector screening.

The home provided via fax a CRC with a vulnerable sector check for staff member #131 dated on an identified date. Interview with the DOC revealed this employee's first shift was prior to this date. The home provided via fax a CRC with a vulnerable sector check for staff member #132 dated on an identified date. Interview with the DOC revealed this employee's first shift was prior to this date. The home also provided via fax a CRC with a vulnerable sector check for staff member #133 dated on an identified date. Interview with the DOC revealed this employee's first shift was prior to this date.

Interview with the DOC revealed he/she thought the above mentioned staff members had provided CRCs with vulnerable sector checks but could not provide any proof that this had occurred prior to the staff members being hired. [s. 75. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that criminal reference checks are conducted prior to hiring the staff member who is 18 years of age or older, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff receive retraining annually related to Residents' Bill of Rights; zero tolerance of abuse and neglect; mandatory reporting under section 24 and whistle-blowing protection.

Interviews with staff members #100, #101, #104, #105, #110, and #113 could not recall the last time they received training in zero tolerance of abuse and neglect, mandatory reporting and whistle blowing protection.

Review of staff training records for 2015 revealed 66 per cent of staff did not receive training related to zero tolerance of abuse and neglect and 0 per cent of staff received training related to Resident's Bill of Rights, mandatory reporting under section 24 and whistle-blowing protection.

Interview with the DOC confirmed staff were not provided with retraining and that the numbers showing in the training record are correct. [s. 76. (4)]

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 receive retraining annually related to Residents' Bill of Rights; zero tolerance of abuse and neglect; mandatory reporting under section 24 and whistle-blowing protection, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff receive the required training annually.

Interview with PSWs #117, #118, #122, RPNs #114, #116, #120, and RNs #103 and #112, revealed that they did not receive training related to behavioural management.

Interview with the DOC revealed that the home had set up the training for the staff so that every month the educator presented different topics from responsive behaviour training. Further the DOC indicated not all the staff had attended all of the topics that have been presented through the training.

Review of the training records of the home for 2015 indicated:
88.2 per cent staff of the home had not received training relating in behaviour management;
82.0 per cent staff had not received training related to dementia, delirium, and depression;
81.5 percent had not received training related to sexually expressive behaviour;
90.0 percent had not received training related to sundowning and repetitive behaviour.

Interview with a Psychogeriatric Resource Consultant/Educator indicated that not all of the staff had responded to the training sessions that the home had set up on a monthly basis.

Interview with the DOC confirmed not all the staff had received the required training for 2015. He/she had recognized this as a weakness and had developed a plan with the ADOC to have all staff trained for this year. [s. 221. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all direct care staff receive the required training in behaviour management annually, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff including the training on the relationship between power imbalances between staff and residents, situations that may lead to abuse and neglect and how to avoid such situations.

Review of the home's policy #RCSM P-10 titled "Abuse Policy" reviewed September 9, 2016, revealed there is no mention of the above mentioned training. Interview with the DOC confirmed the home's policy does not include such training. [s. 96. (e)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was 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.

Record review and staff interviews revealed resident #001 was abusing at least seven residents in at least 39 separate incidents during an identified time period. Interview with the Administrator revealed he/she knew resident #001's actions may constitute a criminal offence and had failed to immediately notify the police or instruct his/her staff to do so. [s. 98.]

WN #14: 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 has failed to ensure that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.

Interviews with the DOC and Administrator confirmed that the home does not conduct an annual evaluation to determine the effectiveness of the home's policy to promote zero tolerance of abuse and neglect. [s. 99. (b)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to inform the Director no later than one business day after the occurrence of the incident of the resident who was missing for less than three hours and who returned to the home with no injury or adverse change in condition.

On an identified date, the MOHLTC ACTION Line received a complaint related to an incident when an identified resident was found outside the home and was brought back to the home by the DOC. The staff on the home area had not been notified until the end of the shift.

Review of resident #003's chart revealed the resident was admitted to the home on an identified date, with a history of wandering behavior. The resident was admitted on a secure home area. Resident #003 had not expressed any exit seeking behavior while on the secure home area, so the home had transferred the resident on the first floor.

Review of resident #003 progress notes on an identified date, revealed resident #003 had been seen by the ADOC walking without supervision on a street away from the home. The ADOC brought the resident back home and reported the incident to the Administrator and DOC.

An interview with the ADOC confirmed he/she found the resident walking alone on the street away from the home on an identified date, and he/she brought him/her back to the home. The ADOC also confirmed he/she notified the Administrator and the DOC but had not submitted the critical incident system report to the MOHLTC.

An interview with the DOC confirmed resident #003 had been found and brought back to the home by the ADOC on an identified date, who informed the Administrator and the DOC. Further the DOC confirmed he/she had not notified the MOHLTC as he/she had not considered this incident to be reportable as the resident was found and brought back. The DOC also confirmed he/she misunderstood the regulation and he/she should have reported the incident to the MOHLTC. [s. 107. (3)]

Issued on this 3rd day of January, 2017

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) :	SUSAN SEMEREDY (501), GORDANA KRSTEVSKA (600)
Inspection No. / No de l'inspection :	2016_321501_0019
Log No. / Registre no:	028951-16, 029182-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 28, Nov 16, 2016
Licensee / Titulaire de permis :	ATK CARE INC. 1386 INDIAN GROVE, MISSISSAUGA, ON, L5H-2S6
LTC Home / Foyer de SLD :	RIVER GLEN HAVEN NURSING HOME 160 High Street, P.O. Box 368, Sutton West, ON, L0E-1R0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Karen Ryan

To ATK CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 901

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 shall protect residents from sexual abuse from resident #001:
1. Implement one to one staff 24/7 ongoing for resident #001 to be in place for 24 hours a day,
2. Immediately report all interactions between resident #001 and any female resident to the police, and;
3. Ensure all direct care staff are aware of this order.

Grounds / Motifs :

1. The licensee has failed to protect resident #002 and six other residents from abuse.

On an identified date, an anonymous call was received by the Ministry of Health and Long Term Care (MOHLTC) ACTION Line indicating a resident was touching residents of the opposite sex in an inappropriate manner.

On an identified date, Registered Nurse (RN) #103 called the MOHLTC ACTION Line and made a report indicating resident #001 was abusing other residents. Resident #001 had been in the home since an identified date, and had allegedly been inappropriately touching residents of the opposite sex since one month following his/her admission.

A search of the CIS (Critical Incident System) revealed the only CIS submitted for this incident was on the same date RN #103 called. The CIS revealed that there have been at least 27 separate incidents of abuse of at least five residents by resident #001 since an identified month. The report indicated resident #001 was inappropriately touching residents of the opposite sex. At least one of the residents expressed fear according to the CIS.

Staff members #100 and #101 told the inspector that there were a total of seven residents identified so far. Both staff told the inspector that this behaviour had been going on for quite a while. One staff member told the inspector that management was not doing anything to stop the abuse and both indicated resident #001 sought out unsupervised residents when he/she believed that the staff were distracted by activities on the care unit.

The Administrator told the inspector that they had not taken resident #001 seriously and confirmed they have not notified the police at the time of the interview. The Administrator also agreed with the inspector that this constitutes abuse and told the inspector that he/she was planning to contact the police. There were no interventions in place to protect the affected residents from resident #001 until after the Registered Nurse (RN) called the MOHLTC ACTION Line on an identified date.

Based on the scope of seven residents and the severity of the action of resident #001 and the inaction by the licensee, an immediate order was served (501)

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

Order # / Ordre no : 001

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 home must ensure that the following processes are in place for residents with responsive behaviours:

1. Ensure that someone is in charge of reviewing, assessing and following up on reported responsive behaviours.
2. The licensee will assess residents for responsive behaviour on admission or when the resident's responsive behaviour changes.
3. There are written strategies for staff to follow when the home cannot manage responsive behaviours and there is evidence of ongoing abusive behaviours. For example, the home needs to identify when and how specialized psychiatric resources are to be accessed.
4. Arrange for resident #001 and any other residents with inappropriate behaviours to have access to specialized psychogeriatric care or someone with expertise in dealing with ongoing abuse.

Grounds / Motifs :

1. The licensee has failed to ensure that there are written approaches to care developed to meet the
needs of the residents with responsive behaviours that include:
• screening protocols
• assessment
• reassessment, and

• identification of behavioural triggers that may result in responsive behaviours, whether cognitive,
physical, emotional, social, environmental or other.

Review of a Critical Incident Report submitted on an identified date, revealed resident #001 was discovered by a staff member to be standing beside resident #005's wheelchair, pressing his/her body up against his/hers on identified date. Resident #001 was noted to be touching resident #005 inappropriately.

Review of resident #001's progress notes revealed this was not the first time he/she had touched other residents of the opposite sex. Other incidents included were documented as having occurred on identified dates and times:

1. Resident #001 found in resident #008's room, in bed with resident.
2. Resident #001 was following residents of the opposite sex down the hallway and was noted to guide three identified co-residents into his/her room.
3. Resident #001 found in hallway behaving inappropriately with another unidentified resident.
4. PSW reported finding resident #001 with identified co-resident in room behaving inappropriately.
5. Resident #001 moved down to another floor this evening. Shortly after arriving, resident was found in the lounge behaving inappropriately with resident #004.
6. PSW witnessed resident #001 grab onto resident #002's hand. Shortly after resident #001 grabbed onto resident #004's hand and was walking up the hallway looking into rooms.
7. Resident #001 continues to act inappropriately with resident #007.
8. Resident #001 was walking up and down the hall, resident acted inappropriately with resident #006 and was grabbing resident #004.
9. Resident #001 was acting inappropriately with resident #002 who stated "I am scared."
10. Resident #001 acted inappropriately with another resident which scared that resident and made him/her anxious.
11. Resident #001 trying to get into resident #007's room and was acting inappropriately with resident #004.
12. Resident #001 trying to act inappropriately with resident #004 and was trying to act inappropriately with other residents of the opposite sex on the home area.
13. Resident #001 was sitting on the couch in the lounge beside an unidentified co-resident, acting inappropriately.

14. Staff reported that resident #001 was observed adjusting his/her clothes while leaving the front lounge. Staff entered the front lounge while resident #001 exited and observed resident #004 sitting on the couch partially unclothed.
15. Resident #001 was sitting with resident #007 on the couch. Resident #001 was trying to act inappropriately with resident #007.
16. Previous shift RN reported to writer that resident #001 was acting inappropriately with resident #004 in the front lounge.
17. Resident #001 observed acting inappropriately with resident #007.
18. PSW reported that resident #001 acted inappropriately with resident #004.
19. Resident #001 went into resident #004's room and was acting inappropriately.
20. Resident #001 was seen by PSW in resident #003's room acting inappropriately.
21. Resident #001 observed by writer to be in resident #002's room acting inappropriately.
22. Resident #001 was observed wandering into resident #002 and #007's rooms. Resident #001 was observed acting inappropriately with resident #002.
23. Resident #001 was found in the front lounge with resident #004 and was acting inappropriately. PSW reported resident #001 was trying to wheel another resident from a different floor to his/her room.
24. PSW reported to writer that resident #001 was witnessed acting inappropriately with resident #002. Resident #002 yelled at resident #001 to "get out."
25. Resident #001 was acting inappropriately with resident #006 in the lounge.
26. Resident #001 observed walking into resident #003's room and grabbing his/her hand. Resident #001 also observed acting inappropriately with resident #003.
27. Another resident reported to the staff that resident #001 acts inappropriately with resident #007 every night.
28. Resident #001 was standing in the hallway acting inappropriately with resident #004. Writer intervened and resident #001 yelled at writer and showed his/her fist against writer's face and made threatening comments. RN filled in a referral for BSO and left a message with the POA and also started behavioural monitoring on resident.
29. Resident #001 acting inappropriately with resident #007 after dinner. Resident #001 was entering into other resident rooms and taking off yellow wander strips.
30. Resident #001 was trying to act inappropriately with resident #006 when he/she was sitting in the dining room. Another identified resident complained that

resident #001 walks in his/her room very often and he/she does not like that.
31. Resident #001 witnessed by PSW to act inappropriately with resident #003.
32. Resident #001 was noted acting inappropriately with resident #003.
33. Resident #001 was walking in the halls, when another resident was also walking in the halls and a PSW noticed them engaged in inappropriate behaviour.
34. Resident #001 was noted in resident #002's room standing by his/her chair where he/she was sitting. Resident #001 was touching him/her inappropriately. Resident #002 was smiling and looking at resident #001.
35. Reported to writer by PSW that resident #001 was inappropriately touching an unidentified resident.
36. Resident #001 was standing at the door of resident #002 who was in front of him/her with an opened piece of clothing.
37. Resident #001was observed acting inappropriately with resident #002 in the front lobby while resident was already upset and looking for his/her spouse.
38. Resident #001 was entering into resident #002's room and when re-directed, came out of the room and pointed out resident #006 who was sitting in the wheelchair at the desk and asked writer "can I get him/her then?"
39. Resident #001 found by staff in resident #002's room while he/she was asleep in his/her chair acting inappropriately.

Most of the above progress notes indicated that resident #001 was successfully redirected and staff would continue to monitor.

Resident #001 was admitted to the home on an identified date, and even before admission a CCAC (Community Care Access Centre) Placement Services Behavioural Assessment Tool completed on an identified date, noted the resident had inappropriate behaviour. This behaviour was described as touching others inappropriately and indicated a neighbour reported to a family member that resident #001 grabbed at him/her inappropriately when he/she was helping him/her. It occurred only once and redirection proved effective. Interviews with the ADOC and DOC confirmed this was never assessed by the registered staff of the home and measures were not taken to monitor or mitigate the risks to other residents in resident #001's initial plan of care.

Interview with PSW #115 who witnessed the first reported inappropriate behaviour of resident #001 at the home on an identified date, revealed he/she thought something was odd because resident #008's door was closed. The PSW walked into the room during nourishment time and observed resident #008

partially unclothed while sitting beside resident #001. Resident #001's clothes were undone and he/she was inappropriately touching resident #008. The PSW redirected resident #001 out of the room while the resident acknowledged he/she had done something wrong. According to the PSW, resident #008 appeared to be asleep and when woken up, was unaware of what had happened. The PSW reported the incident to the RPN who then reported it to the RN in charge.

Further interview with PSW #115 revealed that before the above mentioned incident, resident #001 was observed going into nonverbal resident rooms to stand and watch. The PSW indicated resident #001 was also observed luring other identified residents into unoccupied rooms and was redirected before anything happened. The PSW also described resident #001 as looking to see where staff were and then proceeding to go into other residents' rooms.

Review of progress notes revealed the RPN documented the above mentioned incident and stated that the RN made a call to the ADOC. Interview with the ADOC revealed the RN contacted him/her that day, explained the situation and asked for direction of what to do. Interview with the Administrator revealed the RN also called him/her that day to inform him/her of the situation. According to the Administrator, he/she informed the RN to call the MOHLTC and police and start an Unusual Occurrence Report. Interview with RN #128 revealed he/she did not recall the Administrator telling him/her to do anything else other than ensure the report was written and to continue to observe resident #001. Review of the DOC's binder of Unusual Occurrence Reports revealed a report was written to describe the occurrence which was signed by the RPN. There is no indication on the report that any further action was taken. Interviews with the ADOC, DOC and Administrator confirmed that they were aware of the incident and did not follow up with registered staff to ensure assessments were completed and interventions implemented to address resident #001's responsive behaviours.

Review of resident #001's progress notes revealed the physician made a note on an identified date, that there were concerns regarding the resident's behaviour and before considering medication, wanted the staff to implement behavioural monitoring. Review of the behaviour monitoring sheets from an identified time period, revealed resident #001 did not make any verbal or physical advances. The sheets did reveal resident #001 had other identified behaviours.

Review of resident #001's progress notes revealed there was no reason given for behaviour monitoring that started for another identified time period. The behaviour monitoring sheets revealed there was one day in which the resident made physical advances that happened several times during the day and was extremely disruptive. During this period there was also other responsive behaviours noted.

Review of resident #001's progress notes revealed that on an identified date, the resident was observed doing up an identified piece of clothing while leaving the front lounge and staff noted that resident #004 was sitting on the couch partially unclothed. According to the note, the RPN notified the ADOC and RN and behaviour monitoring was initiated. Review of the behaviour monitoring sheets for an identified period of time, revealed there was one day that resident #001 made verbal advances, two days that he/she made physical advances and one day when he/she was observed walking down the hall with an identified piece of clothing undone. There were also other responsive behaviours noted.

Review of resident #001' progress notes revealed that on an identified date, the resident was standing in the hallway touching resident #004 inappropriately and when staff intervened resident #001 started yelling aggressively. The note indicated that the RN filled in a referral for Behavioural Support Ontario (BSO), left a message with the SDM and also started behaviour monitoring. Interview with RN #129 revealed he/she never completed the BSO referral because he/she did not hear back from resident #001's SDM to provide consent. Review of the behaviour monitoring sheets for another period of time, revealed resident #001 made verbal and physical advances. There were also several other responsive behaviours noted.

Review of the home's policy #RCSM G-45-05 titled "Behavioural Management Program Assessment" reviewed August 16, 2016, revealed that upon completion of the seven days of behavioural monitoring, when behaviours are evident, the RN will initiate a referral to the Behavioural Support Team.

Interview with RN #128 revealed he/she was not aware that RNs are responsible to assess the behaviour monitoring sheets and more often than not these sheets just get filed. The RN indicated that if he/she happens to see that such sheets have multiple behaviours then he/she will write this in the progress notes and inform the ADOC. Interview with RN #129 who documented that a BSO referral

was going to be initiated for resident #001 pending SDM consent, admitted that the home's process to deal with responsive behaviours lacks cohesiveness as no one understands who is responsible for what. Interview with the DOC and ADOC revealed that this is an area the home needs to improve upon to ensure that someone is in charge of reviewing, assessing, and following up on reported responsive behaviours.

Review of resident #001's progress notes, assessments and written plan of care revealed there were no assessments of the behavioural monitoring sheets or interventions implemented during each of the above four time periods. Interview with the DOC confirmed there was no review of these sheets, assessments completed and interventions implemented to respond to resident #001's needs. (501)

2. On an identified date, the MOHLTC ACTION Line received a complaint related to an incident when a resident was found away from the home, walking alone. The resident was taken back to the home by the Assistant Director of Care (ADOC).

Review of resident #003's chart revealed the resident was initially admitted to the secure home area on the second floor. Further review of the resident's chart failed to reveal that the resident had been assessed for the responsive behaviour of wandering when admitted to the home. The chart review also revealed the resident had been transferred to home area on the first floor because no exit seeking behaviour had been identified. However, it failed to reveal that the resident had been reassessed regarding his/her change in the responsive behaviour.

Review of resident #003's progress notes revealed on an identified date, while driving to work, the ADOC had observed the resident walking on a street without supervision. The ADOC took the resident back to the home. Review of the resident's progress notes for an identified month, prior to the elopement, revealed the resident had been walking up and down from the front lounge to his/her room. The progress notes further revealed the night prior to resident #003's elopement, the night nurse documented that the resident had been agitated on several occasions walking here and there in the hallways throughout the night. However, the resident's plan of care had failed to reveal that the resident had been assessed for experiencing any responsive behaviour or there had been any written plan of care developed .

Interview with RPN #126 revealed that the staff observed the resident and documented in the observation record. The RPN stated that the resident was not assessed for the specific identified behaviors of wandering and agitation.

Interview with the DOC revealed the home had a policy for guiding the staff to manage responsive behaviours however there was no responsive behaviour program established in the home with written approaches to care, or developed to meet the needs of the residents with responsive behaviour that include assessment, reassessment and identification of behavioural triggers that may result in responsive behaviour, whether cognitive, physical, emotional, social, environmental or other. The DOC further confirmed they contracted an outside BSO team that would come to the home when a resident had been referred, to assess the resident, identify triggers and develop residents' written plan of care using their tools. Further the DOC confirmed after the resident had been admitted to the home, the staff observed the resident for seven days using a tool titled Behavioural Assessment with 30 different responsive behaviours to be chosen from with frequency. The staff provide general approaches to manage residents' responsive behaviour and if the staff were unable to manage the responsive behaviour anymore, they refer the resident to the outside BSO team.

Interview with the Administrator confirmed the home used services from the outside BSO team to manage the responsive behaviour of the residents in the home and the home is working now with the two sister homes to establish a responsive behaviour program in the home to manage the residents' behaviour.

Based on the potential risk of harm, noncompliance regarding more than one resident with responsive behaviours and the home's lack of strategies to prevent, minimize and respond to responsive behaviours, an order is being served.
(600)

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that residents are protected from abuse. The plan shall include, but not be limited to the following:

1. The development and implementation of a system to ensure:

• The home's policy and procedure clearly identifies who will be responsible for reporting matters to the Director under s. 24 and how and when these matters will be reported;
• An immediate investigation is commenced after a report of any abuse by anyone;
• Substitute Decision Makers (SDMs) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect that has resulted in physical injury or pain to the resident or that causes distress to the resident;
• Residents and/or SDMs are notified of the results of the alleged abuse or neglect investigation immediately upon the completion;
• At least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
• Criminal reference checks are conducted prior to the hiring of all new staff members who are 18 years of age or older.

2. Develop an education plan that includes:

• The training of all staff so they understand the home's policy of zero tolerance

of abuse and neglect, Residents' Bill of Rights, mandatory reporting and whistle blowing protection;
• Training so that staff and managers are aware and can demonstrate an understanding of capacity and consent;
• Training regarding when to contact the police, including steps to take prior to and after notification of the police;
• A clear identification of when all staff will receive education on reporting incidents such as any alleged, suspected, or witnessed incidents of neglect to SDM under the requirements of the legislation;
• How the home will maintain a record of training provided including dates, times, attendees, trainers and material taught.

For all the above, as well as for any other elements included in the plan, please include who will be responsible for implementing, as well as a timeline for achieving compliance, for each part of the plan.

This plan is to be submitted via email to inspector susan.semeredy@ontario.ca by November 24, 2016.

Grounds / Motifs :

1. The licensee has failed to protect resident #002 and six other residents from abuse.

On an identified date, an anonymous call was received by the Ministry of Health and Long Term Care (MOHLTC) ACTION Line indicating a resident was touching residents of the opposite sex in an inappropriate manner.

On an identified date, Registered Nurse (RN) #103 called the MOHLTC ACTION Line and made a report indicating resident #001 was abusing other residents. Resident #001 had been in the home since an identified date, and had allegedly been inappropriately touching residents of the opposite sex since one month following his/her admission.

A search of the CIS (Critical Incident System) revealed the only CIS submitted for this incident was on the same date RN #103 called. The CIS revealed that there have been at least 27 separate incidents of abuse of at least five residents by resident #001 since an identified month. The report indicated resident #001 was inappropriately touching residents of the opposite sex. At least one of the residents expressed fear according to the CIS.

Staff members #100 and #101 told the inspector that there were a total of seven residents identified so far. Both staff told the inspector that this behaviour had been going on for quite a while. One staff member told the inspector that management was not doing anything to stop the abuse and both indicated resident #001 sought out unsupervised residents when he/she believed that the staff were distracted by activities on the care unit.

The Administrator told the inspector that they had not taken resident #001 seriously and confirmed they have not notified the police at the time of the interview. The Administrator also agreed with the inspector that this constitutes abuse and told the inspector that he/she was planning to contact the police. There were no interventions in place to protect the affected residents from resident #001 until after the Registered Nurse (RN) called the MOHLTC ACTION Line on an identified date.

Based on the scope of seven residents and the severity of the action of resident #001 and the inaction by the licensee, an immediate order was served. [s. 19. (1)]

2. The licensee has failed to protect seven residents from an identified type of abuse.

One type of abuse as outlined in section 2.(1) of the Regulation (O.Reg.79/10) means any non-consensual touching, behaviour or remarks of an identified nature or identified exploitation directed towards a resident by a person other than a license or staff member.

Review of a Critical Incident Report submitted on an identified date, revealed resident #001 was discovered by a staff member to be standing beside resident #005's wheelchair and was behaving inappropriately.

Review of resident #001's progress notes revealed this was not the first time he/she had touched other residents of the opposite sex. Other incidents included were documented as having occurred on identified dates and times:

1. Resident #001 found in resident #008's room, in bed with resident.
2. Resident #001 was following residents of the opposite sex down the hallway and was noted to guide three identified co-residents into his/her room.

3. Resident #001 found in hallway behaving inappropriately with another unidentified resident.
4. PSW reported finding resident #001 with identified co-resident in room behaving inappropriately.
5. Resident #001 moved down to another floor this evening. Shortly after arriving, resident was found in the lounge behaving inappropriately with resident #004.
6. PSW witnessed resident #001 grab onto resident #002's hand. Shortly after resident #001 grabbed onto resident #004's hand and was walking up the hallway looking into rooms.
7. Resident #001 continues to act inappropriately with resident #007.
8. Resident #001 was walking up and down the hall, resident acted inappropriately with resident #006 and was grabbing resident #004.
9. Resident #001 was acting inappropriately with resident #002 who stated "I am scared."
10. Resident #001 acted inappropriately with another resident which scared that resident and made him/her anxious.
11. Resident #001 trying to get into resident #007's room and was acting inappropriately with resident #004.
12. Resident #001 trying to act inappropriately with resident #004 and was trying to act inappropriately with other residents of the opposite sex on the home area.
13. Resident #001 was sitting on the couch in the lounge beside an unidentified co-resident, acting inappropriately.
14. Staff reported that resident #001 was observed adjusting his/her clothes while leaving the front lounge. Staff entered the front lounge while resident #001 exited and observed resident #004 sitting on the couch partially unclothed.
15. Resident #001 was sitting with resident #007 on the couch. Resident #001 was trying to act inappropriately with resident #007.
16. Previous shift RN reported to writer that resident #001 was acting inappropriately with resident #004 in the front lounge.
17. Resident #001 observed acting inappropriately with resident #007.
18. PSW reported that resident #001 acted inappropriately with resident #004.
19. Resident #001 went into resident #004's room and was acting inappropriately.
20. Resident #001 was seen by PSW in resident #003's room acting inappropriately.
21. Resident #001 observed by writer to be in resident #002's room acting inappropriately.
22. Resident #001 was observed wandering into resident #002 and #007's

rooms. Resident #001 was observed acting inappropriately with resident #002.
23. Resident #001 was found in the front lounge with resident #004 and was acting inappropriately. PSW reported resident #001 was trying to wheel another resident from a different floor to his/her room.
24. PSW reported to writer that resident #001 was witnessed acting inappropriately with resident #002. Resident #002 yelled at resident #001 to "get out."
25. Resident #001 was acting inappropriately with resident #006 in the lounge.
26. Resident #001 observed walking into resident #003's room and grabbing his/her hand. Resident #001 also observed acting inappropriately with resident #003.
27. Another resident reported to the staff that resident #001 acts inappropriately with resident #007 every night.
28. Resident #001 was standing in the hallway acting inappropriately with resident #004. Writer intervened and resident #001 yelled at writer and showed his/her fist against writer's face and made threatening comments. RN filled in a referral for BSO and left a message with the POA and also started the behavioural monitoring on resident.
29. Resident #001 acting inappropriately with resident #007 after dinner. Resident #001 was entering into other resident rooms and taking off yellow wander strips.
30. Resident #001 was trying to act inappropriately with resident #006 when he/she was sitting in the dining room. Another identified resident complained that resident #001 walks in his/her room very often and he/she does not like that.
31. Resident #001 witnessed by PSW to act inappropriately with resident #003.
32. Resident #001 was noted acting inappropriately with resident #003.
33. Resident #001 was walking in the halls, when another resident was also walking in the halls and a PSW noticed them engaged in inappropriate behaviour.
34. Resident #001 was noted in resident #002's room standing by his/her chair where he/she was sitting. Resident #001 was touching him/her inappropriately. Resident #002 was smiling and looking at resident #001.
35. Reported to writer by PSW that resident #001 was inappropriately touching an unidentified resident.
36. Resident #001 was standing at the door of resident #002 who was in front of him/her with an opened piece of clothing.
37. Resident #001was observed acting inappropriately with resident #002 in the front lobby while resident was already upset and looking for his/her spouse.
38. Resident #001 was entering into resident #002's room and when re-directed,

came out of the room and pointed out resident #006 who was sitting in the wheelchair at the desk and asked writer "can I get him/her then?"
39. Resident #001 found by staff in resident #002's room while he/she was asleep in his/her chair acting inappropriately.

Most of the above progress notes indicated that resident #001 was successfully redirected and staff would continue to monitor.

Interview with housekeeper #101 revealed that on an identified date, he/she witnessed resident #001 looming over resident #005 in his/her wheelchair with a specific body area close to his/her face. Two PSWs were busy at the time so the housekeeper went to get RN #103 and while doing so, noticed that resident #001 was touching resident #005 inappropriately. The housekeeper redirected resident #001 who complied. The housekeeper indicated that resident #001 would sometimes become aggressive when redirected. The housekeeper then reported the incident to RN #103. The housekeeper also mentioned that he/she has reported many instances to registered staff when he/she has found resident #001 touching other residents because according to him/her and PSW #100, resident #001 seems to engage in this type of activity when he/she thinks the nursing staff are busy.

An interview with RN #103 who is a casual RN revealed he/she was first made aware of resident #001's behaviour of inappropriately touching residents of the opposite sex on an identified date, when the housekeeper reported the above mentioned incident. According to the RN, he/she spoke with the Administrator on the telephone who advised him/her to call the MOHLTC and inquire how the home could get funding for one-to-one supervision which he/she did. The RN told the inspector that he/she was surprised to read in resident #001's progress notes that this inappropriate behaviour had been going on for several months. Review of the progress notes and an Unusual Occurrence Report and interview with the RN revealed he/she also contacted both SDMs involved, contacted resident #001's physician, set up one-to-one supervision for resident #001 and assessed resident #005 who did not appear to suffer any ill effects from the encounter. The RN admitted that he/she was aware this was an allegation of abuse and needed to be reported to the MOHLTC but did not contact the police as he/she felt resident #001 could be managed by the home in the immediate future and it was up to management to make additional decisions upon their return the following day.

The inspector conducted record reviews, observations and interviews regarding the status of the seven residents which revealed the following:

Record review revealed resident #005 was admitted to the home on an identified date and a had an identified cognitive performance score (CPS) indicating severely impaired. According to a Minimum Data Set (MDS) assessment dated on an identified date, and interview with the SDM, there is a language barrier and the resident's speech is unintelligible. Observations and interviews with RN #103, PSWs #100 and #105 revealed the resident is wheelchair bound and unable to communicate. Interview with the SDM revealed he/she was informed of the incident that occurred on an identified date, on the same day by a RN. The SDM told the inspector he/she did not think resident #005 was capable of consenting to such activity and believed that residents who are not in their full state of mind should have people take responsibility to ensure the resident's dignity and safety. The SDM felt that the home should have done something sooner in regards to resident #001's behaviour as further conversations with the management revealed this was not the first time resident #001 had made such advances to residents of the opposite sex.

Record review revealed resident #002 was admitted to the home on an identified date, with identified medical conditions. A mini mental assessment was completed on an identified date, for resident #002 resulting in a score that indicated moderate cognitive impairment. Review of the resident's plan of care and interview with RN #103 revealed resident #002 often appears sad and lonely. RN #103 told the inspector resident #002 may not be capable of consenting to an identified activity but may not resist. Review of the incidents regarding resident #001 and #002 revealed that sometimes resident #002 is fine with accepting the attention of resident #001 while other times, he/she is not. Interview with resident #002 revealed he/she was unsure whether he/she would welcome a relationship with a co-resident, stating "maybe yes, maybe no." Interview with resident #002's SDM revealed he/she was informed of an incident regarding resident #001 approximately six weeks prior, did not have any concerns and believed that resident #002 may be capable of consenting to this identified activity.

Record review revealed resident #006 was admitted to the home on an identified date with identified medical conditions. Resident #006's current CPS indicates resident is severely impaired. Resident was unable to carry on a conversation with the inspector but did make identified gestures and made these gestures

with the inspector's hands. Observations and interviews revealed resident #006 is wheelchair bound. Interviews with RN #103 and #112 revealed they did not believe resident #006 would be capable to consent to anything. An interview with RPN #106 revealed resident #006 often makes certain noises which may provoke resident #001 to be inappropriate. An interview with resident's SDM revealed he/she does not believe resident #006 is capable to consent to such identified activity but loves to be shown affection. The SDM was aware there was a roaming resident that touches residents of the opposite sex but the home had not informed him/her that any incidents had occurred between this resident and their family member.

Record review revealed resident #003 was admitted to the home on an identified date with identified medical conditions. Resident #003's current CPS score indicates mild impairment. Observation, staff interviews and interview with resident's SDM revealed resident understands English but will only speak an identified language. Interview with resident #003's SDM indicated he/she was upset that the home did not contact him/her when the incident happened in an identified month but waited until the first week of the next month. Record review revealed incidents occurred between resident #001 and #003 in months previous to the the reported month. The SDM indicated he/she did not believe resident #003 was capable to consent to this identified activity as he/she has indicated that that part of his/her life is over.

Record review revealed resident #004 was admitted to the home on an identified date with identified medical conditions. Resident #004's current CPS score indicates severe impairment. Record review, staff interviews, interview with resident's SDM and observation revealed resident has little memory. Interview with resident's SDM revealed resident #004 would not be able to consent to this identified activity. Resident's SDM was satisfied that the home was taking care of the situation as long as the resident had one-to-one monitoring to protect his/her parent and other residents.

Record review revealed resident #007 was admitted to the home on an identified date and has a current CPS that indicates moderate impairment and a Minimal Mental State Examination (MMSE) conducted on an identified date revealing mild cognitive impairment functioning. An interview with resident #007 revealed he/she was indecisive about having relations with another co-resident. Record review revealed resident #007 was observed having a consensual activity with resident #001 on an identified date, and when interviewed by the DOC regarding

the incident, the resident indicated he/she was lonely. An interview with resident #007's SDM revealed he/she is uneasy with the situation because he/she is worried about safety and does not feel resident #007 knows what he/she is doing.

Record review revealed resident #008 was admitted to the home on an identified date, with identified medical conditions. Resident #008's current CPS indicates moderate impairment. According to staff members #104 and #110, resident #008 is very cognitively impaired and has been known to walk up to residents or staff and act inappropriately. Interview with resident #008's SDM revealed he/she was informed of the incident that occurred on an identified date, when resident #001 was found with resident #008. The SDM indicated resident #008's medical condition has progressed significantly and would be unable to defend him/herself and if somebody would attempt contact with him/her, he/she would not protest. The SDM indicated resident #008 would not be capable to consent to such activity.

Record review revealed resident #001 was admitted to the home on an identified date, with identified medical conditions. Resident #001's CPS indicates severe impairment and a MMSE completed on an identified date, revealed severely impaired cognitive functioning. Observation revealed that resident #001 is able to ambulate independently but is not able to carry on a conversation. Staff interviews and an interview with resident #001's SDM revealed resident was admitted to the home when his/her spouse was in the hospital for palliative care. According to the SDM and DOC, resident #001 has been grieving the passing of his/her spouse which occurred on an identified date.

Record review of resident #001's progress notes and interviews with PSWs #105 and 115 revealed resident #001 was displaying interest in residents of the opposite sex shortly after admission onto an identified floor. Interview with PSW #115 revealed even before resident #001 was observed with resident #008, he/she was watching and luring residents of the opposite sex to empty rooms but was able to be redirected. Record review revealed resident #001 was moved from one floor to another to the first floor to be with his/her spouse, and shortly after being transferred was found acting inappropriately with resident #004. There was no evidence to indicate either residents were assessed for capacity at the point of interaction.

Interviews with housekeeper #101 and PSW #100 revealed they have viewed

resident #001's touching of residents as abuse because they believe the residents are not able to consent to the touching. According to these staff members, resident #001 waits until the nursing staff are busy and will then attempt to engage a resident who is often unable to consent due to dementia. These staff members have reported it several times to registered staff and believe management have let this go on too long. Interview with RN #103 who reported the incident on an identified date, revealed he/she knew it was abuse the first time it was reported to him/her, was shocked to learn it had happened several times previously and believed that management did nothing to protect vulnerable residents. Interview with RPN #106 and #110 revealed each time they witnessed or received a report from PSWs regarding resident #001 acting inappropriately with residents of the opposite sex, they have documented these activities and believe the ADOC and DOC should be monitoring these documentations every 24 hours. RPN #106 and #110 also indicated that they were never questioned regarding their multiple documentations regarding resident #001 and do not feel management did enough to protect the residents.

Interviews with the ADOC and DOC revealed they do not monitor the 24 hour report in the electronic documenting system as it is the RNs in charge that review these. The expectation is that the RNs will inform them if there are situations they cannot handle. Interview with the ADOC revealed he/she was aware of the first reported incident when resident #001 was found with resident #008 but did not conduct an investigation or do any follow up that was documented. Further interview with the ADOC revealed he/she did not report any of the incidents involving resident #001 and other residents to the MOHLTC because in speaking with the DOC and Administrator, it was not interpreted as abuse. Interview with the DOC confirmed that the home did not protect the above residents from abuse because he/she is now aware that consent needs to be given and in order to ensure consent, the home needs to do much more in terms of assessment. The DOC thought that monitoring and redirecting was enough but now realizes that this was an ineffective measure to prevent future occurrences and protect residents.

The Administrator told the inspector on the first day of the inspection that the actions of resident #001 constituted abuse because it was not known that the residents of the opposite sex had given consent. The Administrator confirmed he/she was aware of the first incident regarding resident #001 and resident #008 on an identified date, the day the incident occurred and because he/she was on vacation, overlooked any follow up.

Based on the scope of seven residents and the severity of the action of resident #001 and the inaction by the licensee, an order is being served. (501)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 27, 2017

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Order / Ordre :

The licensee will ensure that a person who has reasonable grounds to suspect that any abuse of a resident by anyone that has occurred or may occur that resulted in harm or a risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director.

Grounds / Motifs :

1. The licensee has failed to immediately report the suspicion of abuse and the information upon which it is based on to the Director.

Record review and staff interview revealed resident #011 was abusing other residents in at least 26 separate incidents during an identified time period. Resident #011 was sent to the hospital on two identified dates for continually being abusive.

Interview with RN #103 revealed resident #011 was abusive with other residents on an identified date, throughout the day, and was sent to the hospital accompanied by the police. One of the residents who was abused complained of pain and was sent to the hospital. RN #103 indicated that he/she did not report this incident to the MOHLTC as he/she was not aware that this was his/her responsibility.

Review of a critical incident report revealed resident #011's abusive behaviour was not reported until an identified date, after inspector #501 met with police detectives who were in the home to investigate the incident involving resident #001 on an identified date. Interview between inspector #501 and the DOC and Administrator confirmed the home had not reported this incident as they were not aware that the suspicion of resident to resident abuse needed to be immediately reported (501)

2. Record review and staff interviews revealed resident #001 was abusing at least seven residents of the opposite sex in at least 39 separate incidents during an identified time period. Staff interviews revealed some were aware this constituted abuse whereas others were not. Interviews with the ADOC, DOC and Administrator confirmed they had not investigated these incidents to find out if consent had been obtained and therefore should have known that these incidents could be regarded as abuse. Not until an identified date, were there phone calls made to the MOHLTC regarding resident #001 touching resident #005 by RN #103 and an anonymous caller.

Based on the severity of harm related to abuse, the scope involving several residents and the home's lack of awareness of reporting requirements to the Director, an order is being served
(501)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 22, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 28th day of September, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Susan Semeredy

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