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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Mar 21, 2017	2017_590554_0003	034871-16	Critical Incident System

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

RIVERVIEW MANOR NURSING HOME
1155 WATER STREET PETERBOROUGH ON K9H 3P8

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

KELLY BURNS (554)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 10, to January 13, 2017

Intakes inspected include: #034871-16, and #000970-17.

Summary of Intakes:
1) #034871-16 - Critical Incident Report (CIR) - alleged sexual abuse, resident to resident involving resident #001 to resident #002;
2) #000970-17 - Critical Incident Report - alleged sexual abuse, resident to resident involving resident #001 to resident #003.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Office Manager, Resident Service Coordinator, Nursing Administrative Service Manager, Manager of Resident Quality, Environmental Services Manager, Life Enrichment Coordinator, Registered Nurse(s), Registered Practical Nurse(s), Personal Support Worker(s), Behaviour Support Staff (BSO), Life Enrichment Aide, and Resident(s).

During the course of the inspection, the inspector, toured the long-term care home, reviewed clinical health records; observed staff to resident interactions, as well as resident to resident interactions; reviewed annual retraining records, specific to zero tolerance of abuse, resident rights and mandatory reporting, reviewed licensee investigational notes related to Critical Incident Reports inspected upon, reviewed licensee policies, specific to, Zero Tolerance of Abuse and Neglect of Residents, Reporting Incidents of Abuse, Critical Incident Reporting, Investigational Procedures, and Caring For A Resident Expressing Sexual Behaviours.

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

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

5 WN(s)
3 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for resident #003, set out the planned care for the resident; the goals the care is intended to achieve; and clear directions to staff and others who provide direct care to the resident, specific to safe-guarding resident #003 from resident #001.

Related to Intake #000970-17, for Resident #003:

While conducting an inspection for a Critical Incident Report (CIR) unrelated to resident #003, Inspector #554 was reviewing progress notes for resident #001, and noted the following documentation:

- On an identified date at a specific hour – Personal Support Worker (PSW) reported to Registered Practical Nurse (RPN) #012 that resident #001 was observed inappropriately touching resident #003. PSW indicated that resident #003 was asleep on the couch in the lounge at the time.

Registered Practical Nurse #012 indicated (to the inspector, on January 11, 2017) that this incident was reported to him/her by Personal Support Worker #013. RPN #012 indicated that resident #001 is cognitively impaired and it is his/her belief (RPN) that resident #003 is unable to give consent and further indicated resident #003 was sleeping at the time. Registered Practical Nurse #012 indicated resident #001 has inappropriately

touched resident #003 in the past. Registered Practical Nurse indicated staff are aware to keep resident #001 away from specific residents, but was not sure if there were specific direction to keep resident #001 away from resident #003.

Progress notes, for both residents #001 and #003, were reviewed (by the inspector) for the period of approximately four months, the following was documented, by registered nursing staff:
- On an identified date – A Personal Support Worker (PSW) witnessed resident #001 inappropriately touching resident #003. This incident of alleged sexual abuse between resident #001 and #003 was previously reported to the Director (in an identified Critical Incident Report) and previously inspected under another inspection report.
- On an identified date (next day) – Resident #003 was asleep on the couch in the lounge, resident #001 observed by nursing staff, trying to approach and touch resident #003. Resident #001 indicating it was his/her belief that resident #003 was his/her spouse. Resident #003 was taken to his/her room to sleep, and staff returned to their night duties. Registered Practical Nurse indicated in his/her documentation that resident #001 was observed wandering the hallways, entering other resident's rooms looking for resident #003.
- On an identified date (approximately month later) – Resident #001 was awake and up in his/her wheelchair at 0215 hours, was observed approaching resident #003, referring to resident as his/her spouse and asking resident #003 if he/she was ready to go to bed.
- On an identified date (approximately month later) – Staff reported witnessing resident #001 being sexually inappropriate towards resident #003.

Personal Support Workers #006 and #008 both indicated resident #001 targets specific residents, but neither could recall if resident #003 had been inappropriately touched by resident #001.

Personal Support Worker #007, and the Administrator, both indicated (to the inspector, January 10, 2017 and January 11, 2017) it was their belief that resident #003 was targeted by resident #001.

The written plan of care for resident #003 was reviewed (current in place at time of this inspection) and failed to set out the planned care for the resident; the goals the care is intended to achieve; and clear directions to staff and others who provide direct care to the resident, specific to safe-guarding resident #003 from resident #001. [s. 6. (1)]

2. The licensee failed to ensure that the care set out in the plan of care is provided to the

resident as specified in the plan.

Related to Intake #034871-16, related to Resident #001:

Resident #001 was admitted to the long-term care home on an identified date. Resident #001 has a history which includes, cognitive impairment.

Registered Practical Nurse (RPN) #005, Personal Support Workers (PSW) #006, #007 and #008, the Director of Care and the Administrator all indicated (to the inspector, on January 10, and January 13, 2017) that resident #001 is known to exhibit responsive behaviours, specifically aggression and sexual expressions which are directed towards specific residents and staff.

The Administrator submitted a Critical Incident Report (CIR) for an alleged incident of resident to resident sexual abuse, which was reported to have occurred on an identified date, at approximate hour and involved residents #001 and #002.

The Critical Incident Report, as well at the clinical health record, specifically a progress note, for the above date, details are as follows:

- Environmental Services Manager (ESM) entered resident room and saw resident #001 seated on the bed of co-resident (#002). ESM indicated (in his/her statement, as well as to the inspector) that resident #002 was lying on the bed and was asleep. Resident #001 was observed, by ESM being sexually inappropriate towards resident #003. Resident #001 was assisted, by nursing staff, off of the bed, into his/her wheelchair and removed resident #002's room. Documentation in the progress notes indicated when ESM entered resident #002's room, the resident #001's wheelchair alarms were not alarming.

The plan of care (in place at the time, dated for specific time period) for resident #001 directs the following:
- Aids to Daily Living – need for a wheelchair. Interventions include, seek out and determine resident's whereabouts; wireless alarm in bed and Posey alarm in wheelchair; ensure that Posey alarm is secure and in working order when in wheelchair and wireless alarm when in bed.
- Wandering – needs to be monitored. Interventions include, seek out and determine resident's whereabouts; when wandering and or presenting as restless ensure resident does not enter other resident's rooms; offer to redirect to his/her own room.
- Physically Abusive – needs to be monitored. Interventions include, remove anyone that

may be in danger from the area; resident noted as high risk for aggression.
- Agitated Behaviour – can become agitated with staff and co-residents. Interventions include, if resident #001 presents restless, ensure resident does not enter other resident's rooms; redirect to his/her own room.
- Inappropriate Socially – inappropriate behaviours towards specific residents, especially resident #003 and another identified resident, and sexual comments towards identified staff. Interventions include, staff to supervise any interactions between resident #001 and co-residents, especially residents #003 and another identified resident; two staff for care at all times; specific staff for showers and baths (when possible); safety checks every 15 minutes and 1:1 supervision (initiated on an identified date); ensure resident does not wander to the other side of the long-term care home; 1:1 staff need to ensure that a safe distance is maintained (between resident and staff) due to unpredictable behaviour. (Note: The 1:1 was discontinued as per direction of management, as per progress note dated for a specific date)

An investigation of the alleged incident was conducted by the Administrator and Director of Care. Witness statements contained within the licensee's investigation documented the following:

- Personal Support Worker (PSW) #008 indicated (in his/her statement, on an identified date) that he/she had toileted resident #001 between the hours of 0930 and 1000, and was placed back into his/her wheelchair. PSW #008 indicated that resident #001 continuously got out of his/her wheelchair and that the personal alarms were known to fall out.

- Personal Support Worker #007 indicated (in his/her statement, on an identified date) that he/she toileted resident #001 after the incident and observed that the chair/bed alarm was still on resident #001's bed, indicating the chair alarm had not been placed into resident's wheelchair.

Environmental Services Manager indicated (to the inspector, on January 10, 2017) that when he/she entered resident #002's room on the identified date, resident #002 was not in his/her wheelchair, and observed sitting on resident #002's bed. ESM indicated when he/she entered resident room that he/she heard no alarms (chair and or Posey) sounding. ESM indicated that the wireless chair alarm was not observed in the wheelchair and that the Posey alarm was on the chair but was not turned on.

Personal Support Worker #008 indicated (to the inspector, on January 11, 2017) that

there was to have been both a wireless chair alarm and a Posey alarm on resident #001's wheelchair. PSW #008 indicated that he/she could not recall if the alarms (chair and Posey) for resident #001 were in place that day. PSW #008 indicated it was his/her belief, that the unit (resident home area, identified unit) was very busy with residents with responsive behaviours, not just resident #001, and it was difficult to monitor each resident.

2. Resident #001's plan of care (in place at the time of this inspection) indicated the following:

- Aids to Daily Living – Interventions include, wireless alarm in bed and chair; Posey alarm in wheelchair for safety; ensure both alarms are secure and in working order.

On an identified date, and at an approximate hour, resident #001 was observed (by the inspector) sitting in his/her wheelchair with 1:1 staff present. Resident #001 was observed to have Posey alarm attached to his/her wheelchair, the alarm was functioning (light flashing); no wireless chair alarm was observed during this observation.

Personal Support Worker #008, who was the assigned 1:1 staff, indicated (to the inspector) that there was to have been both a wireless chair alarm and a Posey alarm on resident #001's wheelchair. PSW #008 indicated it was his/her belief that the wireless alarm was broken, as it was not on resident's bed when he/she (PSW) came on shift today.

Personal Support Worker #007 indicated (to the inspector, on January 10, 2017) that he/she noted that resident #001 did not have a wireless chair alarm on his/her wheelchair and had inquired as to why the alarm was not in use; PSW #007 indicated hearing from Life Enrichment Aide (LEA) #010 that the alarm had not been available for some time.

LEA #010 indicated (to the inspector, on January 10, 2017) that there was to be both a wireless chair alarm and a Posey alarm on resident #001's wheelchair for the safety of others. LEA #010 indicated that he/she was assigned as the 1:1 staff for resident #001 on an identified date, and that the wireless chair/bed alarm was not available for use. LEA #010 indicated he/she also worked last week, on two identified dates, as the assigned 1:1 (for resident #001), and indicated that the wireless bed/chair alarm was not available for use on those dates either; LEA indicated he/she reported to registered nursing staff that the wireless alarm (chair/bed) were not available for use, but could not recall who he/she reported this to, or on the date to which it was reported.

The licensee failed to ensure that the care set out in the plan was provided to resident #001, specific to personal alarms (wireless chair/bed and Posey) not being in place and or operational on identified dates. [s. 6. (7)]

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 there is a process in place and monitored, ensuring that the written plan of care for resident #003, set out the planned care for the resident; the goals the care is intended to achieve; and clear directions to staff and others who provide direct care to the resident; and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

Under LTCHA, 2007, 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.

Under LTCHA, 2007, s. 20 (1) - Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written

policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee's policy, Zero Tolerance of Abuse and Neglect of Residents (#AM-6.9), as well as the policy, Reporting of Incidents of Abuse (#AM-6.7) (both effective June 2015) define sexual abuse and such includes, any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a staff member.

Both policies, Zero Tolerance of Abuse and Neglect of Residents, as well as Reporting of Incidents of Abuse, directs that:
- Any person who has reasonable grounds to suspect that a resident has been neglected or abused is obligated by law to immediately report the suspicion and the information upon which the suspicion is based to the Director, Home's Administrator or the manager on call;
- Each incidence of neglect or abuse shall be considered and immediately reported as a critical incident and such, shall be reported to the Director of Operations (OMNI) and the Ministry of Health and Long Term Care by telephone and computerized submission of a Mandatory Critical Incident System;
- In cases where a staff member witnesses/suspects/hears about an act of abuse or neglect, the first course of action shall be to ensure the resident is taken to a safe and secure environment; once the resident is physically safe, the staff shall report the incident to direct manager, Director of Care or Administrator;
- A resident's family or substitute decision maker shall be contacted to inform them of any alleged, suspected or witnessed incident of abuse immediately after it is reported;
- The police shall be contacted to inform them of any alleged, suspected or witnessed incident of abuse of a resident immediately after it is reported.

Related to Intake #000970-17, for Resident #001 and #003:

Resident #001 has a history which includes cognitive impairment. Resident #001 wanders about the long-term care home in his/her wheelchair, and is known to exhibit responsive behaviours.

On January 10, 2017, Behavioural Support, Personal Support Worker #007, Behavioural Support, Registered Practical Nurse #005, the Director of Care and the Administrator indicated that resident #001 exhibits responsive behaviours, which include, inappropriate non-consensual touching of co-residents and/or staff.

The health care record, specifically progress notes, for Resident #001 were reviewed (by the inspector) during this inspection, the following was noted:

- On an identified date, and at an approximate hour, Personal Support Worker (PSW #013) reported to Registered Practical Nurse (RPN #012) that resident #001 was observed inappropriately touching resident #003. As per PSW #013, resident #003 was asleep on the couch in the lounge at the time of this observation.

Registered Practical Nurse #012 indicated (to the inspector, on January 11, 2017) that resident #003 was asleep at the time of the alleged incident. Registered Practical Nurse #012 indicated that resident #003 is cognitively impaired and is unable to provide consent. Registered Practical Nurse #012 indicated that the touching of resident #003, by resident #001, would be considered sexual in nature.

Registered Nurse (RN #014), who was the assigned Charge Nurse, on the identified date indicated (to the inspector, on January 12, 2017) no awareness of the alleged resident to resident abuse incident. RN #014 indicated that the alleged incident should have been reported to him/her, so that further interventions could have been taken.

The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with as Registered Practical Nurse #012, did not:
- Report the alleged resident to resident abuse incident, which was said to have occurred on an identified date, to the direct manager (Charge Nurse – RN #014), and or Director of Care, Administrator or manager on call;
- Report the alleged resident to resident abuse incident (identified date) to the Director, using the after-hours contact number;
- Notify residents #001 and/or #003 substitute decision maker on the identified date;
- Notify police of the alleged abuse incident on the identified date.

The Director of Care indicated (to the inspector, on January 12, 2017) that Registered Practical Nurse #012 had received annual retraining on home specific polices (e.g. zero tolerance of abuse and neglect); DOC indicated it is an expectation that staff will follow such policies.

Registered Practical Nurse #012 indicated in hindsight, the incident reported to him/her by Personal Support Worker on the identified date would be considered resident to

resident sexual abuse as per the licensee's definition. [s. 20. (1)]

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 there is a process in place and monitored, ensuring hat the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure a person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, specifically, abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" is defined as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than the licensee or staff member.

Related to Intake #000970-17, for Resident #001 and #003:

A Critical Incident Report (CIR, dated for an identified date), involving resident #001, was being inspected by an inspector. During the inspection of the CIR, the following was noted and written in the health care record of resident #001:

- On an identified date, and at an approximate hour, Personal Support Worker (PSW #013) reported to Registered Practical Nurse (RPN #012) that resident #001 was observed (by PSW) inappropriately touching resident #003. As per the progress note, PSW #013 reported to RPN #012 that resident #003 was asleep on the couch in the lounge at the time of the observed incident. According to the progress note, resident #003 was not injured during this alleged incident.

The Director of Care indicated (to the inspector, on January 12, 2017) that she, and the Administrator were aware of the alleged resident to resident sexual abuse incident, involving resident #003 by resident #001, a day or two before submitting the CIR.

The Director of Care submitted the Critical Incident Report (CIR) to the Director on a identified date, specific to the alleged incident of resident to resident sexual abuse, which was said to have occurred approximately four days earlier. [s. 24. (1)]

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 there is a process in place and monitored, ensuring that person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, specifically, abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, to be implemented voluntarily.

WN #4: 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 failed to ensure that all staff have received retraining annually relating to, The Resident's Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and whistle-blowing protections.

During this inspection (dates of January 10, to January 13, 2017) two Critical Incident Reports relating to resident to resident abuse, were inspected upon; areas of non-compliance were identified which lead the inspector to inquire as to annual retraining of staff.

The Manager of Resident Quality, who oversees staff education for the long-term care home, as well as the Director of Care indicated (to the inspector, on January 13, 2017) that all staff did not receive annual retraining specific to the requirements under LTCHA, 2007, s. 76 (4).

Manager of Resident Quality and the Director of Care indicated the following:

- 73.4% of staff completed their annual retraining in 2016 specific to Resident's Bill of Rights;
- 93.4% of staff completed their annual retraining in 2016, specific to the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24;
- 90.1% of staff completed their annual retraining in 2016, specific to whistle-blowing protections.

Manager of Resident Quality indicated that all staff are expected to complete their annual retraining; and further commented that staff are assigned time during work hours, but some staff did not complete as requested. [s. 76. (4)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's substitute decision maker (SDM) and any other person specified by the resident were notified within twelve hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of a resident.

A Critical Incident Report (CIR, dated for a specific date), involving resident #001, was being inspected by an inspector. During the inspection of the CIR, the following was noted to be written in the health care record of resident #001.

Related to Intake #000970-17, for Resident #003:

- On an identified date, and at an approximate hour, Personal Support Worker (PSW #013) reported to Registered Practical Nurse (RPN #012) that resident #001 was observed (by PSW) inappropriately touching resident #003. As per the progress note, PSW #013 reported to RPN #012 that resident #003 was asleep on the couch in the lounge at the time of the observed incident.

The progress note, in resident #001's health record, indicated that resident #003 was neither injured or found in distress as a result of the alleged incident. The alleged incident was not documented within resident #003's health record.

The Director of Care indicated (to the inspector, on January 12, 2017) that she, and the Administrator were aware of the alleged resident to resident sexual abuse incident, involving resident #003 by resident #001, a day or two before submitting the CIR.

Director of Care indicated that the substitute decision maker for resident #001 and or resident #003 were not notified of the alleged resident to resident abuse incident until approximately four days post incident. [s. 97. (1) (b)]

Issued on this 21st day of March, 2017

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

Original report signed by the inspector.