Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 26, 2018	2018_643111_0011	011024-18	Critical Incident System

Licensee/Titulaire de permis

Glen Hill Terrace Christian Homes Inc.
200 Glen Hill Drive South WHITBY ON L1N 9W2

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

Glen Hill Strathaven
264 King Street East Bowmanville ON L1C 1P9

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 5 to 8, 2018

A critical incident report (CIR) (Log # 011024-18) related to an alleged resident to resident abuse, was inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Recreation Care Aide (RCA) and residents.

During the course of the inspection, the inspector reviewed the health records of current residents and one discharged resident, reviewed the licensee's investigations, BSO meeting minutes and the following licensee's policies: Responsive Behaviours and Prevention of Abuse and Neglect.

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.
7 WN(s)
0 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. 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 :

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

The licensee was issued a Compliance Order (CO #001) for s.19(1) on June 22, 2018 during and RQI inspection (#2018_578672_0004) with a compliance date of September 20, 2018. The CO involved resident #001 and resident #003. The following additional findings were noted during this critical incident inspection and included resident #001 and resident #003, but will be issued as a Written Notification (WN) due to the outstanding Compliance Order.

A critical incident report (CIR) was submitted to the Director on a specified date for a suspected resident to resident abuse incident. The CIR indicated the incident occurred the day before it was submitted and involved resident #001 towards resident #002. Resident #002 was upset as a result of the incident. The CIR indicated resident #001 was no longer in the home.

Review of the progress notes for resident #001 for a three month period (from the date of the last inspection until the resident was discharged) indicated there were four incidents of either witnessed or alleged abuse involving resident #001 as follows:
-On a specified date and time, RN #110 documented PSW #109 witnessed resident #004 being abused by resident #001 in a specified area. Resident #004 sustained a fall as a result with no injuries but was upset. The incident was also reported to RPN #111 and RN #110.
-On a specified date and time (two weeks later), RPN #107 documented resident #001 was witnessed in a specified area, and was abusive towards an unidentified resident. The RPN reported the incident to RPN #102 and the DOC. There was no documented evidence of the recipient resident involved in the incident.
-On a specified date and time (one week later), the Administrator documented restorative care aide (RCA #108) had witnessed resident #001 being abusive towards an unidentified resident and reported the incident to the DOC. There was no indication which recipient resident involved in the incident.
-On a specified date and time(one month later), RPN #104 documented that another charge nurse reported to the RPN that resident #001 had been abusive towards an unidentified resident. There was no specific information documented related to the incident, which charge nurse who initially reported the incident, and there was no documented evidence of when the incident occurred or which recipient resident was involved in the incident. The Administrator indicated an investigation was completed the following day and confirmed that resident #001 was abusive towards resident #002. The Administrator indicated resident #001 was no longer in the home.

Interview with RPN #107 on a specified date, by Inspector #111, indicated the first witnessed abusive incident that occurred, involved resident #001 towards resident #003. The RPN indicated the incident was immediately reported to RPN #102 and DOC.

Interview with RPN #102 on a specified date, by Inspector #111, indicated the RPN became aware of the second abusive incident the same day the incident occurred and involved resident #001 towards resident #002, when RPN #107 reported witnessing the incident. The RPN indicated the incident was reported to the DOC. The RPN indicated the third incident involved resident #001 towards resident #002, was reported to the RPN by RCA #108 and reported the incident to the Administrator.

Interview with RCA #108 on a specified date, by Inspector #111, indicated the third incident, involved resident #001 and resident #002, had occurred on a specified date and time and at a specified area. The RCA indicated immediately intervening and then reporting the incident to RPN #102.

The licensee failed to ensure resident #002, #003 and #004 were protected from abuse by resident #001 until, the resident was discharged from the home.

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 :

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

Review of the licensee's policy "Abuse and Neglect of a Resident -Actual or Suspected" (VII-G-10.00 revised January 2018) indicated:
-all staff members are required to report any abuse or suspected abuse immediately to

the Administrator, Director of Care or designate.
-assess the resident immediately and the Registered Staff will complete a resident assessment.
-document all events related to a reported/alleged abuse in the resident chart with clear descriptions and great detail.
-the resident's physician will examine the resident as soon as possible after the incident.
-failure to report abuse of any kind is subject to disciplinary action.
Under investigation:
-after safety is ensured the allegation must be thoroughly investigated as follows: all staff involved are required to complete statements before leaving at the end of their shift.
-written signed and dated (including time) statements immediately from: the staff members reporting the incident, any witnesses, the resident (this could be an interview with the resident statement written by the DOC or designate, read back and signed by the resident), the alleged abuser.

Review of the progress notes (for resident #001, #002, #003 and #004) over a two month period, interviews with staff and review of the licensee's investigation into the witnessed and/or alleged abuse indicated:
-On a specified date and time, PSW #109 reported to RPN #111, witnessing an altercation with resident #001 towards resident #004. RPN #111 then reported the incident to RN #110. There was no indication the physician was notified and the licensee's investigation had no written statements obtained from the staff members who were aware of the incident or any other witnesses as per the licensee's policy.
-On a specified date and time (two weeks later), RPN #107 documented resident #001 was witnessed being abusive towards an unidentified resident. The RPN indicated the DOC and RPN #102 were notified of the incident. There was no documented evidence to indicate who the recipient resident was. Interview with RPN #107 by Inspector #111, confirmed the recipient resident was resident #003. Review of the health record for resident #003 had no documented evidence of the incident to indicate the resident was assessed, no indication the physician was notified and there was no written investigation regarding this incident as per the licensee's policy.
-On specified date and time (one week later), the Administrator documented resident #001 was witnessed by RCA #108 to be abusive towards an unidentified resident. The Administrator did not indicate who the recipient resident was. Interview with the Administrator by Inspector #111, confirmed the recipient resident was resident #002 and confirmed there was no written investigation into the witnessed abuse incident. Review of the health record for resident #002 had no documented evidence of the incident to indicate the resident was assessed, no indication the physician was notified regarding

the incident and there was no written investigation completed as per the licensee's policy.

-On a specified date and time(one month later), RPN #104 documented that another charge nurse reported resident #001 had been abusive towards resident #002. There was no documented evidence what the abusive behaviour referred to, no indication the resident was assessed or to indicate the physician was notified and the licensee's investigation also had no written statements from staff who were aware or responded to the incident, as per the licensee's policy.

Interview with DOC by Inspector #111, indicated the expectation is that registered nursing staff are to document in each residents health record, the subjective and objective assessment of each resident involved in any abuse. The DOC indicated the investigation should include supervisors to speak with all the staff involved and get all staff to provide a written statement regarding any abusive incident.

Interview with the Administrator by Inspector #111 confirmed that an investigation was completed related to two of the abusive incidents involving resident #001 but no written statements were obtained from staff who were aware or responded to the incident. The Administrator confirmed that there were no written investigations for the other two abusive incidents involving resident #001. The Administrator confirmed no awareness which charge nurse was involved in the first incident that occurred and did not interview staff to get further details related to that incident.

The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with, specially related to documenting the incident and the assessments of each resident involved, notifying the physician, completing an investigation into all alleged, suspected or witnessed incidents of resident to resident abuse, and obtaining written statements from staff who were present or aware

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WN #3: 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 :

The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated: (i) Abuse of a resident by anyone.

Review of the progress notes for resident #001 for three month period in (until the resident was discharged) indicated there was one incident of witnessed abuse involving resident #001 towards resident #003 and two incidents of witnessed abuse involving resident #001 towards resident #002 that were not immediately investigated.

Interview with RPN #107 by Inspector #111, indicated the incident that occurred on specified date involving resident #001 towards resident #003 was immediately reported to RPN #102 and the DOC.

Interview with RCA #108 by Inspector #111, indicated the incident that occurred on a specified date, involving resident #001 towards resident #002 was immediately reported to RPN #102.

Interview with RPN #102 by Inspector #111, indicated the incident that occurred on a specified date, was reported to the RPN by RPN #107 (involving resident #001 and #003), and was reported to the DOC. The RPN indicated no awareness of any investigation into this incident. RPN #102 indicated the incident that occurred on a specified date, was reported to the RPN by RCA #108 and the RPN reported the incident

to the Administrator.

Interview with the DOC by Inspector #111, indicated the expectation for registered nursing staff to immediately report any alleged, suspected or witnessed incidents of abuse of a resident to their supervisor who is to immediately initiate the investigation into the incident. The DOC indicated the investigation should include supervisors to speak with all the staff involved and get all staff to provide a written statements regarding the incident. The DOC indicated not working in the home until after the last incident (was reported to the former DOC). The DOC confirmed there was no documented evidence of an investigation into the three incidents of resident to resident abuse that occurred.

Interview with Administrator by Inspector #111, confirmed the resident to resident abuse incident that occurred on a specified date, involved resident #001 towards resident #003. The Administrator indicated they did not feel the incident was considered abuse and therefore did not complete an investigation (despite meeting the definition of the specified abuse and contacting the police). The Administrator confirmed awareness that resident #001 had a prior history of specified responsive behaviours and indicated the police were called every time there was an incident with resident #001. The Administrator indicated the abusive incident that occurred on a specified date, involving resident #001 towards resident #002, and was not considered to be abuse and was not investigated. The Administrator indicated the investigation into the third incident that occurred on specified date, was not investigated until the next day, as the staff had not reported the incident to management. The Administrator confirmed that the RN was aware of the incident the same day the incident occurred and did not initiate the investigation.

The licensee failed to ensure an immediate investigation was completed into three incidents of resident to resident abuse involving resident #001 towards resident #002 and resident #003. Two of the incidents had no documented evidence to indicate an investigation was completed and the third incident was not investigated until the following day.

WN #4: 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 :

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

Review of the progress notes for resident #001 for a three month period (until resident #001 was discharged), interview of staff and review of the licensee's investigations indicated there were three separate incidents of witnessed resident to resident abuse involving resident #001 towards resident #002 and resident #03.

Interview with the DOC by Inspector #111, indicated the expectation is for registered nursing staff to immediately report any alleged, suspected or witnessed incidents of abuse of a resident to the Ministry of Health and Long Term Care (MOHLTC) (Director). The DOC indicated not working in the home when the first two incidents occurred but confirmed no documented evidence the Director was notified of either incident. The DOC confirmed the Director was not informed of the last incident until the following day.

Interview with Administrator by Inspector #111, confirmed awareness that resident #001 had a prior history of specified responsive behaviours towards other residents. The Administrator confirmed awareness of the first alleged abuse incident involving resident #001 towards resident #003. The Administrator indicated they did not feel the incident was considered abuse and therefore did not inform the Director (despite notifying the SDM and contacting the police). The Administrator confirmed awareness of the second alleged abuse incident involving resident #001 towards resident #002, but did not consider this incident abuse and therefore did not inform the Director (despite notifying the SDM and contacting the police). The Administrator also confirmed the third alleged abuse incident involving resident #001 towards resident #003 was considered abuse but was not reported to the Director until the next day.

The licensee failed to ensure that three incidents of resident to resident abuse involving resident #001 towards resident #002 (twice) and resident #003 were immediately reported to the Director. The Director was never informed of the two alleged resident to resident abuse incidents that occurred on two specified dates. The Director was also not informed of the third resident to resident abuse incident that occurred, until the following day.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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 :

The licensee has failed to ensure the behavioural triggers had been identified for the resident demonstrating responsive behaviours (where possible)and strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

Review of the progress notes for resident #001 for a three month period in 2018 (until the resident was discharged), indicated there was one incident of resident to resident responsive behaviour and three incidents of either witnessed or alleged resident to resident abuse involving resident #001 towards three different residents (resident #002, #003 and resident #004) as follows:
-On a specified date and time, resident #001 was witnessed by PSW #109 engage in a specified responsive behaviour towards resident #004, resulting in resident #004 sustaining a fall. RN #110 indicated resident #001 was to be monitored frequently.
-Approximately two weeks later, resident #001 was witnessed in a specified area, engaging in a specified responsive behaviours towards resident #003. The RPN indicated the DOC instructed staff to ensure resident #001 was not left alone with co-residents and a guard device to be placed across the resident's door at all times. The resident was again to be monitored frequently.
-Approximately one week later, resident #001 was witnessed by RCA #108 engage in a specified responsive behaviour towards resident #002. The RCA intervened and

reminded resident #001 that the behaviour was not appropriate. The Administrator indicated resident #001 was placed on hourly monitoring.
-The following month (CIR), RPN #104 was notified by another charge nurse that resident #001 had again engaged in a specified responsive behaviour towards resident #002. The following day, resident #001 was discharged from the home.

Review of the written plan of care for resident #001 (in place at time of incidents) indicated the resident demonstrated identified responsive behaviours towards residents and staff. There were interventions in the plan of care to address the responsive behaviours that including, a formal caution from Director of Resident and Family Services (DRFS).

Review of the BSO Meeting minutes during the three months the incidents occurred for resident #001 indicated:
-in the first month: resident #001 had one incident of physical aggression towards a resident and one incident of an identified responsive behaviour "but the [recipient] resident was capable". Under actions, indicated the specified psycho-geriatric assessment team had closed the file as the resident had no further incidents. A specified intervention was put in place by the BSO team, to a specified area, where the incident occurred.
-the following month: resident #001 was involved in another incident of the same identified responsive behaviour towards another resident. Under actions, indicated the recipient resident was able to consent and the recipient resident was given a specified intervention.

Review of the monitoring tools in place for resident #001 indicated there were three different types of monitoring tools used. There was no clear direction when the tools were to be used, which tool was to be used, or how long the tools were to be in place.

Interview with RPN #107 by Inspector #111, indicated the first incident (involving resident #001 and resident #003) was witnessed by the RPN, having immediately intervened and the incident was reported to the BSO. The RPN confirmed that resident #003 was cognitively impaired and confirmed awareness of resident #001's ongoing history of identified responsive behaviours.

Interview with RCA #108 by Inspector #111, indicated the second incident that occurred (involving resident #001 and resident #002) was witnessed by the RCA, the RCA indicated having immediately intervened and reported the incident o the BSO. The RCA

indicated resident #002 had a specified diagnosis that would impair ability to consent.

Interview with RPN #102 by Inspector #111, indicated they were the lead for Behavioural Supports Ontario (BSO), reviewed the nursing 24 hour reports for any responsive behaviours in the home, reviewed and responded to any email referrals from staff, completed the psycho-geriatric referrals, completed the BSO assessment tools (i.e. Behavioural Assessment Tool(BAT)), informed staff which monitoring tools were to be completed, met with residents who were demonstrating responsive behaviours, worked with the Nurse Practitioner (NP) for re-assessment of residents medications and met each month, with each unit to discuss residents who were demonstrating responsive behaviours, and who were not responding to interventions. RPN #102 indicated minutes were kept of these monthly meetings and included which residents were being reviewed. RPN #102 indicated resident #001 had two BSO tools completed for specified responsive behaviours and was also referred to psycho-geriatric services. RPN #102 identified a possible trigger for resident #001's specified responsive behaviour as the time when the responsive behaviours started back in 2017 and when the first CIR was submitted. The RPN indicated that was when the referral to psycho-geriatric services was also completed. RPN #102 indicated residents with high risk responsive behaviours were to be monitored every 15 minutes using the specified monitoring tool, then progress to every 30 minutes and then finish with every hour checks. RPN #102 indicated resident #001 remained on monitoring but unsure which monitoring level. The RPN indicated resident #001 was also started on a new medication, determined the medication was ineffective as it caused other negative side effects. RPN #102 indicated the resident was also relocated to another area of the home on more than one occasion. RPN #102 indicated resident #001 was placed back on every 15 minute monitoring, an door alarming device put in place, and every unit was notified to be aware of the resident's specified responsive behaviours after the second incident occurred involving resident #002. RPN #102 confirmed awareness of all the responsive behaviour and/or abuse incidents involving resident #001, indicated the incident involving resident #002, did not consider those incidents as abuse.

Interview with DOC by Inspector #111, indicated was not working in the home until after the first three incidents occurred. The DOC indicated the expectation is for registered nursing staff to document in each residents health record, the subjective and objective assessment of each resident involved in any witnessed, suspected or alleged abuse incidents. The DOC indicated they would have also assigned a PSW to monitor the aggressive resident with one to one as soon as they became aware of the responsive behaviour.

The licensee failed to ensure that the behavioural triggers had been identified for resident #001 who was demonstrating specified abusive responsive behaviours, and that strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

WN #6: 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 :

The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident' s health or well-being.

Review of the progress notes for resident #001, #002 and resident #003 for a three month period in 2018, until the resident was discharged, indicated there were three incidents of witnessed resident to resident abuse involving resident #001 towards two residents (resident #002 and resident #003) that were not immediately reported to the SDM's. of resident #002 and resident #003. The last incident involving resident #001 and #002 that was reported to the Director, had no documented evidence the SDMs' of either resident were immediately notified, until the following day when the Administrator

became aware of the incident.

Interview with RPN #107 by Inspector #111, indicated the first resident to resident abuse incident that occurred on a specified date involving resident #001 towards resident #003, confirmed the SDM of resident #003 was not made aware of the incident as the RPN was directed not to by management.

Interview with RPN #102 by Inspector #111, indicated the RPN became aware of the first resident to resident abuse incident (involving resident #001 and resident #003) that occurred by RPN #107 the same day. RPN #102 indicated RPN #107 should have notified the SDM of resident #003 regarding the incident. The RPN confirmed the second incident of resident to resident abuse (involving resident #001 and resident #002) was also not reported to the SDM of resident #002, as the management determined the incident was not abuse (despite reporting the incident to the police).

Interview with the DOC by Inspector #111, indicated the expectation was for registered nursing staff to immediately report any alleged, suspected or witnessed incidents of abuse of a resident to the each of the resident's SDMs. The DOC indicated not working in the home when the incidents occurred but confirmed there was no documented evidence the SDM of resident #002 or resident #003 were notified of witnessed or suspected resident to resident abuse. The DOC confirmed the SDM of resident #001 and #002 were not informed of the last incident that occurred, until the following day.

Interview with the Administrator by Inspector #111, confirmed awareness that resident #001 had a prior history of specified responsive behaviours and/or abuse. The Administrator confirmed awareness of the first resident to resident abuse incident (involving resident #001 towards resident #003). The Administrator stated "did not feel" the actions of resident #001 towards resident #003 was considered abuse and therefore did not inform the SDM of resident #003 (despite notifying the SDM of resident #001 and the police). The Administrator confirmed awareness of the second resident to resident abuse incident (involving resident #001 towards #002) and indicated that incident was also not considered abuse and the resident had no negative effect, therefore did not inform the SDM of resident #002 (despite notifying the SDM of resident #001 and contacting the police). The Administrator confirmed the last incident that occurred (involving resident #001 towards resident #002) was not reported to either SDM until the day after the incident occurred.

The licensee failed to ensure that three incidents of resident to resident abuse involving

resident #001 towards resident #002 and resident #003, immediately informed the SDM's of the incidents. The SDM of resident #003 was never informed of the incident that occurred, the SDM of resident #002 was never informed of the first incident that occurred, and the SDM's of resident #001 and resident #002 were not informed of the resident to resident abuse incident that occurred, until the following day.

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

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident: (ii) names of any staff members or other persons who were present at or discovered the incident, and (iii) names of staff members who responded or are responding to the incident.

Review of the progress notes for resident #001 and resident #002, interviews with staff and review of the licensee's investigation indicated on a specified date, time and location, resident #001 was involved in resident to resident abuse towards #002. Resident #002 reported the incident to RPN #100. RPN #100 reported the incident to resident #001's charge nurse (RPN #104) and also reported the incident to RN #112. The following day, resident #002 reported the incident to again, to RPN #101 and was upset and crying regarding the incident. The progress notes indicated RPN #102 was also aware of the incident. The investigation indicated PSW #105 and #106 were also aware of the incident.

Review of the critical incident report (CIR) that was submitted to the Director only identified RPN #100 and RPN #101. The CIR was completed by the Administrator.

Interview with the Administrator by Inspector #111, confirmed that RN #112, RPN #102, #104 and PSW #105 and #106 were aware of the resident to resident abuse incident that occurred on a specified date and were not included in the CIR.

The licensee failed to ensure that the report to the Director included the names of any staff members or other persons who were present at or discovered the incident, and the names of staff members who responded or are responding to the incident.

Issued on this 10th day of October, 2018

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

Original report signed by the inspector.