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
May 24, Jun 6, 2017	2017_643111_0003	005466-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

REACHVIEW VILLAGE
130 REACH STREET UXBRIDGE ON L9P 1L3

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

LYNDA BROWN (111), CRISTINA MONTOYA (461), SAMI JAROUR (570), SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 20 -24, 2017 & March 27-29, 2017.

The following inspections were completed concurrently during the RQI inspection:
-Log # 000862-17 critical incident related to alleged staff to resident physical abuse
-Log # 003427-17 critical incident related to alleged resident to resident sexual abuse
-Log # 004015-17 complaint related to alleged resident to resident sexual abuse (cross referenced Log#003427-17)
-Log # 005086-17 critical incident related to alleged staff to resident physical abuse
-Log # 005438-17 critical incident related to alleged staff to resident verbal abuse
-Log # 005548-17 critical incident related to alleged staff to resident physical abuse.

During the course of the inspection, the inspector(s) toured the home, observed dining service, medication pass, and residents, reviewed health records of current and deceased residents, Resident Council and Family Council meeting minutes, medication incidents, staff schedules and training records, the licensee's investigations, and the following licensee's policies: Personal Assistive Safety Devices (PASD'S), skin and wound, Resident non-abuse, responsive behaviours, and medication administration policies.

During the course of the inspection, the inspector(s) spoke with the Executive Director(ED), Director of Care (DOC), resident's, Personal Support Workers (PSW), Dietary Aides (DA), Registered Nurses (RN), Registered Practical Nurses (RPN), RAI Co-ordinator , Back-up RAI Co-ordinator, Restorative Care , Activation Aide (AA), Laundry Aide (LA), Public Health Inspector, Clinical Nurse Consultant, and Regional Manager Education and Resident Services (RMERS).

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **15 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 failed to ensure that residents were protected from abuse by anyone and ensure that residents were not neglected by the licensee or staff.

Under O.Reg. 79/10, s.2(1) "physical abuse" means, subject to subsection (2),(a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Under O.Reg. 79/10, s.2(1)(b) "sexual abuse" means, any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Related to log # 005548-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident physical abuse incident that occurred two days earlier at a specified time. The CIR indicated resident #051 report to RN #149, PSW #148 had been physically abusive to the resident resulting in pain and injury to a specified area.

Review of the licensee's investigation, interview of staff and review of the health care record of resident #051 indicated:
-on the specified date and time, PSW #126 responded to resident #051 who was heard yelling. The resident reported the alleged physical abuse by PSW #148 resulting in pain and injury to a specified area to PSW #126 and RN #149. The resident was upset regarding the incident. RN #149 interviewed both PSW #148 (who was assigned to the resident) and PSW #126 (who was working when the incident occurred) immediately following the incident. PSW #148 reported resident #051 was physically aggressive while assisting the resident with care and had to restrain the resident. PSW #126 reported finding the resident already placed into the mobility aide (as the resident had been placed on the toilet). The RN did not document the incident on the resident's health record or the assessment of the resident, did not report the incident to the SDM, physician, police or the Director. The RN reported the allegation to the DOC two days later regarding the incident and also documented the incident two days later in the progress notes (but not indicate when the incident actually occurred).

Interview with the DOC by Inspector #111 indicated the SDM, police, physician and the Director were notified two days after the allegation was made when she became aware of the allegation from RN #149. The DOC indicated RPN #105 completed the head to toe assessment of resident #051 two days later. The DOC indicated the physician assessed the resident three days after the allegation was made and the physician did not see any injury to indicate abuse and concluded the allegation was unfounded. The DOC called RN #149 to discuss reporting requirements related to abuse and to document the

incident. The DOC indicated no other actions were taken. The DOC indicated a head to toe assessment should have been completed at the time the allegation was made.

The licensee's policy of "Resident Non-Abuse" was not complied with as there was no documented evidence of a head to toe assessment completed until two days after the incident, the RN did not obtain consent to take pictures of the injuries or evidence at the time of the incident and did not immediately remove the alleged staff member from providing care to residents. The RN failed to document the incident on the day the incident occurred. The RN sent an email to the DOC which was not read until two days after the incident occurred.

Review of the staff schedule indicated PSW #148 continued to provide care to residents the remainder of the shift despite an allegation of staff to resident physical abuse resulting in injury and pain to the resident. The PSW also provided care to resident the following day and was not removed from duty until two days later when the DOC became aware of the allegation. There was no documented evidence the resident and/or family was provided support and referrals to professional services during or after the investigation as per the licensee’s policy.

The licensee failed to ensure that Resident #051 was protected from physical abuse:
-a staff member failed to follow the licensee's abuse policy, by failing to document the incident, including the assessment of the resident and failing to taking immediate actions as per the licensee's policy, and the licensee failed to take appropriate actions as the staff member involved failed to follow the resident's plan of care, as indicated under LTCHA, s. 20(1) refer to WN #6.
-failing to notify the SDM immediately of an alleged staff to resident physical abuse incident that resulted in injury and pain towards resident #051,as the SDM was not notified until two days later, as indicated under O.Reg. 79/10, s.97(1) refer to WN #14.
-failing to immediately notify the police of an alleged staff to resident physical abuse, as the police were not notified until two days later, as indicated under O.Reg.79/10, s.98 refer to WN #15.
-a staff member failed to ensure the plan of care for resident #051 related to toileting and transferring was provided to the resident, as indicated under LTCHA, 2007, s.6(7), refer to WN #5.
-failing to ensure when a person had reasonable grounds to suspect that staff to resident physical abuse had occurred, immediately reported the suspicion and the information upon which it was based to the Director, as indicated under LTCHA, 2007, s.24(1) refer to WN #8. [s. 19. (1)]

2. Related to log #003427-17 & #004015-17:

A critical incident report (CIR) was submitted to the Director on a specified date for a witnessed incident of resident to resident sexual and physical abuse that occurred. The CIR indicated on the specified date and time, resident #047 was observed by PSW #114 to inappropriately touch resident #027 and then became physically aggressive towards resident #027. The CIR indicated resident #027 was assessed and had no injury as a result. The CIR indicated both residents had moderate cognitive impairment. The CIR indicated the actions taken to prevent a recurrence included: 1:1 PSW for resident #047 for a specified period of time and then placed on every DOS (dementia observation system) with every 30 minute checks, redirecting resident #027, identifying and recognizing triggers for resident #047 and increased involvement in activities.

A complaint was also submitted to the Director by a non-staff member regarding the incident towards resident #027.

An interview with the DOC by Inspector #111, indicated resident #047 had prior incidents of sexually inappropriate responsive behaviours towards residents. #027 & #043. The DOC indicated the SDM of resident #043 had also reported a concern regarding resident #047 inappropriate responsive behaviours towards the resident.

Review of the health care records of resident #027, #043 and #47 indicated there were six incidents when resident #047 displayed either sexually inappropriate responsive behaviours and/or sexual abuse towards resident #027 or resident #043 on the following dates: two days in one specified month and three days the following specified month.

During an interview with RPN #107, RPN #127, RN #116 and PSW #140 by Inspector #111, it was indicated resident #047 previously displayed sexually inappropriate responsive behaviours towards resident #027 and resident #043 but the behaviours no longer occurred.

Review of the current written plan of care (and in place at time of the incidents) for resident #047 related to responsive behaviours had no indication the resident displayed sexually inappropriate responsive behaviours towards residents, specifically resident #027 & resident #043.

The strategies implemented by staff included redirection of resident #047 after each

incident. After the sixth incident of sexually inappropriate behaviour, 1:1 staffing was implemented and a Dementia Observation Survey (DOS) (every 30 minute check) was put in place. Additional 1:1 staffing was implemented with resident #047for a ten day period after the last incident occurred despite the resident no longer exhibiting sexually inappropriate responsive behaviours. A referral to pscyhogeriatric services was completed three weeks after the last incident occurred.

The licensee failed to ensure that resident #027 & resident #048 were protected from sexual abuse by resident #047:
-failing to follow the licensee's non-abuse policy, by failing to document what sexually inappropriate behaviours referred to with each incident, who was involved in the incidents, and taking immediate actions to protect the female residents, as per the licensee's policy, as indicated under LTCHA, s. 20(1) refer to WN #6.
-failing to notify the SDM within 12 hours of a suspected resident to resident sexual abuse incident that occurred until two days later, towards resident #0027 by resident #047, as indicated under O.Reg. 79/10, s.97(1)(b), refer to WN #14.
-failing to ensure the behavioural triggers had been identified for resident #047 demonstrating sexually inappropriate responsive behaviours where possible and strategies were developed and implemented to respond to these behaviours where possible, as indicated under O.Reg. 79/10, s.53(4)(c), refer to WN #11.
-failing to ensure that procedures and interventions were developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents, as indicated under O.Reg. 79/10, s.55(a), refer to WN #12. [s. 19. (1)]

3. Related to Log #000862-17 :

A critical incident report (CIR) was submitted to the Director on a specified date for a suspected staff to resident physical abuse and improper care that occurred the day before. The CIR indicated resident #048 reported the allegation to the Regional Manager of Education and Resident Services (RMERS) who was acting as the ED at that time. The CIR indicated a PSW was physically abusive resulting in pain to a specified area and another PSW provided improper care preventing the resident to be able to communicate. The CIR did not identify the staff members involved in the allegation.

Review of the licensee's investigation, review of the health record of resident #048 and the staff scheduling indicated PSW #125 was the staff member involved in the alleged

physical abuse. PSW #126 was the staff member involved in the alleged improper care. There was no documented evidence a head to toe assessment was completed for the resident post incident. PSW #126 was not interviewed by the DOC regarding the allegation until eight days later, despite continuing to work in the home providing care to residents on four more days. The RMERS was also notified of the allegation by the resident and did not report the allegation to the Director until the following day.

After review of the CIR, licensee's investigation of alleged abuse for resident #048, and interviews with the DOC and RMERS, it was determined that the licensee failed to comply with the licensee's resident non-abuse policy as PSW #126 was not required to immediately leave the premises pending the investigation as per licensee's policy; there was no documented evidence of a full assessment of the resident when the RMERS became aware of the allegation, the investigation was not completed using the toolkit to conduct the investigation, and there was no disciplinary action taken toward staff involved in incident.

The licensee failed to ensure that resident #048 was protected from physical abuse:
-failing to follow the home's abuse policy, by failing to immediately remove staff from the premises pending the investigation, and failing to complete and document a full assessment of the resident, and failing to use the investigation toolkit as per the licensee's policy, as indicated under LTCHA, s. 20(1) refer to WN #6.
- failing to ensure the person who had reasonable grounds to suspect that staff to resident physical abuse and improper care had occurred, immediately reported the suspicion and the information upon which it was based to the Director, as indicated under LTCHA, 2007, s.24(1), refer to WN #8.
- failing to ensure that the 24-hour admission care plan for resident #048, set out clear directions to staff in relation to the resident's needs for communication, dressing and bathing, as indicated under O.Reg. 79/10, s. 24(3)(b), refer to WN #9.(570) [s. 19. (1)]

4. Related to Log #005086-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident physical abuse that occurred the day before at a specified time. The CIR indicated that resident #050 reported a PSW was physically abusive towards the resident. The CIR was amended six days later and indicated the resident was assessed and no harm or injury was noted to the resident and determined to be unfounded. The CIR was amended again five days later, indicating the home received new information related to the incident and reopened the investigation. The CIR identified

several staff names but it was unclear which staff member was directly involved in the allegation.

Review of the licensee's investigation notes, review of resident #050 health record and interviews of staff indicated the following:
- PSW #131 was the staff member directly involved in the allegation of abuse. PSW #138 was also working with PSW # 131 and was aware of the incident but did not report the incident until 8 days later.
- Resident #050 also reported the allegation to PSW #134 & #139 and RN #132 on the day the incident occurred. The DOC was notified of the allegation by RN #132 and PSW #134 & #139 the following day. RN #132 documented resident #050 was found upset and tearful and reported that PSW #131 had caused pain to specified areas as a result of the incident.
-The DOC documented the day after the incident was witnessed, that Police and SDM were contacted when the DOC became aware.
-PSW #133 also witnessed the incident but did not report the incident until 13 days later. PSW #133 reported that PSW #147 was also present and aware of the incident. PSW #147 did not report the incident.
-The head to toe assessment was not completed until the following day.

During an interview with the DOC by Inspector #570, indicated the alleged staff to resident physical abuse incident that occurred on a specified date and time became aware of the incident the following day by RN #132, PSWs #134 and PSW #139. The DOC indicated that PSW #133 was aware of the incident but did not immediately report the incident to her supervisor and RN #132 did not call the manager on call for direction and did not call the MOHLTC after hours pager to report the alleged abuse.

During an interview with PSW #133 by Inspector #570, indicated did not report the witnessed incident of staff to resident physical abuse by PSW #131 towards resident #050 in resident #050's room. PSW #133 indicated reported the incident the same day it occurred to PSW #147. The PSW indicated the incident was reported to the Clinical Manager RN #116 12 days later.

The licensee failed to ensure that resident #50 was protected from physical abuse by:
-failing to follow the licensee's non-abuse policy, by several staff who witnessed or who suspected staff to resident physical abuse, reported the allegation immediately, failing to document the incident at the time the incident occurred and completing a head to toe assessment of the resident, and failing to take immediate actions with the staff member

involved in the incidents, and those staff members who failed to report the incident immediately, as per the licensee's policy, as indicated under LTCHA, s. 20(1) refer to WN #6.
-failing to notify the SDM within 12 hours of a suspected resident to resident sexual abuse incident that occurred until two days later, towards resident #027 by resident #047, as indicated under O.Reg. 79/10, s.97(1)(b), refer to WN #14.
-failing to ensure that appropriate action was taken in response to every such incident, as there was no documented evidence of any actions taken regarding 3 PSW's (#138, #133 & #147) being aware of or witnessing staff to resident verbal and/or physical abuse towards resident #050, no actions regarding RN #132 failing to report immediately an allegation of staff to resident physical abuse that resulted in pain., and no action regarding PSW #131 involved in the allegation, as indicated under LTCHA, 2007, s.23(1)(b) refer to WN #7.
-failing to ensure the behavioural triggers had been identified for resident #047 demonstrating sexually inappropriate responsive behaviours where possible and strategies were developed and implemented to respond to these behaviours where possible, as indicated under O.Reg. 79/10, s.53(4)(a)(b), refer to WN #11.
-failing to ensure that procedures and interventions were developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents, as indicated under O.Reg. 79/10, s.55(a), refer to WN #12.

A compliance order was warranted as the scope was that there were three separate incidents of alleged staff to resident physical abuse and/or neglect, and one resident to resident sexual abuse. The severity was such that in all of these incidents, staff who witnessed the incidents did not immediately report the allegation or suspicions, staff did not take immediate actions to protect the residents, and long term actions were not taken to address these concerns after the home completed their investigations as they were all determined to be unfounded. In addition, the licensee's compliance history indicated ongoing non-compliance with failing to immediately investigate any alleged, suspected or witnessed incidents of abuse of a resident, and failing to immediately report to the Director, the same.A Voluntary Plan of Correction (VPC) was issued during a critical incident inspection in March 2014 under inspection #2014_293554_0009 for LTCHA, 2007, s. 23(1) & s.24(1); A VPC was issued during a complaint inspection in July 2014 under inspection #2014_293554_0029 for LTCHA, 2007, s.23(1); A VPC was issued during the RQI Inspection in July 2015 during inspection # 2015_389601_0016 for LTCHA, 2007, s.23(1) & s.24(1); and during the RQI Inspection in October 2016 under

inspection #2016_328571_0029. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with 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 license has failed to ensure that the report to the Director shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by the licensee or staff that led to the report: a description of the individuals involved in the incident, including, ii. Names of any staff members or other persons who were present at or discovered the incident.

Related to Log # 000862-17:

A critical incident report (CIR) was submitted to the Director on a specified date for a suspected staff to resident physical abuse and improper care that occurred the day before. The CIR indicated resident #048 reported the allegation to the Regional Manager of Education and Resident Services (RMERS) who was acting as the ED at that time. The CIR indicated a PSW was physically abusive resulting in pain to a specified area and another PSW provided improper care preventing the resident to be able to communicate. The CIR did not identify the staff members involved in the allegation.

Interview with RPN #124 and DOC by Inspector #461, and review of the home's investigation, indicated PSW #125 was the staff member involved in the physical abuse resulting in discomfort. PSW #126 was the staff member who failed to provide care according to the resident's needs and preferences related to communication. The DOC confirmed the CIR did not contain the names of the staff involved in the incident. [s. 104. (1) 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 the report to the Director includes a description of the individuals involved in the incident, including, names of any staff members or other persons who were present at or discovered the incident, with respect to alleged, suspected or witnessed incidents of abuse of a resident by the licensee or staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

The licensee has failed to ensure that no drugs are used or administered to a resident in the home unless the drug has been prescribed for the resident.

A review of medication incidents for the last three months was completed. A review of the resident's health records was also completed and the following medication incidents were reported:

1) Resident #044 has diagnoses that include dementia and a cardiac condition. On a specified date, RPN#107 discovered the three month medication review was signed by the physician three months prior, and included a discontinuation of one of the resident's cardiac medications. This three month medication review was not processed at the time it was signed, therefore resulting in resident #044 receiving the cardiac medication for approximately 10 weeks without a physician order. Review of the clinical records for resident #044 indicated RPN #107 requested the SDM be contacted the next morning. Documentation indicated the SDM was notified of the medication incident two days after the incident was discovered.

Interview with RPN#107 by Inspector #623 confirmed that on a specified date and time, the RPN received a phone call from the Pharmacy indicating they had not received the most recent three month medication review for resident #044. RPN indicated that was when the medication incident was discovered. RPN#107 indicated the physician was immediately contacted and received direction to discontinue the cardiac medication.

2) Resident #033 has diagnoses that includes dementia, and multiple cardiac conditions. The resident was receiving a cardiac medication twice daily at a specified dose. On a specified date, the attending physician wrote an order for the cardiac medication to be

discontinued due to change in cardiac function. The order was not processed until 9 days later when RPN#137 discovered the medication incident. RPN#137 notified the physician and instructions were received to process the order and monitor the cardiac status. The SDM was notified of the change in medication and pharmacy was notified of the medication incident.

Interview with RPN #105 by Inspector #623 indicated the expectation at the time the medication incident occurred, the RPN on the unit would have a designated time with the physician on doctors day. The RPN would take all resident three month medication reviews that were required to the physician and review. After the physician completed the review, any new orders were then processed by the RPN for the unit. RPN#105 indicated that depending on the time of day, this task could be passed on to the next shift for completion. RPN indicated that this process has now changed and there is a designated RN for physician rounds on doctors day.

Interview with the DOC by Inspector #623 indicated that when a physician order is written it is the expectation the RPN or RN working on the unit is responsible for processing the order, which includes notifying the pharmacy, make any changes in direction as ordered and notify the resident or SDM as appropriate and document the changes in the progress notes. The DOC confirmed that within 24 hours of the order being written, two checks of the order should be completed by the RN/RPN as part of the process. [s. 131. (1)]

2. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

1) Resident #027 has diagnoses that include dementia and cardiac conditions. Review of the physician medication orders indicated a specified transdermal cardiac medication was to be applied at bedtime and removed the following morning before applying the next medication. Review of the medication incident report indicated on a specified date and time, RPN #130 was removing the cardiac transdermal medication from resident #027 as ordered and discovered two additional transdermal medications still on the resident from the two previous days. The eMAR indicated they were documented as removed by PRN #105. RPN #130 removed both transdermal medications, completed an assessment of resident #027, and notified the physician.

Interview with RPN #105 by Inspector #111, indicated the RPN had signed that the eMAR indicating the transdermal cardiac medications were removed from resident #027 but could not recall if the medications were actually removed ,and may have forgot to remove

the patch.

Interview with the DOC by Inspector #111 indicated she met with RPN #105 to review the medication incident and counselling was provided regarding signing for medication administration is to be completed after the process is completed and not before. The DOC confirmed the medication was not administered to resident #027 as ordered on the specified dates by RPN #105.

2) Resident #034 has diagnoses that includes multiple cardiac conditions. Review of the physician medication orders indicated a cardiac transdermal medication to be applied every morning and removed at bedtime to prevent pain. Review of a medication incident report indicated on specified date and time, RPN #137 discovered resident #034 had one cardiac transdermal medication in place that should have been removed the day before. Review of the eMAR indicated RPN #108 signed that the medication was removed. RPN #137 completed an assessment of resident #034 and contacted the physician for further instructions. Pharmacy was not notified of the medication incident.

Interview with the DOC by Inspector #623 indicated she met with RPN #108 to review the medication incident and confirmed that the medication was not administered to resident #034 as prescribed, despite documenting that it was removed.

3) Resident #040 has diagnoses that include pain to specified areas. The resident was prescribed a specified medication for that pain once weekly. On a specified date, RN #109 discovered the medication card containing the prescribed medication (that was to be administered on the prescribed date) was still contained the medication card and had not been administered. A review of the Medication Administration Record (MAR) indicated the medication was signed as given on by RPN #105.

Interview with RPN #105 by Inspector #623,confirmed she/he signed for the administration of prescribed pain medication but did not administer the medication. The RPN indicated the incident occurred as the medication is packaged in a card that is kept in a separate area of the medication cart from the rest of the medication strip packaging. The RPN indicated she/he only administered the medications that were packaged in the strip packaging and did not complete the proper checks to ensure that all medications were administered as ordered.

4) Resident #046 was assessed in hospital on a specified date and diagnosed with an infection to a specified area. Physician orders were received which included an antibiotic

at a specified dose twice daily for one week. to start immediately. The order was processed and the medication was initiated by RPN #137 using the emergency drug box. The emergency box contained the prescribed medication but at half the dose required therefore, would require two tablets. RPN #137 administered only 1 tablet of the antibiotic to resident #046. The error was discovered when the second dose of the antibiotic was to be administered.

Interview with the DOC by Inspector #623 indicated that RPN#137 was involved in the medication incident due to failure to correctly verify the packaging of the antibiotic from the emergency drug box and resulted in resident #046 only receiving half of the prescribed dose of the antibiotic. [s. 131. (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 drugs are only used or administered to a resident in the home when the drug has been prescribed to the resident and drugs are administered in accordance with the directions for use specified by the prescriber and have a process in place to monitor compliance, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health,
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider

Related to resident #040: on a specified date, a specified medication was not administered as ordered for pain to specified areas. A review of the clinical records was completed by Inspector #623 for a one month period, including progress notes, physician orders and the medication incident report (Form LTC-F-220-05-Aug.2012) completed by RN #109. Review of the progress notes indicated no documented evidence that the medication incident occurred and the immediate actions taken to assess and maintain the resident's health after the error was discovered. Review of the Medication Incident Report by Inspector #623 for the incident revealed the following:
- the section of the report titled "Actions Taken" (e.g. Assessment/treatment if applicable) had no information written.
- Pharmacy notified - box is checked "no"
- Section 2 - Pharmacy comments/corrective actions(s) if applicable - had no information entered.

Interview with RN #109 by Inspector #623 indicated he/she completed the medication incident report and did not inform the pharmacy because it was not a pharmacy error, it was a nurse error. The RN indicated that the expectation of the home is for the registered nurse to document in the progress notes in PointClickCare (PCC) when the incident occurred, the assessment of the resident and the notification of the physician and SDM. RN #109 confirmed that for the identified medication incident involving resident #040 not receiving a specified medication as prescribed, there was no documentation completed in the progress notes in PCC including an assessment of the resident and notification of the SDM.

2. Related to resident #046: on a specified date, an antibiotic was ordered for an infection to a specified area and the wrong antibiotic dose was administered to resident #046. The order was processed and the medication was initiated by RPN #137 using a "starter

pack" from the emergency drug box. The started pack of the antibiotic had half the required dose that was prescribed and would require two tablets.RPN#137 administered 1 tablet to resident #046 at a specified time. Review of the clinical records including the progress notes for resident #046 indicated that the medication incident was not documented in the clinical record including any immediate actions taken to assess and maintain the residents health or notification to the pharmacy of the error.

3. Related to resident #034: on a specified date and time, RPN #137 discovered a cardiac transdermal medication on the resident that was to be removed the day before. Review of the Medication Administration Record (eMAR) indicated that RPN #108 signed that the transdermal medication had been removed. The medication incident report indicated pharmacy was not notified of the error. Review of the medication orders indicated the cardiac transdermal medication was to prevent pain.

4) Related to resident #027: on a specified date and time RPN #130 was removing a cardiac transdermal medication from the resident as ordered and discovered two additional transdermal medications still in place from two previous days. The eMAR was signed indicating the transdermal medication were removed by RPN #105. An assessment of resident #027 was completed and documented by RPN #130. The physician was notified and orders were received. The SDM was also notified. The medication incident report indicated the pharmacy was not notified.

Interview with the DOC by Inspector #623 confirmed that she met with RPN #108 to review the medication error involving resident #034 and the expectation of the home related to safe medication administration practise. The DOC confirmed that the pharmacy was not notified of the error. The DOC also confirmed the pharmacy was not notified of the medication incident involving resident #027 . The DOC indicated the medication incident with resident #040 was discovered by RN #109 four days later. This medication was prescribed once weekly and the medication was found in the medication card not given but was signed as given in the eMAR. DOC indicated that she met with RN #109 and reviewed the process of medication error documentation including proper charting and assessments. DOC confirmed that the expectation is when a medication error is discovered, the Revera medication incident report (LTC-F-220-05) is completed, which includes an assessment of the resident, notification of MD and SDM, notification of pharmacy if appropriate. DOC confirmed that any medication errors should be documented in the progress notes including any follow-up monitoring that is required. The DOC also confirmed that for the medication incident with resident #040 documentation was not completed including evidence of any assessment or monitoring

and notification of SDM, MD and pharmacy.

Interview with the Revera Regional Clinical Consultant (RRCC) by Inspector #623 confirmed that the expectation for reporting of medications incidents is that the registered nurse will document in the progress notes a record of the incident and the immediate actions taken to assess and maintain the resident's health. The RRCC also indicated documentation should also include notification of the Physician, SDM and pharmacy.

The licensee failed to document, together with a record of the immediate actions taken to assess and maintain the resident's health and reported to the pharmacy service provider. [s. 135. (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 that every medication incident involving a resident and every adverse drug reaction is:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health,
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #5: 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. (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 :

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan related to transferring and toileting.

Related to log #005548-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident physical abuse incident that occurred two days earlier at a specified time. The CIR indicated resident #051 report to RN #149, PSW #148 had been physically abusive to the resident resulting in pain and injury to a specified area.

Review of the written plan of care for resident #051 indicated under transferring: the resident required 2 staff assistance with use of a mechanical lift. Interventions included: resident can become verbally and physically aggressive towards staff during the transfer process; Staff are to ensure a full explanation is given and time for each task-too much commotion or quick movements may trigger the responsive behaviour. Under toileting: required extensive assistance on/off the toilet with 2 staff and with use of mechanical lift.

Review of the licensee's investigation into the alleged staff to resident physical abuse incident indicated PSW #148 reported to the incident to RN #149 immediately following the incident. Resident #051 had been placed on the toilet with 2 staff assistance (PSW #126 & #148) and use of the mechanical lift. PSW #126 re-entered the bathroom after hearing the resident yelling. The PSW found the resident in the mobility aide, in the room with PSW #148. The resident reported to PSW #126 that PSW #148 had been physically abusive and was holding a specified area. PSW #126 also reported finding the resident already transferred in the mobility aide. PSW #148 had transferred the resident off the toilet with the mechanical lift and into the mobility aide and dressed the resident without a second staff member to assist. The resident became physically aggressive towards PSW #148 during this process.

PSW #148 failed to follow resident #051 written plan of care related to transferring and toileting as the PSW transferred the resident from the toilet to the mobility aide and with the use of a mechanical lift without the assistance of another staff member and continued the transfer despite the resident becoming aggressive. [s. 6. (7)]

WN #6: 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 the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Review of the licensee's "Resident Non-Abuse" policy (ADMIN1-010.02) reviewed July 31, 2016 indicated under procedure:
-Anyone who becomes aware of or suspects abuse or neglect of a Resident must immediately report that information to the Executive Director, or if unavailable, to the most senior supervisor on shift.
-The priority is to ensure the safety and comfort of the abuse victim by taking steps to provide for their immediate safety and well-being, then complete full assessments to determine the Resident's needs and document them on the Resident's plan of care.
-Employees who violate this policy will be required to leave the premises immediately.
-In cases of physical and/or sexual abuse, staff shall ensure to preserve potential evidence: staff are to ensure that consent is obtained to take pictures of any injuries or evidence; accurate, detailed descriptions of injuries/condition are documented in the resident's chart.

Review of the licensee's "Resident Non-Abuse" policy (ADMIN1-010.04) reviewed July 31, 2016 indicated under procedure:
-During or after the investigation, support and referrals to professional, legal, medical and psychosocial resources in the community will be offered to a resident who has been abused or neglected, and his/her family members as required.

Review of the licensee's policy "Resident Non-Abuse" (ADMIN1- P10-ENT), reviewed July 31, 2017 directed the following:
- That an immediate and thorough investigation is completed. The Tool Kit for conducting

an Alleged Abuse Investigation and/or Tips for Handling a Third Party investigation may be referenced.
- The Executive Director has the authority to place an employee on administrative leave with pay pending results of investigation.

Related to Log #000862-17:

A critical incident report (CIR) was submitted to the Director on a specified date for a suspected staff to resident physical abuse and improper care that occurred the day before. The CIR indicated resident #048 reported the allegation to the Regional Manager of Education and Resident Services (RMERS) who was acting as the ED at that time. The CIR indicated a PSW was physically abusive resulting in pain to a specified area and another PSW provided improper care preventing the resident to be able to communicate.

After review of CIR, licensee's investigation of alleged abuse for resident #048, and interviews with the DOC and RMERS, it was determined that the licensee failed to comply with the licensee's resident non-abuse policy (ADMIN1-010.02) and (ADMIN1-P10-ENT) as PSW #126 was not required to leave the premises pending investigation as per licensee's policy; there was no documented evidence of a full assessment of the resident when the ED became aware of the allegation, the investigation was not completed using the toolkit to conduct the investigation, and there was no disciplinary action taken toward the staff involved in incident. [s. 20. (1)]

2. Related to Log #005086-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident physical abuse that occurred the day before at a specified time. The CIR indicated that resident #050 reported a PSW was physically abusive towards the resident. The CIR was amended six days later and indicated the resident was assessed and no harm or injury was noted to the resident and determined to be unfounded. The CIR was amended again five days later, indicating the home received new information related to the incident and reopened the investigation.

The licensee's Resident Non-Abuse policy (ADMIN1-010.02) was not complied with when PSW # 133, #138 and #147 who either witnessed or suspected an incident of staff to resident emotional and/or physical abuse occurred and did not immediately report the incident to their immediate supervisor. In addition, when RN #132 became aware of the

allegation of staff to resident physical abuse, did not complete the head to toe assessment as per the licensee's policy. [s. 20. (1)]

3. Related to log # 005548-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident physical abuse incident that occurred two days earlier at a specified time. The CIR indicated resident #051 report to RN #149, PSW #148 had been physically abusive to the resident resulting in pain and injury to a specified area.

The licensee's Resident Non-Abuse policy (ADMIN1-010.02) and (ADMIN1-010.04) was not complied with as a head to toe assessment was not immediately completed on resident #051 when the incident occurred, consent was not obtained by the RN to take pictures of the injuries to preserve the evidence, PSW #148 was not required to leave the premises immediately and continued to provide care to residents, and the RN did not document the incident for two days. There was no documented evidence to indicate support or referrals to professional, legal, medical and psychosocial resources in the community was offered to the resident who had allegedly been physically abused, and his/her family members as required. [s. 20. (1)]

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 :

Related to Log #005086-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident physical abuse that occurred the day before at a specified time. The CIR indicated that resident #050 reported a PSW was physically abusive towards the resident. The CIR was amended six days later and indicated the resident was assessed and no harm or injury was noted to the resident. The CIR was amended again five days later, indicating the home received new information related to the incident and reopened the investigation.

Review of the licensee's investigation notes, review of resident #050 health record and interviews of staff indicated:
-PSW #131 was the staff member directly involved in the incident.
-PSW #138 was also working with PSW #131 and was aware of the incident but did not report the incident until eight days later.
-Resident #050 also reported the allegation to PSW #134 & #139 and RN #132 the same day. The resident reported that PSW #131 caused pain to specified areas as a result.
-PSW #133 witnessed the incident but did not report the incident until 13 days later. PSW #133 indicated PSW #131 had a history of being emotionally abusive towards resident #050. PSW #133 reported that she/he informed PSW #147 of the incident. PSW #147 did not report the incident either.
-the head to toe assessment was not completed the following day.
-Review of the employee records for PSW #131 indicated the staff member had documented evidence of prior disciplinary actions for emotional abuse towards resident, neglect of residents and violation of residents rights.

Interview with the DOC by Inspector #570, indicated she became aware of the witnessed staff to resident physical abuse incident the following day by RN #132, PSWs #134 & #139. The DOC indicated that PSW #133 was also aware of the incident but did not immediately report the incident to the supervisor. The DOC indicated that RN #132 did not call the manager on call for direction and did not call the MOHLTC after hours pager to notify of the alleged incident of physical abuse. The DOC indicated the investigation was still ongoing (26 days later).

There was no documented evidence of any other actions taken regarding 3 PSW's (#138, #133 & #147) being aware of or witnessing staff to resident physical and/or

emotional abuse towards resident #050, no actions regarding RN #132 failing to report immediately an allegation of staff to resident physical abuse that resulted in pain. And at the time of the exit of the inspection, no action regarding PSW #131. [s. 23. (1) (b)]

WN #8: 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 the 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:

Related to Log #000862-17:

A critical incident report (CIR) was submitted to the Director on a specified date for a suspected staff to resident physical abuse and improper care that occurred the day before. The CIR indicated resident #048 reported the allegation to the Regional Manager of Education and Resident Services (RMERS) who was acting as the ED at that time. The CIR indicated a PSW was physically abusive resulting in pain to a specified area and another PSW provided improper care preventing the resident to be able to communicate.

Review of the licensee's investigation and review of the health record of resident #048 indicated PSW #125 was the staff member involved in the allegation of physical abuse and PSW #126 was the staff member involved in the allegation of improper care. Resident #048 also had diagnoses that required a communication device for all forms of communication.

Interview with the RMERS by Inspector #461 confirmed awareness of the allegation of staff to resident physical abuse on a specified date but not inform the Director immediately. The RMERS indicated the DOC was notified of the incident the following day. Interview with the DOC by Inspector #461 indicated she notified the Director immediately when she was made aware of the alleged abuse incident the day after.[s. 24. (1)]

2. Related to Log # 005548-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident physical abuse incident that occurred two days earlier at a specified time. The CIR indicated resident #051 report to RN #149, PSW #148 had been physically abusive to the resident resulting in pain and injury to a specified area.

Interview with the DOC by Inspector #111, indicated RN #149 was aware of the allegation of staff to resident physical abuse on the day the incident occurred but not report the allegation to the Director. The DOC indicated RN #149 reported the incident to the DOC two days later and the DOC then reported the allegation to the Director. [s. 24. (1)]

3. Related to Log #005086-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident physical abuse that occurred the day before at a specified time. The CIR indicated that resident #050 reported a PSW was physically abusive towards the resident. The CIR was amended six days later and indicated the resident was assessed and no harm or injury was noted to the resident. The CIR was amended again five days later, indicating the home received new information related to the incident and reopened the investigation.

Review of the licensee’s investigation notes, review of resident #050 health record,

interviews of staff and interview with the DOC by Inspector #570, indicated: the witnessed staff to resident physical abuse incident resulting in pain involved PSW #131 and was witnessed by PSW #133. PSW #133 did not report the witnessed staff to resident physical abuse until 13 days later. RN #132, PSWs #134 & #139 were also aware of the witnessed staff to resident physical abuse but did not report to the DOC until the following day. The DOC indicated the RN not call the MOHLTC after hours pager to notify of the witnessed incident of physical abuse. The DOC reported the witnessed staff to resident physical abuse the day after the incident occurred when the DOC became aware. (570) [s. 24. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (3) The licensee shall ensure that the care plan sets out,
(a) the planned care for the resident; and O. Reg. 79/10, s. 24 (3).
(b) clear directions to staff and others who provide direct care to the resident. O. Reg. 79/10, s. 24 (3).

Findings/Faits saillants :

The licensee failed to ensure that the 24-hour admission care plan for resident #048, set out clear directions to staff in relation to the resident's needs for communication, dressing and bathing.

Related to Log #000862-17:

A critical incident report (CIR) was submitted to the Director on a specified date for a suspected staff to resident physical abuse and improper care that occurred. The CIR indicated resident #048 reported the allegation to the Regional Manager of Education and Resident Services (RMERS) who was acting as the ED at that time. The CIR indicated a PSW was physically abusive resulting in pain to a specified area and another PSW provided improper care preventing the resident to be able to communicate.

Review of resident's 24-hour admission care plan indicated: communication: does not speak, Dressing: total dependence, Pain: occasional – daily and Bathing: prefers shower, help with part of bathing. No specific preferences for resident were identified in the 24-hour care plan related to using a specified communication device to communicate, dressing in a certain manner to prevent pain, and days preferred for shower.

Interview with the DOC by Inspector #461 indicated that the internal investigation determined that PSWs #125 and #126 were involved in the incidents. The DOC indicated the investigation determined the allegations were unfounded as it was a miscommunication of resident's needs to the staff on admission. The DOC indicated that resident's admission written care plan and Kardex were updated five days after admission.

Interview with PSW #125, #126, RMERS and the DOC by Inspector #461 indicated it was confirmed that residents' needs for bathing communication and dressing were not clearly communicated to the staff on the 24 hour admission care plan. PSW"s # 125 & #126 were also not aware of resident #048 needs and preferences specifically related to dressing, bathing and communication causing the resident discomfort.

The licensee failed to ensure that the 24-hour admission care plan for resident #048, set out clear directions to staff in relation to needs and preferences for communication, dressing and bathing. [s. 24. (3) (b)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

The licensee has failed to ensure that alternatives to the use of the PASD have been considered, and tried where appropriate related to the use of a Broda chair in the tilted position for resident #014.

1) Resident #014: on 3 specified dates, observations of the resident by Inspector #111 and #623 identified the resident seated in a tilted mobility aide.
Review of the current written care plan for resident #014 indicated the resident required the use of a PASD(tilted mobility aide) to assist with mobility, comfort and positioning.

Interventions included: PASD is applied as per manufacturer's instructions, check every 2 hours and reposition when up in mobility aide and if exhibiting any signs of discomfort (physical or emotional), inform the Nurse immediately.

Review of the clinical record including assessments and progress notes for resident #014 indicated the resident was identified as requiring the PASD three years prior. There was no documented evidence to indicate that alternatives to the use of the PASD were considered.

Interview with RPN #111 and #108 by Inspector #623, indicated resident #014 used the PASD when up. RPN #108 indicated no awareness of the process for implementing a PASD for a resident. RPN #111 was not aware of any assessment that was to be completed prior to initiating a PASD.

2) Resident #036: on 3 specified dates, observations of the resident by Inspector #623 identified that the resident was out of bed, the resident was seated in a tilted mobility aide. Review of the current written care plan for resident #036 indicated the resident required the use of a PASD(tilted mobility aide) to assist with comfort and positioning. Interventions included: informed consent obtained from SDM/resident, check every 2 hours and reposition when up in mobility aide and if exhibiting any signs of discomfort (physical or emotional), inform the Nurse immediately.

Review of the clinical record including assessments and progress notes for resident #036 indicated the resident was required to use a mobility aide approximately three years prior. There was no documented evidence to indicate when the PASD was initiated and that alternatives to the use of the PASD were considered.

Interview with PSW #102 by Inspector #623, indicated resident #036 indicated the resident used the PASD when up in mobility aide for proper positioning.

3) Resident #039: on 3 specified dates, observations of the resident by Inspector #623 identified that the resident was out of bed, the resident was seated in a tilted mobility aide. Review of the current written care plan for resident #039 indicated the resident required support for mobility and uses a tilted mobility aide -see PASD focus. Under PASD, uses the PASD for comfort, reposition with 2 staff and if exhibiting any signs of discomfort (physical or emotional), inform the Nurse immediately.

Review of the clinical record for resident #039 including assessments and progress notes

by Inspector #623 had no documented evidence to indicate that alternatives to the use of the PASD were considered.

Interview with PSW #100 by Inspector #623, indicated resident #039 used a PASD when up. The PSW indicated that the resident is repositioned every two hours.

Interview Revera Regional Clinical Consultant and DOC by Inspector #623 indicated it is the expectation that all PASD's will have alternatives considered and tried where appropriate and documented clearly in the progress notes. The Regional Clinical Consultant and DOC both confirmed they were unable to locate documentation to support that alternatives to the use of the PASD were considered prior to the implementation of the PASD for resident #014, #36 and #039.[s. 33. (4) 1.]

2. The licensee has failed to ensure that the used of a PASD to assist a resident with a routine activity of daily living is included in a plan of care only if the use of the PASD has been approved by:
i. a physician
ii. a registered nurse
iii. a registered practical nurse
iv. a member of the College of Occupational Therapists of Ontario
v. a member of the College of Physiotherapists of Ontario, or
vi. Any other person provided for in the regulations.

Review of the clinical records for resident's #014, #036 and #039 had no documented evidence of approval for the use of the specified PASD's (tilted mobility aide) for resident's #014, #036 and #039. [s. 33. (4) 3.]

3. The licensee has failed to ensure that the use of the PASD has been consented to by the resident or if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Review of the clinical records for resident's #014, #036 and #039 had no documented evidence to indicate the SDM provided consent for the use of the specified PASD's for resident's #014, #036 and #039.

Interview with Revera Regional Clinical Consultant and DOC by Inspector # 623 confirmed that it is the expectation that SDM consent will be obtained and documented in the progress notes, for the use of the PASD for residents who are incapable of

consenting for themselves and documented in the progress notes, for the use of the required PASD. The Regional Clinical Consultant and DOC both verified that they could not provided documented evidence that the appropriate approval was obtained for the use of the PASD that are currently used by resident's #014, #036 and #039. [s. 33. (4) 4.]

WN #11: 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 failed to ensure that actions taken to meet the needs of the resident with responsive behaviours include: assessment, reassessments, interventions, and documentation of the resident's responses to the interventions.

Related to Log #003427-17 & #004015-17:

A critical incident report (CIR) was submitted to the Director on a specified date for a witnessed incident of resident to resident sexual and physical abuse that occurred. The CIR indicated on the specified date and time, resident #047 was observed by PSW #114 to inappropriately touch resident #027 and then became physically aggressive towards resident #027. The CIR indicated resident #027 was assessed and had no injury as a result. The CIR indicated both residents had moderate cognitive impairment. The CIR indicated the actions taken to prevent a recurrence included: 1:1 PSW for resident #047 for a specified period of time and then placed on every DOS (dementia observation system) with every 30 minute checks, redirecting resident #027, identifying and

recognizing triggers for resident #047 and increased involvement in activities.

Interview with the DOC by Inspector #111, indicated resident #047 had prior incidents of inappropriate touching towards two residents (resident #027 & # 043) over a two month period in 2017. The DOC indicated sometime in the first month period, a family member of resident #043 reported an incident with resident #047. The DOC indicated that 1:1 staffing was put in place to manage resident #047 responsive behaviours after the last incident in the second month period.

Review of health record for resident #043 indicated diagnoses which included dementia. Review of the progress notes of resident #043 indicated on a specified date and time, RN #116 documented the resident's family member reported to the RN that there was a resident that was displaying sexually inappropriate behaviours towards resident #043 which made the resident uncomfortable. The family member was notified that staff would monitor and keep both residents apart whenever they are seen together. There was no documented evidence of the incident in resident #047 progress notes.

Interview with RN #116 by Inspector #111, indicated the incident that occurred on the specified date and time, that was reported by a family member involved resident #043 and resident #047.

Review of the written plan of care for resident #047 had no documented evidence of sexually inappropriate responsive behaviours. The resident was put on DOS monitoring tool with every half hours checks on February 6 to 12, 2017 related to sexually inappropriate behaviours. There was no documented evidence of a referral to BSO.

Interview with PSW # 125 by Inspector #111 indicated the only responsive behaviours resident #047 displayed were verbal and physical aggression towards staff when care was being provided. The PSW indicated the resident previously demonstrated sexually inappropriate behaviours towards resident #027 and the staff were directed to keep the resident's separated.

Review of the health care records of resident #027, #043 & #047 indicated there were ongoing incidents of resident to resident sexually inappropriate responsive behaviours and/or sexual abuse by resident #047 towards two residents (resident #027 & resident #043) over a two month period. Not all of the incidents were documented in both residents health records, the behaviours were not clearly identified as to what the sexually inappropriate behaviour was, the residents involved in the sexually inappropriate

behaviour were not always identified and interventions identified were inconsistently implemented. Interview of staff indicated some staff were aware of the sexually inappropriate responsive behaviours while others were not, and some staff were not aware that resident #043 was also a recipient of these behaviours by resident #047. The BSO team was not in place at time of the incidents, staff did not follow interventions as per the licensee's policy on Dementia Care or as per the BSO binder, and a referral to psycho-geriatric services was not completed until two weeks after the last incident occurred. 1:1 monitoring was also not considered until after the last incident occurred. The written plan of care for resident #047 had no documented evidence of sexually inappropriate responsive behaviours. [s. 53. (4) (c)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

The licensee failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents.

Related to Log #003427-17 & #004015-17:

A critical incident report (CIR) was submitted to the Director on a specified date for a witnessed incident of resident to resident sexual and physical abuse that occurred. The

CIR indicated on the specified date and time, resident #047 was observed by PSW #114 to inappropriately touch resident #027 and then became physically aggressive towards resident #027. The CIR indicated resident #027 was assessed and had no injury as a result. The CIR indicated both residents had moderate cognitive impairment. The CIR indicated the actions taken to prevent a recurrence included: 1:1 PSW for resident #047 for a specified period of time and then placed on every DOS (dementia observation system) with every 30 minute checks, redirecting resident #027, identifying and recognizing triggers for resident #047 and increased involvement in activities.

Interview with the DOC by Inspector #111, indicated resident #047 had prior incidents of inappropriate touching towards two residents (resident #027 & # 043) in January and February 2017. The DOC indicated sometime in January 2017, a family member of resident #043 reported an incident with resident #047. The DOC indicated that 1:1 staffing was put in place to manage resident #047 responsive behaviours after the last incident in February 2017.

Review of the licensee's policy "LTC- Dementia Care-Assessment and Care Planning" (CARE3-010.01) revised July 31, 2016 indicated under Responsive Behaviours:
-all residents experiencing challenging or disruptive responsive behaviours will have a comprehensive assessment using a validated tool (e.g PIECES Assessment).
-Monitoring of responsive behaviours will be completed using an objective systematic tracking tool such as the Dementia Observation System (DOS)
-Monitoring of sexually inappropriate behaviour will be completed using a tracking tool such as the Sexually Inappropriate Tracking Tool.

Review of the BSO Binder indicated the BSO Initiation process was to be initiated when a resident has a new or worsening behaviour: 1.Complete a BSO referral form 2.Initiate a BAT tool, 3.Start a 7 day DOS, 10. Minimize risks of behaviour-how can you improve safety for others during assessment (every 30 minute checks, 1:1 staffing, etc.) 11. Update care plan to ensure current interventions are present. Remember to clearly document all behaviours in progress note and include intervention attempted.

Review of the health care record for resident #047 indicated:
-the resident was cognitively impaired,
-the progress notes for resident #047 (over a two month period), indicated there were four documented incidents of sexually inappropriate responsive behaviours towards unidentified residents, two incidents that were not documented,and the last incident identified resident #027 as the recipient of the sexually inappropriate responsive

behaviour,
-the physician ordered a referral for a psychogeriatric assessment related to sexually inappropriate responsive behaviours two weeks after the last incident occurred. .

Review of the written plan of care for resident #047 had no documented evidence of sexually inappropriate responsive behaviours. The resident was put on DOS monitoring tool with every half hours checks on February 6 to 12, 2017 related to sexually inappropriate behaviours. There was no documented evidence of a referral to BSO.

Interview with BSO staff by Inspector #111 indicated the BSO team had just restarted and unable to recall if resident #047 was identified demonstrating sexually inappropriate responsive behaviours. The BSO staff member indicated there were BSO meeting minutes.

Review of BSO meeting minutes indicated the BSO team had their first meeting ten days after the last incident occurred involving resident #047 and resident #027 but no residents were identified. The meeting that occurred the following month, identified resident #047 but did not indicate what responsive behaviours, triggers or strategies that were identified.

Interview with PSW # 125 by Inspector #111 indicated the only responsive behaviours resident #047 displayed were verbal and physical aggression towards staff during personal care. The PSW indicated awareness of the resident previously demonstrated sexually inappropriate responsive behaviours towards resident #027 and the staff were directed to keep the two resident's separated.

There were ongoing incidents of resident to resident sexually inappropriate responsive behaviours and/or sexual abuse by resident #047 towards two residents (resident #027 and resident #043) over a two month period. Not all of the incidents were documented in both resident's health records, the behaviours were not clearly identified as to what the sexually inappropriate behaviour was, the residents involved in the sexually inappropriate behaviour were not always identified and interventions were inconsistently implemented. The BSO team was not in place at time of the incidents, staff did not follow interventions as per the licensee's policy on Dementia Care or as per the BSO binder, and a referral to Ontario Shores was not completed until February 21, 2017 three weeks after the last incident occurred. The written plan of care for resident #047 had no documented evidence of sexually inappropriate responsive behaviours. [s. 55. (a)]

WN #13: 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 failed to ensure the resident's SDM and any other person specified by the resident, were immediately notified upon becoming aware of an 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.

Related to log #005548-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident physical abuse incident that occurred two days before at a specified time. The CIR indicated resident #051 reported to RN #149, receiving physical abuse resulting in pain and injury to a specified area by PSW #148. The CIR indicated the SDM was notified of the allegation.

Interview with the DOC by Inspector #111 indicated the SDM was notified two days after the allegation of abuse was reported. [s. 97. (1) (a)]

2. Related to Log #005086-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident physical abuse that occurred the day before at a specified time. The CIR indicated that resident #050 reported a staff member was physically abusive towards the resident resulting in pain and upset. The CIR indicated the SDM was notified.

Interview with the DOC by Inspector #570, indicated she became aware the day after the alleged staff to resident physical abuse incident that occurred and contacted the SDM. The DOC indicated the incident was reported by RN #132, PSWs #134 & #139 . The DOC indicated that PSW #133 was also aware of the incident but did not immediately report the incident. The DOC indicated that RN #132 did not immediately notify the SDM of the alleged incident of physical abuse. (570) [s. 97. (1) (a)]

3. The licensee failed to ensure the resident's SDM and any other person specified by the resident,were notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.

Related to log # 003427-17 & 004015-17:

A critical incident report (CIR) was submitted to the Director on a specified date for a witnessed incident of resident to resident sexual and physical abuse that occurred. The CIR indicated on the specified date and time, resident #047 was observed by PSW #114 to inappropriately touch resident #027 and then became physically aggressive towards resident #027. The CIR indicated resident #027 was assessed and had no injury as a result. The CIR indicated both residents had moderate cognitive impairment and both SDM's were contacted. A complaint was also received by the Director on a specified date by a non-staff member regarding the incident.

Interview with DOC, review of the licensee's investigation and review of resident #047 & #027 health record indicated on the specified date and time of the incident, PSW #114 witnessed resident #047 inappropriately touch resident #027, and then resident #047 became physically aggressive towards resident #027. Activation aide #122 also witnessed the incident. RPN # 107, RPN #108, RN #116 & RN #123 were also aware of the incident. RPN #107 contacted the SDM of resident #027 immediately regarding the physically aggression. The RPN did not notify the SDM of the sexual abuse. The SDM of resident #027 became aware of the sexual abuse, ten days later when the SDM was notified of the sexual abuse by the DOC. [s. 97. (1) (b)]

WN #14: 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 :

The licensee has failed to ensure 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.

Related to log #005548-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident physical abuse incident that occurred two days before at a specified time. The CIR indicated resident #051 reported to RN #149, receiving physical abuse resulting in pain and injury to a specified area by PSW #148. The CIR indicated the police were notified of the allegation.

Interview with the DOC by Inspector #111 indicated the police were notified two days after the allegation was reported when the DOC became aware of the allegation. [s. 98.]

2. Related to Log #005086-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident physical abuse that occurred the day before at a specified time. The CIR indicated that resident #050 reported a PSW staff member was physically abusive towards the resident. The CIR indicated the police were contacted.

Interview with the DOC by Inspector #570, indicated she was not made aware of the alleged staff to resident physical abuse incident that occurred on a specified date and time until the day after the incident occurred. The DOC indicated she was made aware of the incident by RN #132, PSWs #134 & #139 . The DOC indicated that PSW #133 was also aware of the incident but did not immediately report the incident. The DOC indicated the police were contacted the day after the incident occurred when she became aware of the allegation.(570) [s. 98.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

The licensee failed to ensure when the long-term care home received a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act, submitted a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant.

Related to log #003427-17 & #004015-17:

A critical incident report (CIR) was submitted to the Director on a specified date for a witnessed incident of resident to resident sexual and physical abuse. The CIR indicated on the specified date and time, resident #047 was observed by PSW #114 to inappropriately touch resident #027 and then became physically aggressive towards resident #027.

Review of the licensee's investigation indicated the DOC received a written complaint from a non-staff member regarding the incident that occurred towards resident #027 and additional complaints of improper care by staff towards resident #027. The DOC responded to the complainant four days later acknowledging the complaint, and then a formal written response was provided to the complainant 18 days later by the Interim Executive Director.

Interview with the DOC by Inspector #111 indicated the written complaint received from a non-staff member regarding improper care by staff towards resident #027 and the response to the complainant was not provided to the Director. [s. 103. (1)]

Issued on this 12th day of June, 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) :	LYNDA BROWN (111), CRISTINA MONTOYA (461), SAMI JAROUR (570), SARAH GILLIS (623)
Inspection No. / No de l'inspection :	2017_643111_0003
Log No. / Registre no:	005466-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 24, Jun 6, 2017
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, 000-000
LTC Home / Foyer de SLD :	REACHVIEW VILLAGE 130 REACH STREET, UXBRIDGE, ON, L9P-1L3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Andrea Deluca

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

Order # / Ordre no : 001

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 for achieving compliance with LTCHA, 2007 s. 19 (1) to ensure all residents are protected from physical and/or sexual abuse.

The licensee shall ensure the plan includes:
1. The development and implementation of a monitoring process to ensure that:
-the resident's SDM is immediately notified of every incident of alleged, suspected or witnessed incident of abuse and are notified with 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse of the resident.
-every alleged, suspected or witnessed incident of physical and/or sexual abuse of a resident by a staff member or another resident, that the licensee knows of, or that is reported to the licensee, is immediately investigated and appropriate action is taken to ensure the safety of those residents involved (and any other residents who may be vulnerable), are protected from physical and/or sexual abuse.
-the Director is immediately notified if there are reasonable grounds to suspect the physical and/or sexual abuse of a resident by anyone or by the licensee or staff that resulted in harm or a risk of harm to the resident.
-the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of physical and/or sexual abuse of a resident that the licensee suspects may constitute a criminal offence.
2. Steps to ensure the responsive behaviours policy is reviewed and revised to include procedures and interventions to assist residents who are at risk of harm or who are harmed as a result of a residents sexually inappropriate responsive behaviour, and that minimize the risk of altercations and potentially harmful interactions between and among residents, specifically sexually inappropriate

behaviours.
3. Strategies to ensure all staff and management are aware of the licensee's Resident Non-Abuse policy to ensure they are aware of their roles and responsibilities, related to immediate actions to be taken, documentation requirements, reporting and investigating requirements and definitions of physical and/or sexual abuse; and
4. Clear lines of responsibilities to support the implementation of the plan and planned interventions to address non-adherence.

The plan shall be submitted in writing and emailed to LTCH Inspector-Nursing, Lynda Brown at OttawaSAO@ontario.ca on or before June 2, 2017. The plan shall identify who will be responsible for each of the corrective actions listed and expected time for completion.

Grounds / Motifs :

1. The licensee failed to ensure that residents were protected from abuse by anyone and ensure that residents were not neglected by the licensee or staff.

Under O.Reg. 79/10, s.2(1) "physical abuse" means, subject to subsection (2), (a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Under O.Reg. 79/10, s.2(1)(b) "sexual abuse" means, any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Related to log # 005548-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident physical abuse incident that occurred two days earlier at a specified time. The CIR indicated resident #051 report to RN #149, PSW #148 had been physically abusive to the resident resulting in pain and injury to a specified area.

Review of the licensee's investigation, interview of staff and review of the health care record of resident #051 indicated:
-on the specified date and time, PSW #126 responded to resident #051 who was heard yelling. The resident reported the alleged physical abuse by PSW #148 resulting in pain and injury to a specified area to PSW #126 and RN #149. The

resident was upset regarding the incident. RN #149 interviewed both PSW #148 (who was assigned to the resident) and PSW #126 (who was working when the incident occurred) immediately following the incident. PSW #148 reported resident #051 was physically aggressive while assisting the resident with care and had to restrain the resident. PSW #126 reported finding the resident already placed into the mobility aide (as the resident had been placed on the toilet). The RN did not document the incident on the resident's health record or the assessment of the resident, did not report the incident to the SDM, physician, police or the Director. The RN reported the allegation to the DOC two days later regarding the incident and also documented the incident two days later in the progress notes (but not indicate when the incident actually occurred).

Interview with the DOC by Inspector #111 indicated the SDM, police, physician and the Director were notified two days after the allegation was made when she became aware of the allegation from RN #149. The DOC indicated RPN #105 completed the head to toe assessment of resident #051 two days later. The DOC indicated the physician assessed the resident three days after the allegation was made and the physician did not see any injury to indicate abuse and concluded the allegation was unfounded. The DOC called RN #149 to discuss reporting requirements related to abuse and to document the incident. The DOC indicated no other actions were taken. The DOC indicated a head to toe assessment should have been completed at the time the allegation was made.

The licensee's policy of "Resident Non-Abuse" was not complied with as there was no documented evidence of a head to toe assessment completed until two days after the incident, the RN did not obtain consent to take pictures of the injuries or evidence at the time of the incident and did not immediately remove the alleged staff member from providing care to residents. The RN failed to document the incident on the day the incident occurred. The RN sent an email to the DOC which was not read until two days after the incident occurred.

Review of the staff schedule indicated PSW #148 continued to provide care to residents the remainder of the shift despite an allegation of staff to resident physical abuse resulting in injury and pain to the resident. The PSW also provided care to resident the following day and was not removed from duty until two days later when the DOC became aware of the allegation. There was no documented evidence the resident and/or family was provided support and referrals to professional services during or after the investigation as per the

licensee's policy.

The licensee failed to ensure that Resident #051 was protected from physical abuse:
-a staff member failed to follow the licensee's abuse policy, by failing to document the incident, including the assessment of the resident and failing to taking immediate actions as per the licensee's policy, and the licensee failed to take appropriate actions as the staff member involved failed to follow the resident's plan of care, as indicated under LTCHA, s. 20(1) refer to WN #6.
-failing to notify the SDM immediately of an alleged staff to resident physical abuse incident that resulted in injury and pain towards resident #051,as the SDM was not notified until two days later, as indicated under O.Reg. 79/10, s.97(1) refer to WN #14.
-failing to immediately notify the police of an alleged staff to resident physical abuse, as the police were not notified until two days later, as indicated under O.Reg.79/10, s.98 refer to WN #15.
-a staff member failed to ensure the plan of care for resident #051 related to toileting and transferring was provided to the resident, as indicated under LTCHA, 2007, s.6(7), refer to WN #5.
-failing to ensure when a person had reasonable grounds to suspect that staff to resident physical abuse had occurred, immediately reported the suspicion and the information upon which it was based to the Director, as indicated under LTCHA, 2007, s.24(1) refer to WN #8. [s. 19. (1)]

2. Related to log #003427-17 & #004015-17:

A critical incident report (CIR) was submitted to the Director on a specified date for a witnessed incident of resident to resident sexual and physical abuse that occurred. The CIR indicated on the specified date and time, resident #047 was observed by PSW #114 to inappropriately touch resident #027 and then became physically aggressive towards resident #027. The CIR indicated resident #027 was assessed and had no injury as a result. The CIR indicated both residents had moderate cognitive impairment. The CIR indicated the actions taken to prevent a recurrence included: 1:1 PSW for resident #047 for a specified period of time and then placed on every DOS (dementia observation system) with every 30 minute checks, redirecting resident #027, identifying and recognizing triggers for resident #047 and increased involvement in activities.

A complaint was also submitted to the Director by a non-staff member regarding

the incident towards resident #027.

An interview with the DOC by Inspector #111, indicated resident #047 had prior incidents of sexually inappropriate responsive behaviours towards residents. #027 & #043. The DOC indicated the SDM of resident #043 had also reported a concern regarding resident #047 inappropriate responsive behaviours towards the resident.

Review of the health care records of resident #027, #043 and #47 indicated there were six incidents when resident #047 displayed either sexually inappropriate responsive behaviours and/or sexual abuse towards resident #027 or resident #043 on the following dates: two days in one specified month and three days the following specified month.

During an interview with RPN #107, RPN #127, RN #116 and PSW #140 by Inspector #111, it was indicated resident #047 previously displayed sexually inappropriate responsive behaviours towards resident #027 and resident #043 but the behaviours no longer occurred.

Review of the current written plan of care (and in place at time of the incidents) for resident #047 related to responsive behaviours had no indication the resident displayed sexually inappropriate responsive behaviours towards residents, specifically resident #027 & resident #043.

The strategies implemented by staff included redirection of resident #047 after each incident. After the sixth incident of sexually inappropriate behaviour, 1:1 staffing was implemented and a Dementia Observation Survey (DOS) (every 30 minute check) was put in place. Additional 1:1 staffing was implemented with resident #047 for a ten day period after the last incident occurred despite the resident no longer exhibiting sexually inappropriate responsive behaviours. A referral to pscyhogeriatric services was completed three weeks after the last incident occurred.

The licensee failed to ensure that resident #027 & resident #048 were protected from sexual abuse by resident #047:
-failing to follow the licensee's non-abuse policy, by failing to document what sexually inappropriate behaviours referred to with each incident, who was involved in the incidents, and taking immediate actions to protect the female residents, as per the licensee's policy, as indicated under LTCHA, s. 20(1) refer

to WN #6.
-failing to notify the SDM within 12 hours of a suspected resident to resident sexual abuse incident that occurred until two days later, towards resident #0027 by resident #047, as indicated under O.Reg. 79/10, s.97(1)(b), refer to WN #14.
-failing to ensure the behavioural triggers had been identified for resident #047 demonstrating sexually inappropriate responsive behaviours where possible and strategies were developed and implemented to respond to these behaviours where possible, as indicated under O.Reg. 79/10, s.53(4)(c), refer to WN #11.
-failing to ensure that procedures and interventions were developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents, as indicated under O.Reg. 79/10, s.55(a), refer to WN #12. [s. 19. (1)]

3. Related to Log #000862-17 :

A critical incident report (CIR) was submitted to the Director on a specified date for a suspected staff to resident physical abuse and improper care that occurred the day before. The CIR indicated resident #048 reported the allegation to the Regional Manager of Education and Resident Services (RMERS) who was acting as the ED at that time. The CIR indicated a PSW was physically abusive resulting in pain to a specified area and another PSW provided improper care preventing the resident to be able to communicate. The CIR did not identify the staff members involved in the allegation.

Review of the licensee's investigation, review of the health record of resident #048 and the staff scheduling indicated PSW #125 was the staff member involved in the alleged physical abuse. PSW #126 was the staff member involved in the alleged improper care. There was no documented evidence a head to toe assessment was completed for the resident post incident. PSW #126 was not interviewed by the DOC regarding the allegation until eight days later, despite continuing to work in the home providing care to residents on four more days. The RMERS was also notified of the allegation by the resident and did not report the allegation to the Director until the following day.

After review of the CIR, licensee's investigation of alleged abuse for resident #048, and interviews with the DOC and RMERS, it was determined that the licensee failed to comply with the licensee's resident non-abuse policy as PSW

#126 was not required to immediately leave the premises pending the investigation as per licensee's policy; there was no documented evidence of a full assessment of the resident when the RMERS became aware of the allegation, the investigation was not completed using the toolkit to conduct the investigation, and there was no disciplinary action taken toward staff involved in incident.

The licensee failed to ensure that resident #048 was protected from physical abuse:
-failing to follow the home's abuse policy, by failing to immediately remove staff from the premises pending the investigation, and failing to complete and document a full assessment of the resident, and failing to use the investigation toolkit as per the licensee's policy, as indicated under LTCHA, s. 20(1) refer to WN #6.
- failing to ensure the person who had reasonable grounds to suspect that staff to resident physical abuse and improper care had occurred, immediately reported the suspicion and the information upon which it was based to the Director, as indicated under LTCHA, 2007, s.24(1), refer to WN #8.
- failing to ensure that the 24-hour admission care plan for resident #048, set out clear directions to staff in relation to the resident's needs for communication, dressing and bathing, as indicated under O.Reg. 79/10, s. 24(3)(b), refer to WN #9.(570) [s. 19. (1)]

4. Related to Log #005086-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident physical abuse that occurred the day before at a specified time. The CIR indicated that resident #050 reported a PSW was physically abusive towards the resident. The CIR was amended six days later and indicated the resident was assessed and no harm or injury was noted to the resident and determined to be unfounded. The CIR was amended again five days later, indicating the home received new information related to the incident and reopened the investigation. The CIR identified several staff names but it was unclear which staff member was directly involved in the allegation.

Review of the licensee's investigation notes, review of resident #050 health record and interviews of staff indicated the following:
- PSW #131 was the staff member directly involved in the allegation of abuse. PSW #138 was also working with PSW # 131 and was aware of the incident but

did not report the incident until 8 days later.
- Resident #050 also reported the allegation to PSW #134 & #139 and RN #132 on the day the incident occurred. Tthe DOC was notified of the allegation by RN #132 and PSW #134 & #139 the following day. RN #132 documented resident #050 was found upset and tearful and reported that PSW #131 had caused pain to specified areas as a result of the incident.
-The DOC documented the day after the incident was witnessed, that Police and SDM were contacted when the DOC became aware.
-PSW #133 also witnessed the incident but did not report the incident until 13 days later. PSW #133 reported that PSW #147 was also present and aware of the incident. PSW #147 did not report the incident.
-the head to toe assessment was not completed until the following day.

During an interview with the DOC by Inspector #570, indicated the alleged staff to resident physical abuse incident that occurred on a specified date and time became aware of the incident the following day by RN #132, PSWs #134 and PSW #139. The DOC indicated that PSW #133 was aware of the incident but did not immediately report the incident to her supervisor and RN #132 did not call the manager on call for direction and did not call the MOHLTC after hours pager to report the alleged abuse.

During an interview with PSW #133 by Inspector #570, indicated did not report the witnessed incident of staff to resident physical abuse by PSW # 131 towards resident #050. PSW #133 indicated the incident was reported to PSW #147 about what was witnessed on the same day the incident occurred and reported the incident to the Clinical Manager RN #116 12 days later.

The licensee failed to ensure that resident #50 was protected from physical abuse by:
-failing to follow the licensee's non-abuse policy, by several staff who witnessed or or who suspected staff to resident physical abuse, reported the allegation immediately, failing to document the incident at the time the incident occurred and completing a head to toe assessment of the resident, and failing to take immediate actions with the staff member involved in the incidents, and those staff members who failed to report the incident immediately, as per the licensee's policy, as indicated under LTCHA, s. 20(1) refer to WN #6.
-failing to notify the SDM within 12 hours of a suspected resident to resident sexual abuse incident that occurred until two days later, towards resident #027 by resident #047, as indicated under O.Reg. 79/10, s.97(1)(b), refer to WN #14.

-failing to ensure that appropriate action was taken in response to every such incident, as there was no documented evidence of any actions taken regarding 3 PSW's (#138, #133 & #147) being aware and/or witnessing staff to resident verbal and/or physical abuse towards resident #050, no actions regarding RN #132 failing to report immediately an allegation of staff to resident physical abuse that resulted in pain., and no action regarding PSW #131 involved in the allegation, as indicated under LTCHA, 2007, s.23(1)(b) refer to WN #7.
-failing to ensure the behavioural triggers had been identified for resident #047 demonstrating sexually inappropriate responsive behaviours where possible and strategies were developed and implemented to respond to these behaviours where possible, as indicated under O.Reg. 79/10, s.53(4)(a)(b), refer to WN #11.
-failing to ensure that procedures and interventions were developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents, as indicated under O.Reg. 79/10, s.55(a), refer to WN #12.

A compliance order was warranted as the scope was that there were three separate incidents of alleged staff to resident physical abuse and/or neglect, and one resident to resident sexual abuse. The severity was such that in all of these incidents, staff who witnessed the incidents did not immediately report the allegation or suspicions, staff did not take immediate actions to protect the residents, and long term actions were not taken to address these concerns after the home completed their investigations as they were all determined to be unfounded. In addition, the licensee's compliance history indicated ongoing non-compliance with failing to immediately investigate any alleged, suspected or witnessed incidents of abuse of a resident, and failing to immediately report to the Director, the same.A Voluntary Plan of Correction (VPC) was issued during a critical incident inspection in March 2014 under inspection #2014_293554_0009 for LTCHA, 2007, s. 23(1) & s.24(1); A VPC was issued during a complaint inspection in July 2014 under inspection #2014_293554_0029 for LTCHA, 2007, s.23(1); A VPC was issued during the RQI Inspection in July 2015 during inspection # 2015_389601_0016 for LTCHA, 2007, s.23(1) & s.24(1); and during the RQI Inspection in October 2016 under inspection #2016_328571_0029. [s. 19. (1)] (111)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2017

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 24th day of May, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

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