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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Apr 27, 2015	2015_380593_0001	S-287, 288, 289, 290	Follow up

Licensee/Titulaire de permis

THE LADY MINTO HOSPITAL AT COCHRANE
241 EIGHTH STREET P.O. BOX 4000 COCHRANE ON P0L 1C0

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

VILLA MINTO
241 EIGHTH STREET P.O. BOX 280 COCHRANE ON P0L 1C0

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

GILLIAN CHAMBERLIN (593), SYLVIE LAVICTOIRE (603)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): January 5 - 8, 2015

This inspection encompassed five Critical Incidents and follow up to five compliance orders.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Director of Care (ADOC), Registered Nursing Staff, Dietary Staff, Activation Staff, Personal Support Workers (PSW), residents and residents' family members.

The inspectors also observed the provision of care and services to residents, observed Staff to resident Interactions, observed resident to resident Interactions, observed residents' environment, reviewed resident health care records, reviewed staff training records and reviewed home policies.

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

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 110. (7)	CO #003	2014_281542_0014	603
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2014_281542_0014	603

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to protect residents from abuse by anyone.

A Critical Incident (CI) was submitted to the MOHLTC, as a result of an incident of sexual abuse by resident #006 towards resident #004, occurring the same day according to the CI. Resident #006 was witnessed to pull resident #004 closer to them and touch the resident inappropriately. It was reported that resident #004 did not show any sign of consensus either way. The Critical Incident was amended several days later when a second incident occurred, where resident #005 was ambulating past resident #006 when the resident touched them inappropriately. It was documented that resident #005 seemed unaware of the incident.

Under O.Reg. 79/10, sexual abuse is defined as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member".

During an interview with Inspector #593 January 07, 2015, #s-110 advised that they were walking down the hallway of the home toward a common area within the home with #s-105 when they both noticed resident #004 ambulating towards resident #006, they witnessed resident #006 pull the resident closer towards them. They both walked towards the residents and #s-110 reported hearing #s-105 telling resident #006 "No". The resident was then observed to reach out and inappropriately touch resident #004. #S-110 advised that they were unsure if the interaction was consensual as these residents have held hands previously and resident #004 would smile during the hand holding. #S-110 further advised that they were not aware of any prior inappropriate sexual behaviour by resident #006 and they were not aware of any further incidents that have occurred with this resident.

During an interview with Inspector #593 January 06, 2015, #s-105 advised that, at the time of the incident, resident #006 was seated in one of the common areas within the home. Resident #004 ambulated towards the resident and #s-105 saw resident #006

holding resident #004's hand. The staff member was not sure if they should intervene as it looked consensual, however they were thinking of intervening out of respect for resident #006's family. A moment later they looked again at the two residents and saw resident #006 touching resident #004 inappropriately. #S-105 was unsure if this was consensual as resident #004 just looked confused. They added that resident #004 will gravitate towards some residents in the home as they believe they are their family members. #S-105 further advised that they were not aware of any prior inappropriate sexual behaviour by resident #006 and they are not aware of any further incidents that have occurred. Since this incident, staff have been given directions to prevent this inappropriate behaviour.

A second Critical Incident was submitted to the MOHLTC, as a result of an incident of sexual abuse by resident #006 towards resident #005. Resident #006 was witnessed to reach out and pull resident #005 towards them and proceeded to touch the resident inappropriately. Resident #006 was informed that they are not to touch other residents without their consent. It was documented that resident #006 indicated understanding.

During an interview with Inspector #593 January 06, 2015, #s-106 advised that the incident between residents #005 and #006 occurred in one of the the common areas of the home. They advised that resident #006 was seated when resident #005 ambulated past, resident #006 reached out for the resident and touched them inappropriately, they did not believe this interaction to be consensual. #S-106 intervened and resident #006 became mad when they told them that the behaviour was not appropriate. Since this incident, staff have been given directions to prevent further occurrences.

During an interview with Inspector #593 January 12, 2015, #s-108 advised that they did not witness the above incident, however the incident was reported to them by the staff member who did. They advised that they went to speak to resident #006 about their behaviour and they became angry and upset about this. Regarding consent, #s-108 advised that they were not sure if this interaction was consensual or not as they did not witness the incident. They further advised that the resident's inappropriate behaviour was "hot topic" due to a recent incident with another resident.

#S-108 told Inspector #593 that they were not familiar with resident #006's plan of care, however advised that there are several interventions in place to prevent inappropriate behaviour. They further added that if resident #006 is to display unusual behaviours, #S-108 believed that this may be when the resident is looking to interact inappropriately with other residents. According to #s-108, if staff members in the home observe these

unusual behaviours, they would advise them so they can be more vigilant with the residents behaviours.

During an interview with Inspector #593 January 07, 2015, #s-109 advised that on November 17, 2014 resident #006 was seated in a common area within the home when resident #005 was ambulating past. Resident #006 was observed to pull resident #005 towards them and touched them inappropriately. They further added that there was no prior relationship between the two residents and they did not think that this touching was consensual. #S-109 further advised that there was a possible earlier incident with resident #017 where they did not want to sit near resident #006 and they wanted to get away from resident #006 however there were no witnesses of what actually happened. Since the incident, there are interventions in place to prevent further reoccurrance.

A review of resident #017's progress notes found potential inappropriate behaviour by resident #006 towards this female resident. It was documented that they did not want to sit next to resident #006 because they did not think it was appropriate. When the resident was questioned further they were unable to provide further detail about the incident however the resident was visibly shaken and upset. The note also added that staff are to be vigilant of interactions between resident #006 and resident #017.

During an interview with Inspector #593 January 08, 2015, #s-104 advised that resident #006's medications had just been reviewed due to their inappropriate behaviours. They further advised that they were started on a medication for behaviours prior to admission to the home.

A review of Resident #006's current plan of care updated after the first incident found that the resident is socially inappropriate with touching of other residents inappropriately. Resident #006's whereabouts and other residents' whereabouts are to be monitored and there are other interventions in place to manage these behaviours.

Non-compliance was previously identified under inspection 2014_380593_0005 and a compliance order was issued pursuant to 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.

As evidenced by documented progress notes, staff interviews and documented plans of care, resident #006 was known to exhibit sexually abusive behaviour towards female residents in the home. After the first witnessed incident towards resident #004, resident

#006's care plan was updated to include monitoring around other residents to prevent reoccurrence, however two further incidents occurred shortly after. The licensee has failed to protect residents within the home from resident #006 with known and documented sexually abusive behaviours. [s. 19. (1)]

2. A Critical Incident was submitted to the MOHLTC as a result of an incident of sexual abuse by resident #003 towards resident #007 occurring two days earlier. Resident #003 was found to be sitting in a chair in one of the home's common area reaching out and touching resident #007 inappropriately. Resident #003 removed their hand when told the behaviour was not acceptable and laughed after the incident.

Under O.Reg. 79/10, sexual abuse is defined as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member".

During an interview with Inspector #593 January 12, 2015, #s-108 advised that the incident was reported to them by #s-111 immediately after the incident occurred. #S-108 advised that there were no previous interactions between residents #003 and #007 and they were not known to sit together, however the home is small and the resident #007 would ambulate past while resident #003 was seated. They further advised that resident #007 has some behaviours that may have been seen as an invitation by resident #003, however #s-108 does not believe that this makes the interaction consensual. #S-108 advised that resident #003's behaviours have been challenging to manage as it is difficult to monitor more independent residents who can ambulate around resident #003.

During an interview with Inspector #593 January 8, 2015, #s-111 advised that they were walking through one of the common living areas of the home when they witnessed resident #003 touch resident #007 inappropriately. #S-111 immediately asked resident #003 to remove their hand, the resident did immediately with a grin on their face, however did not say anything. #S-111 further advised that they were unaware of resident #003's behaviours or any directives regarding managing these behaviours.

A second Critical Incident was submitted to the MOHLTC as a result of an incident of sexual abuse by resident #003 towards resident #011. Resident #003 was found to be sitting in a chair in the home where they pulled resident #011, who was ambulating past, towards them and proceeded to touch the resident inappropriately.

During an interview with Inspector #593 January 12, 2015, #s-108 advised that when the

incident occurred they were in the home with their medication cart, both residents #003 and #011 were nearby. They saw resident #011 trying to ambulate past resident #003, resident #003 pulled resident #011 towards themself and was holding onto them, they were unable to get away and resident #003 proceeded to touch the resident inapproprately. #S-108 intervened immediately and said that resident #003 got mad, like the staff member was interfering on their date. #S-108 further added that there is a period of time between 18:00 and 19:00 where the RPN goes on their break and the PSWs are busy answering calls and toileting / bathing residents. According to #s-108, staff feel that there is not enough supervision of residents in the home at this time and believe that it is just a matter of time before another incident occurs.

Regarding resident #003's behaviour's #s-100 advised that there was a decrease in incidents, however they also had a decline in health, so it is hard to evaluate any improvement in behaviours, but as soon as the resident was feeling better, there would be another incident. They further added that they tried really hard to redirect the resident after meals when there is less supervision in the home and this is the time that the resident has had a history of sexual behaviours.

A review of resident #003's current care plan found that the resident has a history of touching other residents inappropriately. Their whereabouts are to be monitored and when in the common areas there are other interventions in place to manage these inappropriate behaviours.

A review of the home's policy #LTC-630 dated December 5, 2012, found that the home strongly believes that all residents in the long-term care facility have a right to dignity, respect and freedom from abuse and neglect and the home has adopted a resident centred, "zero tolerance of abuse and neglect" policy which encompasses the prevention, reporting and total elimination of any type and degree of abuse/neglect.

Non-compliance was previously identified under inspection 2014_380593_0005 and a compliance order was issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s. 19 (1) in relation to sexual abuse by resident #003 towards resident #002 with a documented prior history of sexually abusive behaviours by resident #003 towards other residents in the home.

As evidenced by documented progress notes, staff interviews and documented plans of care, resident #003 had a history of previous sexual abuse towards residents in the home. Furthermore, two additional witnessed incidents of sexual abuse occurred after

the licensee received a compliance order relating to this resident's abusive behaviour. The licensee has failed to protect residents within the home from resident #003 with known and documented sexually abusive behaviours. [s. 19. (1)]

3. A Critical Incident was submitted to the Ministry of Health and Long-Term Care, in relation to reported abuse by a PSW towards several residents in the home. Two PSWs presented a letter to #s-100 with concerns that their co-worker, #s-112 was rough when providing resident care and yelled at residents. After the home completed their investigation, the outcome resulted in written discipline for #s-112 with mandatory attendance in the Employee Assistance Program (EAP), completion of the CNO module, Abuse Prevention: One is One Too Many and signing off on the home's policy: Zero Tolerance of Abuse and Neglect. The employee's cooperation and compliance was to be monitored by the Employee Health Lead.

Under O.Reg. 79/10, emotional abuse is defined as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident".

Under O.Reg. 79/10, verbal abuse is defined as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

During an Interview with Inspector #593 January 08, 2015, #s-113, who initially came forward to #s-100 about the abuse allegations, advised that they had witnessed #s-112 providing rough care to residents and insult and speak poorly to the residents who could not speak back to them. A specific example included: #s-112 would tell resident #010 to their face that they were disgusting and that they smelled. Since the initial incident, which was reported nearly six months earlier, #s-113 advised that there was an initial improvement for a short while, however #s-112 was now even worse towards residents. They advised that there was a recent incident where #s-112 left resident #011 in a soiled brief, #s-113 returned from their break and reported this to the RPN. #S-112 confronted them about this and proceeded to yell and swear at staff in front of residents. #S-113 advised that the behaviour is targeted toward several residents in the home.

Inspector #593 was informed of the following behaviour witnessed by #s-113 :

Resident #011- Would often run into people's feet while ambulating, #s-112 would yell at the resident "two more times and you are on lockdown".

Resident #009- #s-112 told the resident to "shut-up".

Resident #007- #s-112 told the resident to "shut-up".

Resident #002- #s-112 told the resident to "shut-up" and will often yell at this resident.

#S-113 advised that they have not gone forward to the home with these further allegations as they are afraid of the backlash from #s-112.

The letter presented to the ADOC by #s-113 and #s-116 was as follows:

"It has been noticed recently that #S-112 has no patience with some residents in particular. They are more rough with them as well as yelling more at them. Refuses to do one resident at HS".

"Alot of times when coming on shift, if they are having a "rough day" as they call it, you know it will not go well. Nurses in charge have also noticed it and said it through word of mouth. Other staff members should be approached about this matter. Nurse in charge should have approached management before us".

A further email received from #s-116 to the home's ADOC is as follows:

"It was noticed during HS care between the hours of 2030-2200h, #s-112 was seen yelling at one resident #009 telling the resident to STOP IT! With a stern voice, annoyed at how resident was communicating at HS care and then they walked away as another staff member was taking care of them. They were also seen yelling and pointing their finger approaching real close to resident #007's face yelling at them STOP SCREAMING getting frustrated at resident who is yelling".

During an interview with Inspector #593 January 08, 2015, the home's ADOC #s-100 advised that #s-112 continued to work in the home during the investigation into the abuse allegations. This was a decision made with the Human Resources department as they felt that the residents in the home were not at risk and that the staff member would not be alone while working. After the investigation was completed, they informed #s-112 of what the discipline would be including mandatory attendance in the Employee Assistance

Program (EAP). According to the ADOC #s-100, #s-112 was not happy with the outcome and did not feel that it was necessary. The ADOC #s-100 advised that it had been difficult getting #s-112 to attend the EAP and that they have only attended two sessions since the incidence. The ADOC #s-100 advised that #s-112's behaviour and mood initially improved but then they saw a decline in how they coped. They further advised that the PSW had bad days and became stressed very easily.

During an interview with Inspector #593 January 08, 2015, #s-114 confirmed that #s-112 had only attended two EAP sessions since the discipline was given. They further added that full treatment had been approved in this program therefore the staff member was able to attend as many sessions as needed which is a decision made by EAP.

A review of the disciplinary letter given to #s-112 included:

• Regardless of intent, malicious or otherwise, this constitutes resident abuse and as per policy LTC-630 "Zero Tolerance of Abuse and Neglect" and policy LTC-815 "Discipline:, we are issuing a written warning. A copy of LTC-630 is attached. You are required to read it, sign the last page, and return it to your supervisor.

• You are directed to meet with employee health to review the options available to you through the Employee Assistance Program (EAP). Participation in the EAP is now mandatory, as it is our belief that you will benefit from this personally, and learn coping skills which will prevent any further incidents with our residents.

• Lastly, you are required to complete the College of Nurses of Ontario's "Abuse Prevention: One is one too many", which is an online module. This will need to be coordinated with Employee Health who will supervise the education.

• You are being afforded an opportunity to demonstrate that you can and will perform your duties acceptable and in accordance with directives from your supervisor, and you will behave in a manner which upholds the MIC's values. We expect all team members to treat each other, and our clients, with courtesy and respect, and to work in a collaborative and harmonious manner.

• We expect that you will cease any and all inappropriate and aggressive behaviour, and conduct yourself in a professional manner.

The home's investigation notes into the abuse allegations identified the following abusive

behaviour witnessed by numerous staff members in the home:

• During an interview, #s-113 advised that #s-112 was rough with resident #009 and would tell them "No" loudly, resident #009 has told #s-112 that they are mean and the reply from the PSW was laughter. #S-112 told resident #010 that they stink, was rough with care provided towards residents #007 and #010 and has told resident #002 to "shut-up".

• During an interview, #s-116 advised that #s-112 would point their finger at resident #007 and say "Stop", would leave resident #008's care until last so that they would not have to complete this, has told resident #010 that they stink and has said that they would complete resident care but then does not.

• During an interview, #s-117 advised that #s-112 was rough speaking towards resident #011, has told resident #009 to go to their room, responded to resident requests with "I'm busy and can't come".

• During an interview, #s-105 advised that they have witnessed rough care by #s-112 and they had no patience for residents #009 and #011. Has felt uncomfortable for residents on occasions and feels that there was an increase in responsive behaviours when #s-112 is rude or rough. #S-105 has witnessed #s-112 telling residents they were disgusting. Advised that their behaviour is very different when family members are present.

As witnessed by multiple staff members within the home, #s-112 was verbally and emotionally abusive towards five residents on numerous occasions. The home allowed the staff member to continue working with residents during the investigation. Part of the discipline included mandatory attendance in the EAP, however the staff member's attendance had been ad-hoc and abusive behaviour towards residents in the home continued and possibly worsened. As such, the licensee has failed to protect residents from abuse by a staff member in the home. [s. 19. (1)]

4. A Critical Incident was submitted to the Ministry of Health and Long-Term Care, in relation to reported physical restraining of a resident with responsive behaviours. The Administrator received a phone call from #s-103 reporting that they did not agree with how #s-115 was dealing with a resident with responsive behaviours, in order to provide care. According to #s-103, four staff members including #s-115 physically restrained resident #012 to provide care. Later that day, it was reported that #s-115 held resident

#012's arms so that another staff member could provide care.

Under O.Reg. 79/10, physical abuse is defined as "the use of physical force by anyone other than a resident that causes physical injury or pain".

During an interview with Inspector #593 January 8, 2015, the Administrator advised that the incident was reported to them as the ADOC was away. This was a Friday afternoon before a weekend and therefore they did not commence the investigation until four days later on the Tuesday when the ADOC returned. During these four days, the accused #s-115 continued to work, as confirmed by progress notes for resident #012. The investigation commenced on the Tuesday after the incident, #s-115 also worked this day and provided care for resident #012. Both the Administrator and ADOC #s-100 confronted #s-115 and advised of the allegations and that they would be suspended with pay until the investigation was completed. At this time, #s-115 resigned. As a result, the investigation did not continue.

During an interview with Inspector #593 January 7, 2015, #s-103 advised that they reported the abuse allegations to the Administrator. The Administrator advised that they would deal with this after the weekend. #S-103 further advised that they did not witness anything however they were in a family conference regarding resident #012 when #s-115 communicated within the conference that the evening before they had the resident restrained by three to four staff members to be able to complete care. They also made suggestions that the doctor prescribe a strong anti-psychotic as a chemical restraint, which #s-103 thought very unnecessary.

The licensee reported #s-115 to the CNO with a description of events as follows:

A resident in the home was restrained against their will. They would display responsive behaviours when approached by staff to be toileted or changed. Whenever a staff member persisted the behaviours would worsen. Resident was restrained by four staff members under the supervision and the order to restrain resident by #S-115 so they could have care provided.

The following day, other staff members reported the restraining to the home. The staff members told the #S-115 they were not comfortable with the order to restrain. #S-115 contacted the resident's physician on their next shift and explained that the resident had been left in a soiled brief for over 10 hours, however there was no documentation to support this. The doctor's orders were given to #S-115 after the incident based on their

verbal report to the physician.

#S-115 did not contact the physician at the time of the incident. Their documentation showed they contacted the physician during their next shift. The information they provided to the doctor resulted in them ordering a strong anti-psychotic to sedate resident #012 and the order to physically restrain the resident to provide care was verbally given by the physician based on the information #S-115 gave them. There was no documentation to confirm that the resident had been sitting in their feces and urine for ten hours. In fact on this day, the resident's pyjamas were put on and then staff returned an hour later for toileting. The resident was not incontinent at the time.

A review of resident #012's progress notes documented by #s-115 found:

Spoke with the physician and requested they come and see the resident this evening while they were in the building to review progress notes and make necessary med changes in order to accommodate recommendations and assess resident's agitation. The Doctor voiced concern of their incontinence and stated that leaving the resident soiled in their brief is not acceptable for so long (i.e. over 10 hours). The physician left orders related to resident #012.

Resident refused to be toileted before bed. They were displaying responsive behaviours. It required four staff to physically restrain and stand the resident up to toilet. During this time the resident was verbally abusive to staff members. Once calm the resident stood up with assistance and peri care was done.

Writer witnessed resident continue to resist care from all staff members for toileting and for supper. Resident remained calm in chair as long as no one spoke to them or tried to provide care. At HS resident noted to be saturated in urine so staff had no other choice but to physically restrain them in order to provide the care necessary. Resident finally agreed to stay in bed once care was completed.

Resident was blocking the door for family members to leave a room so writer attempted to redirect resident out of their way. Resident was displaying responsive behaviours. Family members waited patiently in room for resident to move out of the way while writer attempted to reapproach 5 minutes later to no avail. Once resident let go of railing writer was able to back the resident up so that family members could get by. Resident continued to display responsive behaviours. Resident had to be physically restrained in order to redirect away from exit. Gentle persuasion (GP) use throughout entire event with

some effectiveness, staff able to remain uninjured from resident but agitation continued until family members were able to leave and distraction was able to be provided.

Resident was resistive to care. Both writer and PSW attempted to toilet and put resident to bed several times. At every interval resident displayed responsive behaviours. Registered staff from the hospital informed of difficulties in caring for resident as well as updated on status of resident's poor hygiene. Later, two staff members and writer were required to physically toilet resident against resident's wishes. Resident reapproached at three hours later by writer and convinced to go to bed. Resident resistive at first but would only agree to go there if staff lay down beside her. Writer did this and resident finally settled to bed at this time. Writer firmly believes that GPA is very important in order to get resident to perform ADLs but understands that sometimes this can be impossible and staff must intervene to ensure safety and quality of care.

During an interview with Inspector #593 January 7, 2015, the ADOC #s-100 advised that after the initial incident, other staff members came forward regarding #s-115's behaviour towards residents in the home. They further advised that they were struggling to deal with this resident's behaviour. #S-100 added that #s-115 did not seem to understand that some of their actions were not appropriate for long-term care. Regarding the incident that occurred with resident #012, #s-115 gave direction to the staff members to physically restrain the resident so that they could provide care. The ADOC #s-100 said that when #s-115 was asked as to whether they would do it again, they replied that yes they would as they believed there was nothing wrong with their behaviour. #S-100 also added that #s-115 would call resident physicians and try to obtain orders to physically restrain residents while providing care and they added that the Physicians would call the ADOC very upset about these requests. #S-100 also added that #s-115 curled up in bed one night with resident #012 to calm the resident and that #s-115 struggled with a therapeutic balance of care towards residents.

A review of the home's policy #LTC-630: Zero Tolerance of Abuse and Neglect dated December 5, 2012 found that the MICS Group of Health Services strongly believe that all residents in the Long-Term Care facility have a right to dignity, respect and freedom from abuse and neglect as found in the "Residents Bill of Rights" and the home has adopted a resident centred, "Zero Tolerance of abuse and neglect" policy which encompasses the prevention, reporting and total elimination of any type and degree of abuse/neglect. Furthermore the policy stated that persons who have abused/neglected or alleged to have abused/neglected and should the allegation of abuse be found to be factual, the person will be immediately suspended pending the results of the

investigation.

As witnessed by multiple staff members and documented in progress notes, #s-115 physically restrained resident #012 on more than one occasion. Furthermore, the home delayed the investigation by four days after being made aware of the incident and during this time #s-115 continued to work and provide care to resident #012. The licensee has failed to protect residents from abuse by a staff member in the home. [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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to immediately report the abuse of a resident by anyone that resulted in harm or risk of harm to the resident.

A Critical Incident (CI) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), in relation to reported abuse by a PSW towards several residents in the home. Two PSWs in the home presented a letter to ADOC #s-100 with concerns that

their co-worker, #s-112 was rough with residents and yelled at residents. After the home completed their investigation, the outcome resulted in written discipline for #s-112.

The CI was submitted however, the incident actually occurred four days earlier than when the CI was reported to the MOHLTC.

A CI was submitted to the MOHLTC, in relation to reported physical restraining of a resident with responsive behaviours. The Administrator received a phone call from #s-103 reporting that they did not agree with how #s-115 was dealing with a resident with responsive behaviours in order to provide care. According to #s-103, four staff members including #s-115, physically restrained resident #012 to provide care. Later that day, it was reported that #s-115 held resident #012's arms so that another staff member could provide care.

The CI was submitted however, the incident actually occurred five days earlier than when the CI was reported to the MOHLTC.

A CI was submitted to the MOHLTC as a result of an incident of sexual abuse by resident #003 towards resident #007. Resident #003 was found to be sitting in a chair in the home reaching out and touching resident #007 inappropriatelty. It was believed that this physical contact was not consensual.

The CI was submitted however, the incident actually occurred two days earlier than when the CI was reported to the MOHLTC.

A CI was submitted to the MOHLTC as a result of an incident of sexual abuse by resident #006 towards resident #005. Resident #006 was witnessed to reach out and pull resident #005 towards them and proceed to touch the resident inappropriately. It was believed that this physical contact was not consensual.

The CI was submitted however, the incident actually occurred three days earlier than when the CI was reported to the MOHLTC.

A CI was submitted to the MOHLTC December 30 as a result of an incident of sexual abuse by resident #003 towards resident #011. Resident #003 was found to be sitting in a chair in the home's common living room where they pulled resident #011 towards resident #003 who was ambulating past and they proceeded to touch the resident inappropriately. It was believed that this physical contact was not consensual.

The CI was submitted however, the incident actually occurred nearly 24 hours earlier than when the CI was reported to the MOHLTC.

During an interview with Inspector #593 January 7, 2015, the home's ADOC #s100 advised that they are usually the one responsible for reporting to the MOHLTC and completing the CIs. They further added that they have been late to report on multiple occasions as they are waiting to report the incident once they had gathered all of the information. They confirmed that this was the situation with the earlier mentioned CIs. Regarding reporting by other staff members, #s-100 advised that this was covered in the annual education and in addition, each staff member was given a copy of each MOHLTC algorithm to use to determine whether they are required to report to the MOHLTC.

A review of the home's policy #LTC-930: Duty to Report dated May 1, 2013, found that abuse of a resident by anyone or neglect of a resident by anyone that resulted in harm or risk of harm to the resident is to immediately be reported to the Ministry. Furthermore, during business hours, the DOC/ADOC will report the incident by initiating the on-line MCIS form using the mandatory report section. The charge nurse will report the incident after hours and holidays by calling the after hour pager. The DOC/ADOC will follow-up with the completion of the MCIS on-line report on the next business day.

Non-compliance was previously identified under inspection 2014_380593_0005. Pursuant to LTCHA, 2007 S.O. 2007, c.8, s. 24 (1) in relation to failing to immediately report the sexual abuse of a female resident in the home by a male resident in the home.

The licensee submitted five critical incident reports over a six month period involving abuse towards residents in the home by other residents and staff members. On all five occasions, the CI was reported between one to five days after the incident occurred. As such, the licensee has failed to immediately report the abuse of a resident to the Director. [s. 24. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that policies are complied with and are implemented in accordance with applicable requirements under the Act.

A review of the home's policy #LTC-630: Zero Tolerance of Abuse and Neglect dated December 5, 2012 found that the policy states that persons who have abused/neglected or alleged to have abused/neglected and should the allegation of abuse be found to be factual, the person will be immediately suspended pending the results of the investigation and as such, the home's policy allows for staff members who have abused or alleged to have abused a resident to continue to work in the home providing direct care, pending the results of the investigation. This policy is not in compliance with sections under the Act s.20.

A Critical Incident was submitted to the Ministry of Health and Long-Term Care in relation to reported abuse by a staff member towards several residents in the home. Two staff members presented a letter to the ADOC with concerns that their co-worker #s-112 was rough when providing resident care and yelled at residents. After the home completed their investigation, the outcome resulted in written discipline for #s-112 with mandatory attendance in the Employee Assistance Program (EAP) and completion of the CNO module, Abuse Prevention: One is One Too Many and signing off on the home's policy: Zero Tolerance of Abuse and Neglect.

During an interview with Inspector #593 January 08, 2015, the home's ADOC #s-100 advised that accused #s-112 continued to work in the home during the investigation into

the abuse allegations. This was a decision made with the HR department as they felt that the residents in the home were not at risk and that they would not be alone while working. After the investigation was completed, #s-112 was issued a written discipline.

A Critical Incident was submitted to the Ministry of Health and Long-Term Care, in relation to reported physical restraining of a resident with responsive behaviours. The Administrator received a phone call from #s-103 reporting that they did not agree with how #s-115 was dealing with a resident with responsive behaviours, in order to provide care. According to #s-103, four staff members including #s-115 physically restrained resident #012 to provide care. Later that day, it was reported that #s-115 held resident #012's arms so that another staff member could provide care.

During an interview with Inspector #593 January 08, 2015, the Administrator advised that the incident of staff to resident abuse was reported to them as the ADOC was away. This was a Friday afternoon before a weekend and therefore they did not commence the investigation until four days later on the Tuesday when the ADOC returned. During these four days, the accused #s-115 continued to work as confirmed by progress note charting for resident #012. The investigation commenced four days after it was reported, #s-115 also worked this day and provided care for resident #012.

The home has failed to suspend both staff members during the abuse investigations who have abused or alleged to have abused a resident or residents in the home. It is not documented in the policy that the home are to suspend suspected staff members during an investigation into abuse or alleged abuse and therefore the policy is not in compliance with sections under the Act s.20. As such, the licensee has failed to ensure that policies are in compliance with and is implemented in accordance with applicable requirements under the Act. [s. 8. (1) (a)]

2. The licensee has failed to ensure that policies are put in place and complied with.

On January 6 and 7, 2015, Inspector #603 observed the medication cart unattended and unlocked in the unlocked medication room beside the nursing station. Inspector #603 interviewed #s-103 and #s-104 who both stated that they do not lock the medication cart at all times. #S-104 explained that as long as the narcotic box is locked in the medication cart, it is ok to leave the medication cart unlocked. #S-103 and #s-104 also explained that there is usually someone at the nursing station and if not, then the medication room's door will be closed and locked.

The home's Narcotics and Controlled Drugs policy # VI-30 revised June 28, 2010 indicated that #1. Narcotics and controlled medication will be stored under double lock. The Home's Narcotics & Controlled Drugs policy # VI-30 indicated that #6. The "Narcotic Key" is always carried by the Charge Registered Staff. Inspector #603 observed that the narcotic key was shared between the Charge Registered Nurse and the Registered Practical Nurses who administered medications. There was no sign off for when the narcotic key was exchanged.

Inspector #603 interviewed #s-101 and #s-104 who explained that the narcotic key usually stays with the Registered Practical Nurse who is in charge of administering medications. The Charge Registered Staff only gets the narcotic key if needed.

The Home's Narcotics & Controlled Drugs policy # VI-30 referred in general that only Registered Nurses administer residents narcotics when in fact both Registered Nurses and Registered Practical Nurses administered narcotics.

The Home's Narcotics & Controlled Drugs policy # VI-30 Revised June 28, 2010 was not complied with.

On January 5 and 6, 2015, Inspector #603 conducted an audit of the medication cart and the medication room for expired drugs. In the medication cart, Inspector #603 noted one bottle of Soflax 100mg exp. 12/14. In the medication room, Inspector #603 noted six bottles of Soflax 100mg exp. 12/14, Depomedrol 40mg per ml exp. 8/14, Flovent HFA 250mcg exp. 8/14.

Inspector #603 interviewed #s-103 and the staff member was not aware of any process for removing expired drugs. #S-104 explained that the RNs on night shift are to check for expired drugs but this does not get done regularly. #S-104 also explained that there is no schedule or formal process in place to check for expired drugs.

#S-101 was not aware who checks for expired drugs however, when giving different medication, they check for expiry dates. While observing #s-101 and #s-103 administering medications, both staff members did not check for expiry dates including resident treatments such as puffers.

The Home's Expired/Discontinued Medications policy # VI-80 revised June 28, 2010 indicated that medications or substances no longer in use, or those past expiry date, will be removed from use and disposed of according to Federal or Provincial Law or returned

to Rexal Pharmacy, as required.

The Home's Expired/Discontinued Medications policy # VI-80 was not complied with.

On January 5 and 6, 2015, Inspector #603 observed #s-101 and #s-103 administer PRN medications. Both staff explained that when PRN medications are given, they go back to assess residents and document the effectiveness of medication on the PRN Medication Administration Record (MAR) or in Point Click Care (PCC). Inspector #603 reviewed resident #016 PRN MAR and progress notes in PCC and there was no documentation on the effectiveness of an analgesic given on a date in January, 2015 at 1730 and for a different analgesic also given on a date in January, 2015 at 2230. Inspector #603 reviewed resident #015's PRN MAR and progress notes in PCC and there was no documentation on the effectiveness of another analgesic given by injection on a day in October, 2014 at 1915.

The Home's Standards of Medication Administration policy # I-10 dated May 21, 2010 indicated that #4. Nurses evaluate resident outcomes following medication administration and take appropriate steps for follow up. The Home's Drug Administration policy # V-10 dated June 28, 2010 indicated #4. Evaluation of the resident's condition after the medication is administered and the effectiveness of the drug. The Home's Medication Charting Procedure #IV-40 reviewed 01-11-30 indicated #12. The efficacy of the P.R.N. medication must be charted on the PRN sheet or the PRN med sheet or the progress notes. #13. Chart all P.R.N. narcotics on PRN sheet or progress notes. The efficacy of the P.R.N. narcotic must be charted on the progress notes.

The Home's Standards of Medication Administration policy # I-10 dated May 21, 2010, the Home's Drug Administration policy # V-10 dated June 28, 2010, and the Home's Medication Charting Procedure #IV-40 reviewed 01-11-30 were not complied with. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's condition has been reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

On January 5, 2015 at 1630, Inspector #603 observed resident #013 sitting in in the home. The resident had a physical device applied. Inspector #603 reviewed care plan and there was no mention of the physical device as the inspector observed. Inspector #603 interviewed #s-101 who explained that the resident needs the device to make sure the resident is safe. #S-101 stated that the resident was not able to remove the device. On January 8, 2015 at 0930, Inspector #603 requested #s-103 to ask the resident to remove the device and the resident was unable to remove the device.

Inspector #603 reviewed resident #013's Medication Administration Record (MAR) and there was no documentation of reassessment and effectiveness of the restraints by Registered Staff for at least the last two and half months.

Inspector interviewed #s-101 and they were not aware that Registered Staff were to document on the resident's condition and effectiveness of the restraint every 8 hours. #S-101 also confirmed that the resident's MAR did not refer to the device. [s. 110. (2) 6.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

On January 5, 2015 at 1630, Inspector #603 observed resident #013 sitting in the home the resident had a device applied. Inspector #603 reviewed the care plan which indicated no mention of a device being utilized. No clear directions were documented on the care plan for the use of the device.

Inspector #603 interviewed #s-101 who explained that the resident needs the device to ensure the safety of the resident. #S-101 stated that the resident was not able to remove the device. On January 8, 2015 at 0930, Inspector #603 requested #s-103 to ask the resident to remove the device and the resident was unable to remove the device. Inspector #603 interviewed #s-101, #s-103, and #s-104 who all agreed they were not viewing the device as a restraint.

The licensee has failed to ensure that a physical restraining device was included in the plan of care. [s. 6. (1) (c)]

2. A Critical Incident was submitted to the MOHLTC as a result of an incident of sexual abuse by resident #006 towards resident #004 occurring the same day. Resident #006

was witnessed to pull resident #004 closer to them and touch them inappropriately. It was reported that resident #004 did not show any sign of consensus either way. The Critical Incident was amended several days later when a second incident occurred, where resident #005 was ambulating past resident #006 when resident #006 pulled resident #005 towards them and touched them inappropriately. It was documented that resident #005 seemed unaware of the incident.

A second Critical Incident was submitted to the MOHLTC, as a result of an incident of sexual abuse by resident #006 towards resident #005. Resident #006 was witnessed to reach out and pull resident #005 towards them and proceeded to touch the resident inappropriately. Resident #006 was informed that they were not to touch residents without their consent. It was documented that resident #006 indicated understanding.

During an interview with Inspector #593 January 6, 2015, #s-105 advised that since this incident, staff have been given directions to prevent further occurrences of inappropriate behaviour by resident #006.

During an interview with Inspector #593 January 6, 2015, #s-106 advised that since this incident, staff have been given directions to prevent further occurrences of inappropriate behaviour by resident #006.

#S-108 advised that they were not familiar with resident #006's plan of care however advised that staff have been given directions to prevent further occurrences of inappropriate behaviour by resident #006.

During an interview with Inspector #593 January 7, 2015, #s-109 advised that since the incident, there are interventions in place to prevent further occurrences of inappropriate behaviour by resident #006.

A review of resident #006 and other residents' progress notes showed a pattern of inappropriate behaviour:

A review of resident #017's progress notes found potential inappropriate behaviour by resident #006 towards this resident. It was documented that they did not want to sit next to resident #006 because they did not think it was appropriate. When the resident was questioned further they were unable to provide further detail about the incident however they were visibly shaken and upset. The note also added that staff are to be vigilant of interactions between resident #006 and resident #017.

In addition, numerous entries were found where resident #006 has shown aggression towards other residents in the home:

• Resident displayed responsive behaviours towards other resident when other resident was walking in their direction. Behaviour was present with no reasons.

• Resident displayed responsive behaviours toward another resident.

• Resident preoccupied by behaviours of others. Became upset with another resident when they bumped into them. Witnessed resident display responsive behaviours toward this resident.

• It was witnessed that a resident was seated at the dining room table and resident was beside them displaying responsive behaviours toward the other resident.

• A resident was ambulating past resident and stopped in front of them. Resident displayed responsive behaviours toward this resident.

• Resident displayed responsive behaviours toward another resident to keep them from sitting in chair next to them; advised by a staff member that it was not okay and then responsive behaviours were directed at the staff member. No remorse shown.

• Resident displayed responsive behaviours to stop another resident from sitting beside them, resident stated with rage that it was not their chair and to go sit somewhere else.

• Resident noted to display responsive behaviours toward another resident before supper.

• Resident passed behind staff member who was standing at the med cart, and hit them on their buttocks. Resident did not apologize or demonstrate remorse when told their behaviour was inappropriate. Staff informed of behavior and aware to monitor for similar behavior.

A review of Resident #006’s current plan of care found that the resident was socially inappropriate with touching of other residents inappropriately. Resident #006's whereabouts and other residents' whereabouts are to be monitored and there are several interventions in place to manage these behaviours.

The resident's current plan of care does not mention numerous interventions that were verbally communicated during the inspection to manage this resident's responsive behaviour. As such, the licensee has failed to ensure that there is a written plan of care for resident #006 that sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

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 ensuring that the plan of care (POC) for resident #006 provides clear directions to staff who provide direct care regarding the management of responsive behaviours and that the POC for resident #013 provides clear direction related to the use of the device, to be implemented voluntarily.

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 :

1. The licensee has failed to ensure that the written policies to promote Duty to Report and Zero Tolerance of Abuse and Neglect are complied with.

A review of the home's policy #LTC-930: Duty to Report dated May 1, 2013, found that abuse of a resident by anyone or neglect of a resident by anyone that resulted in harm or risk of harm to the resident is to immediately be reported to the Ministry. Furthermore, during business hours, the DOC/ADOC will report the incident by initiating the on-line MCIS form using the mandatory report section. The charge nurse will report the incident

after hours and holidays by calling the after hours pager. The DOC/ADOC will follow-up with the completion of the MCIS on-line report on the next business day.

The licensee of Villa Minto submitted five critical incident reports over a six month period involving abuse towards residents in the home by other residents and staff members. On all five occasions, the CI was reported between one to five days after the incident occurred. As such, the licensee has failed to comply with their own policy to immediately report the abuse of a resident to the Director.

A review of the homes policy #LTC-630: Zero Tolerance of Abuse and Neglect dated December 5, 2012, found that the substitute decision maker (SDM) must be notified within 12 hours of the home becoming aware of any incident of abuse or neglect whether alleged, suspected, witnessed or not witnessed. The SDM must also be notified immediately upon completion of the investigation to share the results of the investigation.

During an interview with Inspector #593 January 7, 2015, the homes ADOC #s-100 confirmed that no SDMs were contacted regarding the abuse allegations nor were they informed of the outcome of the investigations once completed. They added that the reason for this was that they felt that there was not sufficient evidence of abuse directed towards these residents. However the accused staff member was issued a disciplinary letter with mandatory training as a result of the investigation.

As such, the licensee has failed to notify the resident's substitute decision maker within 12 hours after becoming aware of any incident of abuse or neglect whether alleged, suspected, witnessed or not witnessed or to notify the SDM immediately upon completion of the investigation to share the results as per the home's Zero Tolerance of Abuse and Neglect policy #LTC-630.

Non-compliance was previously identified under inspection 2014_380593_0005, pursuant to LTCHA, 2007 S.O. 2007, c.8, s. 20 (1) in relation to failing to comply with the home's policy "Zero Tolerance of Abuse and Neglect".

As described previously, the home has failed to comply with multiple aspects of their own policy including immediate reporting to the Director and notification of the SDM. As such, the licensee has failed to ensure that the home's policies #LTC-630: Zero Tolerance of Abuse and Neglect dated December 5, 2012, and #LTC-930: Duty to Report dated May 1, 2013 were complied with. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that every aspect of the home's policies #LTC-630: Zero Tolerance of Abuse and Neglect and #LTC-930: Duty to Report are complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to immediately investigate the abuse of a resident by anyone.

A CI was submitted to the Ministry of Health and Long-Term Care, in relation to reported physical restraining of a resident with responsive behaviours. The Administrator received a phone call from #s-103 reporting that they did not agree with how #s-115 was dealing with a resident with responsive behaviours in order to provide care. According to #s-103, four staff members including #s-115 physically restrained resident #012 to provide care. Later that day, it was also reported that #s-115 held resident #012's arms so that another staff member could provide care.

During an interview with Inspector #593 January 7, 2015, #s-103 advised that they reported the abuse allegations to the Administrator. They added that the Administrator's response was that they would deal with it after the weekend.

During an interview with Inspector #593 January 8, 2015, the Administrator advised that they were involved in this investigation as the ADOC was away at the time and the staff member reported the abuse allegations directly to them. #S-103 reported the allegations to the Administrator on a Friday. The Administrator confirmed that they informed #s-103 that they would begin the investigation after the weekend. The Administrator also advised that they met with the ADOC four days later to discuss the incident and then the ADOC commenced the investigation, four days after the allegations were reported to the Administrator.

As such, the licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident that the licensee knows of, or that is reported to the licensee, is immediately investigated. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that every alleged, suspected or witnessed incident of abuse of a resident that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that an order by the physician was received for a device which was applied to resident #013.

On January 5, 2015 at 1630, Inspector #603 observed resident #013 sitting in the home, the resident had a physical device applied. Inspector #603 interviewed #s-101 who explained that the resident uses the device for saftey. #S-101 stated that the resident was not able to remove the device. On January 8, 2015 at 0930, Inspector #603 requested #s-103 to ask the resident to remove the device and the resident was unable to remove the device.

Inspector #603 reviewed resident #013's health care record and did not find an order for a device to be applied to the resident. #S-103 confirmed there was no order for a device as a restraint. [s. 31. (2) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that all restraining by physical devices are included in the resident's plan of care only if a physician or registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining, to be implemented voluntarily.

WN #9: 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).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision maker (SDM) is notified within 12 hours upon the licensee becoming aware of alleged, suspected or witnessed abuse of the resident and are notified of the results of the investigation, immediately upon the completion of the investigation.

A Critical Incident (CI) was submitted to the Ministry of Health and Long-Term Care, in relation to alleged abuse by a staff member towards five residents in the home. Two staff members in the home presented a letter to the ADOC with concerns that their co-worker #s-112 was rough with residents and yelled at residents. The CI did not indicate that the SDMs were notified for the residents involved.

During an interview with Inspector #593 January 07, 2015, the home's ADOC #s-100 confirmed that no SDMs were contacted regarding the abuse allegations. They added that the reason for this was that they felt that there was not sufficient evidence of abuse directed towards these residents. However the homes ADOC #s-100 also advised that

after the investigation was completed, the outcome resulted in written discipline for #s-112 with mandatory attendance in the Employee Assistance Program (EAP) and completion of the College of Nurse's of Ontario (CNO) module: Abuse Prevention- One is One Too Many and signing off on the home's policy #LTC-630: Zero Tolerance of Abuse and Neglect.

A review of the home's policy #LTC-630 dated December 5, 2012 found that the SDM must be notified within 12 hours of the home becoming aware of any incident of abuse or neglect whether alleged, suspected, witnessed or not witnessed. The SDM must also be notified immediately upon completion of the investigation to share the results of the investigation.

As such, the licensee has failed to immediately notify the resident's SDM upon becoming aware of witnessed abuse of the resident that causes distress to the resident that could potentially be detrimental to the resident's health or well-being. [s. 97. (1) (b)]

2. A CI was submitted to the Ministry of Health and Long-Term Care, in relation to alleged abuse by a staff member towards five residents in the home. Two staff members in the home presented a letter to the ADOC with concerns that their co-worker #s-112 was rough with residents and yelled at residents. The CI did not indicate that the SDMs were called for the residents involved.

During an interview with Inspector #593 January 07, 2015, the home's ADOC #s-100 did confirm that none of the five resident SDMs were contacted to inform them of the outcome of the investigation. They added that the reason for this was that they felt that there was not sufficient evidence of abuse directed towards these residents. However the home's ADOC #s-100 also advised that after the investigation was completed, the outcome resulted in written discipline for #s-112 with mandatory attendance in the Employee Assistance Program (EAP) and completion of the College of Nurse of Ontario (CNO) module: Abuse Prevention- One is One Too Many and signing off on the home's policy #LTC-630: Zero Tolerance of Abuse and Neglect.

A review of the home's policy #LTC-630 dated December 5, 2012 found that the SDM must be notified within 12 hours of the home becoming aware of any incident of abuse or neglect whether alleged, suspected, witnessed or not witnessed. The SDM must also be notified immediately upon completion of the investigation to share the results of the investigation.

As such, the licensee has failed to immediately notify the residents SDM upon completion of the investigation to share the results of the investigation. [s. 97. (2)]

Issued on this 8th day of June, 2015

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GILLIAN CHAMBERLIN (593), SYLVIE LAVICTOIRE (603)
Inspection No. / No de l'inspection :	2015_380593_0001
Log No. / Registre no:	S-287, 288, 289, 290
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Apr 27, 2015
Licensee / Titulaire de permis :	THE LADY MINTO HOSPITAL AT COCHRANE 241 EIGHTH STREET, P.O. BOX 4000, COCHRANE, ON, P0L-1C0
LTC Home / Foyer de SLD :	VILLA MINTO 241 EIGHTH STREET, P.O. BOX 280, COCHRANE, ON, P0L-1C0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Diane Stringer

To THE LADY MINTO HOSPITAL AT COCHRANE, 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)

Linked to Existing Order / Lien vers ordre existant: 2014_380593_0005, CO #001;

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 is required to prepare, submit and implement a plan for achieving compliance under s.19 (1) of the LTCHA. This plan is to include:

1. Identification of the responsive behavioral triggers for resident #006, how these triggers will be managed and the interventions to be taken by each staff discipline when triggers are present.

2. Strategies to be used to engage resident #006 regularly in a variety of scheduled and non-scheduled activities ensuring regular mental and physical stimulation to prevent boredom and possible trigger of behaviours.

3. Details of the steps to be taken to minimize inappropriate behaviours displayed by resident #006 considering psychological, pharmaceutical, behavioural and physical interventions and steps to prevent resident #006 from being alone with residents, seated near other residents or in any situation where resident #006 could behave sexually inappropriately towards another resident.

4. Strategies to be taken to ensure that all staff report allegations of abuse immediately to the licensee.

5. Details of the steps to be taken to ensure that all reported allegations of abuse are immediately investigated and that residents in the home are protected from abuse until the investigation is complete.

Furthermore, the licensee is hereby ordered to comply with Policy #LTC-630 Zero Tolerance of Abuse and Neglect (review date December 05, 2012) specifically to the following sections but not limited to:

A- Measures and strategies to prevent abuse and neglect
B- Reporting alleged / witnessed abuse / neglect
C- Notification
D- Investigation
F- Dealing with persons who have abused / neglected or alleged to have abused / neglected

This plan is to be submitted to Gillian Chamberlin, Long-Term Care Homes Inspector. Ministry of Health and Long-Term Care, gillian.chamberlin@ontario.ca by May 15, 2015.

Grounds / Motifs :

1. A Critical Incident was submitted to the Ministry of Health and Long-Term Care, in relation to reported physical restraining of a resident with responsive behaviours. The Administrator received a phone call from #s-103 reporting that they did not agree with how #s-115 was dealing with a resident with responsive behaviours, in order to provide care. According to #s-103, four staff members including #s-115 physically restrained resident #012 to provide care. Later that day, it was reported that #s-115 held resident #012's arms so that another staff member could provide care.

Under O.Reg. 79/10, physical abuse is defined as "the use of physical force by anyone other than a resident that causes physical injury or pain".

During an interview with Inspector #593 January 8, 2015, the Administrator advised that the incident was reported to them as the ADOC was away. This was a Friday afternoon before a weekend and therefore they did not commence the investigation until four days later on the Tuesday when the ADOC returned. During these four days, the accused #s-115 continued to work, as confirmed by progress notes for resident #012. The investigation commenced on the Tuesday after the incident, #s-115 also worked this day and provided care for resident #012. Both the Administrator and ADOC #s-100 confronted #s-115 and advised of the allegations and that they would be suspended with pay until the investigation was completed. At this time, #s-115 resigned. As a result, the investigation did not continue.

During an interview with Inspector #593 January 7, 2015, #s-103 advised that they reported the abuse allegations to the Administrator. The Administrator advised that they would deal with this after the weekend. #S-103 further advised that they did not witness anything however they were in a family conference regarding resident #012 when #s-115 communicated within the conference that the evening before they had the resident restrained by three to four staff members to be able to complete care. They also made suggestions that the doctor prescribe a strong anti-psychotic as a chemical restraint, which #s-103 thought very unnecessary.

The licensee reported #s-115 to the CNO with a description of events as follows:

A resident in the home was restrained against their will. They would display

responsive behaviours when approached by staff to be toileted or changed. Whenever a staff member persisted the behaviours would worsen. Resident was restrained by four staff members under the supervision and the order to restrain resident by #S-115 so they could have care provided.

The following day, other staff members reported the restraining to the home. The staff members told the #S-115 they were not comfortable with the order to restrain. #S-115 contacted the resident's physician on their next shift and explained that the resident had been left in a soiled brief for over 10 hours, however there was no documentation to support this. The doctor's orders were given to #S-115 after the incident based on their verbal report to the physician.

#S-115 did not contact the physician at the time of the incident. Their documentation showed they contacted the physician during their next shift. The information they provided to the doctor resulted in them ordering a strong anti-psychotic to sedate resident #012 and the order to physically restrain the resident to provide care was verbally given by the physician based on the information #S-115 gave them. There was no documentation to confirm that the resident had been sitting in their feces and urine for ten hours. In fact on this day, the resident's pyjamas were put on and then staff returned an hour later for toileting. The resident was not incontinent at the time.

A review of resident #012's progress notes documented by #s-115 found:

Spoke with the physician and requested they come and see the resident this evening while they were in the building to review progress notes and make necessary med changes in order to accommodate recommendations and assess resident's agitation. The Doctor voiced concern of their incontinence and stated that leaving the resident soiled in their brief is not acceptable for so long (i.e. over 10 hours). The physician left orders related to resident #012.

Resident refused to be toileted before bed. They were displaying responsive behaviours. It required four staff to physically restrain and stand the resident up to toilet. During this time the resident was verbally abusive to staff members. Once calm the resident stood up with assistance and peri care was done.

Writer witnessed resident continue to resist care from all staff members for toileting and for supper. Resident remained calm in chair as long as no one spoke to them or tried to provide care. At HS resident noted to be saturated in

urine so staff had no other choice but to physically restrain them in order to provide the care necessary. Resident finally agreed to stay in bed once care was completed.

Resident was blocking the door for family members to leave a room so writer attempted to redirect resident out of their way. Resident was displaying responsive behaviours. Family members waited patiently in room for resident to move out of the way while writer attempted to reapproach 5 minutes later to no avail. Once resident let go of railing writer was able to back the resident up so that family members could get by. Resident continued to display responsive behaviours. Resident had to be physically restrained in order to redirect away from exit. Gentle persuasion (GP) use throughout entire event with some effectiveness, staff able to remain uninjured from resident but agitation continued until family members were able to leave and distraction was able to be provided.

Resident was resistive to care. Both writer and PSW attempted to toilet and put resident to bed several times. At every interval resident displayed responsive behaviours. Registered staff from the hospital informed of difficulties in caring for resident as well as updated on status of resident's poor hygiene. Later, two staff members and writer were required to physically toilet resident against resident's wishes. Resident reapproached at three hours later by writer and convinced to go to bed. Resident resistive at first but would only agree to go there if staff lay down beside her. Writer did this and resident finally settled to bed at this time. Writer firmly believes that GPA is very important in order to get resident to perform ADLs but understands that sometimes this can be impossible and staff must intervene to ensure safety and quality of care.

During an interview with Inspector #593 January 7, 2015, the ADOC #s-100 advised that after the initial incident, other staff members came forward regarding #s-115's behaviour towards residents in the home. They further advised that they were struggling to deal with this resident's behaviour. #S-100 added that #s-115 did not seem to understand that some of their actions were not appropriate for long-term care. Regarding the incident that occurred with resident #012, #s-115 gave direction to the staff members to physically restrain the resident so that they could provide care. The ADOC #s-100 said that when #s-115 was asked as to whether they would do it again, they replied that yes they would as they believed there was nothing wrong with their behaviour. #S-100 also added that #s-115 would call resident physicians and try to obtain

orders to physically restrain residents while providing care and they added that the Physicians would call the ADOC very upset about these requests. #S-100 also added that #s-115 curled up in bed one night with resident #012 to calm the resident and that #s-115 struggled with a therapeutic balance of care towards residents.

A review of the home's policy #LTC-630: Zero Tolerance of Abuse and Neglect dated December 5, 2012 found that the MICS Group of Health Services strongly believe that all residents in the Long-Term Care facility have a right to dignity, respect and freedom from abuse and neglect as found in the "Residents Bill of Rights" and the home has adopted a resident centred, "Zero Tolerance of abuse and neglect" policy which encompasses the prevention, reporting and total elimination of any type and degree of abuse/neglect. Furthermore the policy stated that persons who have abused/neglected or alleged to have abused/neglected and should the allegation of abuse be found to be factual, the person will be immediately suspended pending the results of the investigation.

As witnessed by multiple staff members and documented in progress notes, #s-115 physically restrained resident #012 on more than one occasion. Furthermore, the home delayed the investigation by four days after being made aware of the incident and during this time #s-115 continued to work and provide care to resident #012. The licensee has failed to protect residents from abuse by a staff member in the home. [s. 19. (1)] (593)

2. A Critical Incident was submitted to the Ministry of Health and Long-Term Care, in relation to reported abuse by a PSW towards several residents in the home. Two PSWs presented a letter to #s-100 with concerns that their co-worker, #s-112 was rough when providing resident care and yelled at residents. After the home completed their investigation, the outcome resulted in written discipline for #s-112 with mandatory attendance in the Employee Assistance Program (EAP), completion of the CNO module, Abuse Prevention: One is One Too Many and signing off on the home's policy: Zero Tolerance of Abuse and Neglect. The employee's cooperation and compliance was to be monitored by the Employee Health Lead.

Under O.Reg. 79/10, emotional abuse is defined as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident".

Under O.Reg. 79/10, verbal abuse is defined as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

During an Interview with Inspector #593 January 08, 2015, #s-113, who initially came forward to #s-100 about the abuse allegations, advised that they had witnessed #s-112 providing rough care to residents and insult and speak poorly to the residents who could not speak back to them. A specific example included: #s-112 would tell resident #010 to their face that they were disgusting and that they smelled. Since the initial incident, which was reported nearly six months earlier, #s-113 advised that there was an initial improvement for a short while, however #s-112 was now even worse towards residents. They advised that there was a recent incident where #s-112 left resident #011 in a soiled brief, #s-113 returned from their break and reported this to the RPN. #S-112 confronted them about this and proceeded to yell and swear at staff in front of residents. #S-113 advised that the behaviour is targeted toward several residents in the home.

Inspector #593 was informed of the following behaviour witnessed by #s-113 :

Resident #011- Would often run into people's feet while ambulating, #s-112 would yell at the resident "two more times and you are on lockdown".

Resident #009- #s-112 told the resident to "shut-up".

Resident #007- #s-112 told the resident to "shut-up".

Resident #002- #s-112 told the resident to "shut-up" and will often yell at this resident.

#S-113 advised that they have not gone forward to the home with these further allegations as they are afraid of the backlash from #s-112.

The letter presented to the ADOC by #s-113 and #s-116 was as follows:

"It has been noticed recently that #S-112 has no patience with some residents in

particular. They are more rough with them as well as yelling more at them. Refuses to do one resident at HS".

"Alot of times when coming on shift, if they are having a "rough day" as they call it, you know it will not go well. Nurses in charge have also noticed it and said it through word of mouth. Other staff members should be approached about this matter. Nurse in charge should have approached management before us".

A further email received from #s-116 to the home's ADOC is as follows:

"It was noticed during HS care between the hours of 2030-2200h, #s-112 was seen yelling at one resident #009 telling the resident to STOP IT! With a stern voice, annoyed at how resident was communicating at HS care and then they walked away as another staff member was taking care of them. They were also seen yelling and pointing their finger approaching real close to resident #007's face yelling at them STOP SCREAMING getting frustrated at resident who is yelling".

During an interview with Inspector #593 January 08, 2015, the home's ADOC #s-100 advised that #s-112 continued to work in the home during the investigation into the abuse allegations. This was a decision made with the Human Resources department as they felt that the residents in the home were not at risk and that the staff member would not be alone while working. After the investigation was completed, they informed #s-112 of what the discipline would be including mandatory attendance in the Employee Assistance Program (EAP). According to the ADOC #s-100, #s-112 was not happy with the outcome and did not feel that it was necessary. The ADOC #s-100 advised that it had been difficult getting #s-112 to attend the EAP and that they have only attended two sessions since the incidence. The ADOC #s-100 advised that #s-112's behaviour and mood initially improved but then they saw a decline in how they coped. They further advised that the PSW had bad days and became stressed very easily.

During an interview with Inspector #593 January 08, 2015, #s-114 confirmed that #s-112 had only attended two EAP sessions since the discipline was given. They further added that full treatment had been approved in this program therefore the staff member was able to attend as many sessions as needed which is a decision made by EAP.

A review of the disciplinary letter given to #s-112 included:

• Regardless of intent, malicious or otherwise, this constitutes resident abuse and as per policy LTC-630 "Zero Tolerance of Abuse and Neglect" and policy LTC-815 "Discipline:, we are issuing a written warning. A copy of LTC-630 is attached. You are required to read it, sign the last page, and return it to your supervisor.

• You are directed to meet with employee health to review the options available to you through the Employee Assistance Program (EAP). Participation in the EAP is now mandatory, as it is our belief that you will benefit from this personally, and learn coping skills which will prevent any further incidents with our residents.

• Lastly, you are required to complete the College of Nurses of Ontario's "Abuse Prevention: One is one too many", which is an online module. This will need to be coordinated with Employee Health who will supervise the education.

• You are being afforded an opportunity to demonstrate that you can and will perform your duties acceptable and in accordance with directives from your supervisor, and you will behave in a manner which upholds the MIC's values. We expect all team members to treat each other, and our clients, with courtesy and respect, and to work in a collaborative and harmonious manner.

• We expect that you will cease any and all inappropriate and aggressive behaviour, and conduct yourself in a professional manner.

The home's investigation notes into the abuse allegations identified the following abusive behaviour witnessed by numerous staff members in the home:

• During an interview, #s-113 advised that #s-112 was rough with resident #009 and would tell them “No” loudly, resident #009 has told #s-112 that they are mean and the reply from the PSW was laughter. #S-112 told resident #010 that they stink, was rough with care provided towards residents #007 and #010 and has told resident #002 to “shut-up”.

• During an interview, #s-116 advised that #s-112 would point their finger at resident #007 and say “Stop”, would leave resident #008’s care until last so that they would not have to complete this, has told resident #010 that they stink and

has said that they would complete resident care but then does not.

• During an interview, #s-117 advised that #s-112 was rough speaking towards resident #011, has told resident #009 to go to their room, responded to resident requests with "I'm busy and can't come".

• During an interview, #s-105 advised that they have witnessed rough care by #s-112 and they had no patience for residents #009 and #011. Has felt uncomfortable for residents on occasions and feels that there was an increase in responsive behaviours when #s-112 is rude or rough. #S-105 has witnessed #s-112 telling residents they were disgusting. Advised that their behaviour is very different when family members are present.

As witnessed by multiple staff members within the home, #s-112 was verbally and emotionally abusive towards five residents on numerous occasions. The home allowed the staff member to continue working with residents during the investigation. Part of the discipline included mandatory attendance in the EAP, however the staff member's attendance had been ad-hoc and abusive behaviour towards residents in the home continued and possibly worsened. As such, the licensee has failed to protect residents from abuse by a staff member in the home. [s. 19. (1)]

(593)

3. A Critical Incident was submitted to the MOHLTC as a result of an incident of sexual abuse by resident #003 towards resident #007 occurring two days earlier. Resident #003 was found to be sitting in a chair in one of the home's common area reaching out and touching resident #007 inappropriately. Resident #003 removed their hand when told the behaviour was not acceptable and laughed after the incident.

Under O.Reg. 79/10, sexual abuse is defined as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member".

During an interview with Inspector #593 January 12, 2015, #s-108 advised that the incident was reported to them by #s-111 immediately after the incident occurred. #S-108 advised that there were no previous interactions between residents #003 and #007 and they were not known to sit together, however the

home is small and the resident #007 would ambulate past while resident #003 was seated. They further advised that resident #007 has some behaviours that may have been seen as an invitation by resident #003, however #s-108 does not believe that this makes the interaction consensual. #S-108 advised that resident #003's behaviours have been challenging to manage as it is difficult to monitor more independent residents who can ambulate around resident #003.

During an interview with Inspector #593 January 8, 2015, #s-111 advised that they were walking through one of the common living areas of the home when they witnessed resident #003 touch resident #007 inappropriately. #S-111 immediately asked resident #003 to remove their hand, the resident did immediately with a grin on their face, however did not say anything. #S-111 further advised that they were unaware of resident #003's behaviours or any directives regarding managing these behaviours.

A second Critical Incident was submitted to the MOHLTC as a result of an incident of sexual abuse by resident #003 towards resident #011. Resident #003 was found to be sitting in a chair in the home where they pulled resident #011, who was ambulating past, towards them and proceeded to touch the resident inappropriately.

During an interview with Inspector #593 January 12, 2015, #s-108 advised that when the incident occurred they were in the home with their medication cart, both residents #003 and #011 were nearby. They saw resident #011 trying to ambulate past resident #003, resident #003 pulled resident #011 towards themself and was holding onto them, they were unable to get away and resident #003 proceeded to touch the resident inapproprately. #S-108 intervened immediately and said that resident #003 got mad, like the staff member was interfering on their date. #S-108 further added that there is a period of time between 18:00 and 19:00 where the RPN goes on their break and the PSWs are busy answering calls and toileting / bathing residents. According to #s-108, staff feel that there is not enough supervision of residents in the home at this time and believe that it is just a matter of time before another incident occurs.

Regarding resident #003's behaviour's #s-100 advised that there was a decrease in incidents, however they also had a decline in health, so it is hard to evaluate any improvement in behaviours, but as soon as the resident was feeling better, there would be another incident. They further added that they tried really hard to redirect the resident after meals when there is less supervision in

the home and this is the time that the resident has had a history of sexual behaviours.

A review of resident #003's current care plan found that the resident has a history of touching other residents inappropriately. Their whereabouts are to be monitored and when in the common areas there are other interventions in place to manage these inappropriate behaviours.

A review of the home's policy #LTC-630 dated December 5, 2012, found that the home strongly believes that all residents in the long-term care facility have a right to dignity, respect and freedom from abuse and neglect and the home has adopted a resident centred, "zero tolerance of abuse and neglect" policy which encompasses the prevention, reporting and total elimination of any type and degree of abuse/neglect.

Non-compliance was previously identified under inspection 2014_380593_0005 and a compliance order was issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s. 19 (1) in relation to sexual abuse by resident #003 towards resident #002 with a documented prior history of sexually abusive behaviours by resident #003 towards other residents in the home.

As evidenced by documented progress notes, staff interviews and documented plans of care, resident #003 had a history of previous sexual abuse towards residents in the home. Furthermore, two additional witnessed incidents of sexual abuse occurred after the licensee received a compliance order relating to this resident's abusive behaviour. The licensee has failed to protect residents within the home from resident #003 with known and documented sexually abusive behaviours. [s. 19. (1)]
(593)

4. The licensee has failed to protect residents from abuse by anyone.

A Critical Incident (CI) was submitted to the MOHLTC, as a result of an incident of sexual abuse by resident #006 towards resident #004, occurring the same day according to the CI. Resident #006 was witnessed to pull resident #004 closer to them and touch the resident inappropriately. It was reported that resident #004 did not show any sign of consensus either way. The Critical Incident was amended several days later when a second incident occurred, where resident #005 was ambulating past resident #006 when the resident

touched them inappropriately. It was documented that resident #005 seemed unaware of the incident.

Under O.Reg. 79/10, sexual abuse is defined as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member".

During an interview with Inspector #593 January 07, 2015, #s-110 advised that they were walking down the hallway of the home toward a common area within the home with #s-105 when they both noticed resident #004 ambulating towards resident #006, they witnessed resident #006 pull the resident closer towards them. They both walked towards the residents and #s-110 reported hearing #s-105 telling resident #006 "No". The resident was then observed to reach out and inappropriately touch resident #004. #S-110 advised that they were unsure if the interaction was consensual as these residents have held hands previously and resident #004 would smile during the hand holding. #S-110 further advised that they were not aware of any prior inappropriate sexual behaviour by resident #006 and they were not aware of any further incidents that have occurred with this resident.

During an interview with Inspector #593 January 06, 2015, #s-105 advised that, at the time of the incident, resident #006 was seated in one of the common areas within the home. Resident #004 ambulated towards the resident and #s-105 saw resident #006 holding resident #004's hand. The staff member was not sure if they should intervene as it looked consensual, however they were thinking of intervening out of respect for resident #006's family. A moment later they looked again at the two residents and saw resident #006 touching resident #004 inappropriately. #S-105 was unsure if this was consensual as resident #004 just looked confused. They added that resident #004 will gravitate towards some residents in the home as they believe they are their family members. #S-105 further advised that they were not aware of any prior inappropriate sexual behaviour by resident #006 and they are not aware of any further incidents that have occurred. Since this incident, staff have been given directions to prevent this inappropriate behaviour.

A second Critical Incident was submitted to the MOHLTC, as a result of an incident of sexual abuse by resident #006 towards resident #005. Resident #006 was witnessed to reach out and pull resident #005 towards them and proceeded to touch the resident inappropriately. Resident #006 was informed

that they are not to touch other residents without their consent. It was documented that resident #006 indicated understanding.

During an interview with Inspector #593 January 06, 2015, #s-106 advised that the incident between residents #005 and #006 occurred in one of the the common areas of the home. They advised that resident #006 was seated when resident #005 ambulated past, resident #006 reached out for the resident and touched them inappropriately, they did not believe this interaction to be consensual. #S-106 intervened and resident #006 became mad when they told them that the behaviour was not appropriate. Since this incident, staff have been given directions to prevent further occurrences.

During an interview with Inspector #593 January 12, 2015, #s-108 advised that they did not witness the above incident, however the incident was reported to them by the staff member who did. They advised that they went to speak to resident #006 about their behaviour and they became angry and upset about this. Regarding consent, #s-108 advised that they were not sure if this interaction was consensual or not as they did not witness the incident. They further advised that the resident's inappropriate behaviour was "hot topic" due to a recent incident with another resident.

#S-108 told Inspector #593 that they were not familiar with resident #006's plan of care, however advised that there are several interventions in place to prevent inappropriate behaviour. They further added that if resident #006 is to display unusual behaviours, #S-108 believed that this may be when the resident is looking to interact inappropriately with other residents. According to #s-108, if staff members in the home observe these unusual behaviours, they would advise them so they can be more vigilant with the residents behaviours.

During an interview with Inspector #593 January 07, 2015, #s-109 advised that on November 17, 2014 resident #006 was seated in a common area within the home when resident #005 was ambulating past. Resident #006 was observed to pull resident #005 towards them and touched them inappropriately. They further added that there was no prior relationship between the two residents and they did not think that this touching was consensual. #S-109 further advised that there was a possible earlier incident with resident #017 where they did not want to sit near resident #006 and they wanted to get away from resident #006 however there were no witnesses of what actually happened. Since the incident, there are interventions in place to prevent further reoccurrance.

A review of resident #017's progress notes found potential inappropriate behaviour by resident #006 towards this female resident. It was documented that they did not want to sit next to resident #006 because they did not think it was appropriate. When the resident was questioned further they were unable to provide further detail about the incident however the resident was visibly shaken and upset. The note also added that staff are to be vigilant of interactions between resident #006 and resident #017.

During an interview with Inspector #593 January 08, 2015, #s-104 advised that resident #006's medications had just been reviewed due to their inappropriate behaviours. They further advised that they were started on a medication for behaviours prior to admission to the home.

A review of Resident #006's current plan of care updated after the first incident found that the resident is socially inappropriate with touching of other residents inappropriately. Resident #006's whereabouts and other residents' whereabouts are to be monitored and there are other interventions in place to manage these behaviours.

Non-compliance was previously identified under inspection 2014_380593_0005 and a compliance order was issued pursuant to 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.

As evidenced by documented progress notes, staff interviews and documented plans of care, resident #006 was known to exhibit sexually abusive behaviour towards female residents in the home. After the first witnessed incident towards resident #004, resident #006's care plan was updated to include monitoring around other residents to prevent reoccurrence, however two further incidents occurred shortly after. The licensee has failed to protect residents within the home from resident #006 with known and documented sexually abusive behaviours. [s. 19. (1)]
(593)

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 : Jun 12, 2015

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The licensee is required to prepare, submit and implement a plan for achieving compliance under s.24 (1) of the LTCHA. This plan is to include:

1. Strategies to be taken to ensure all staff members within the home are aware of the mandatory reporting requirements as per the LTCH Act, 2007.

2. Strategies to be taken to ensure that all staff report allegations of abuse immediately to the licensee and that all abuse or alleged abuse of a resident is reported immediately to the Director.

Furthermore, the licensee is hereby ordered to comply with Policy #LTC-930 Duty to Report (review date May 01, 2013) specifically to the following section but not limited to only this:

- Procedure for Reporting to the Ministry- Immediate

This plan is to be submitted to Gillian Chamberlin, Long-Term Care Homes Inspector. Ministry of Health and Long-Term Care, gillian.chamberlin@ontario.ca by May 15, 2015.

Grounds / Motifs :

1. The licensee has failed to immediately report the abuse of a resident by anyone that resulted in harm or risk of harm to the resident.

A Critical Incident (CI) was submitted to the Ministry of Health and Long-Term Care(MOHLTC), in relation to reported abuse by a PSW towards several residents in the home. Two PSWs in the home presented a letter to ADOC #s-100 with concerns that their co-worker, #s-112 was rough with residents and yelled at residents. After the home completed their investigation, the outcome resulted in written discipline for #s-112.

The CI was submitted however, the incident actually occurred four days earlier than when the CI was reported to the MOHLTC.

A CI was submitted to the MOHLTC, in relation to reported physical restraining of a resident with responsive behaviours. The Administrator received a phone call from #s-103 reporting that they did not agree with how #s-115 was dealing with a resident with responsive behaviours in order to provide care. According to #s-103, four staff members including #s-115, physically restrained resident #012 to provide care. Later that day, it was reported that #s-115 held resident #012's arms so that another staff member could provide care.

The CI was submitted however, the incident actually occurred five days earlier than when the CI was reported to the MOHLTC.

A CI was submitted to the MOHLTC as a result of an incident of sexual abuse by resident #003 towards resident #007. Resident #003 was found to be sitting in a chair in the home reaching out and touching resident #007 inappropriatelty. It was believed that this physical contact was not consensual.

The CI was submitted however, the incident actually occurred two days earlier than when the CI was reported to the MOHLTC.

A CI was submitted to the MOHLTC as a result of an incident of sexual abuse by resident #006 towards resident #005. Resident #006 was witnessed to reach out and pull resident #005 towards them and proceed to touch the resident inappropriately. It was believed that this physical contact was not consensual.

The CI was submitted however, the incident actually occurred three days earlier than when the CI was reported to the MOHLTC.

A CI was submitted to the MOHLTC December 30 as a result of an incident of sexual abuse by resident #003 towards resident #011. Resident #003 was found to be sitting in a chair in the home's common living room where they pulled resident #011 towards resident #003 who was ambulating past and they proceeded to touch the resident inappropriately. It was believed that this physical contact was not consensual.

The CI was submitted however, the incident actually occurred nearly 24 hours earlier than when the CI was reported to the MOHLTC.

During an interview with Inspector #593 January 7, 2015, the home's ADOC #s100 advised that they are usually the one responsible for reporting to the MOHLTC and completing the CIs. They further added that they have been late to report on multiple occasions as they are waiting to report the incident once they had gathered all of the information. They confirmed that this was the situation with the earlier mentioned CIs. Regarding reporting by other staff members, #s-100 advised that this was covered in the annual education and in addition, each staff member was given a copy of each MOHLTC algorithm to use to determine whether they are required to report to the MOHLTC.

A review of the home's policy #LTC-930: Duty to Report dated May 1, 2013, found that abuse of a resident by anyone or neglect of a resident by anyone that resulted in harm or risk of harm to the resident is to immediately be reported to the Ministry. Furthermore, during business hours, the DOC/ADOC will report the incident by initiating the on-line MCIS form using the mandatory report section. The charge nurse will report the incident after hours and holidays by calling the after hour pager. The DOC/ADOC will follow-up with the completion of the MCIS on-line report on the next business day.

Non-compliance was previously identified under inspection 2014_380593_0005. Pursuant to LTCHA, 2007 S.O. 2007, c.8, s. 24 (1) in relation to failing to immediately report the sexual abuse of a female resident in the home by a male resident in the home.

The licensee submitted five critical incident reports over a six month period involving abuse towards residents in the home by other residents and staff

members. On all five occasions, the CI was reported between one to five days after the incident occurred. As such, the licensee has failed to immediately report the abuse of a resident to the Director. [s. 24. (1)] (593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 12, 2015

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2014_281542_0014, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee is hereby ordered to ensure that the Policy #LTC-630 Zero Tolerance of Abuse and Neglect (review date December 05, 2012) is in compliance with applicable requirements under the Act specifically related to the following section:

F- Dealing with persons who have abused / neglected or alleged to have abused / neglected

The licensee is required to review Policy #LTC-630 Zero Tolerance of Abuse and Neglect (review date December 05, 2012) and ensure that section F as above directs that persons who have abused/neglected or alleged to have abused/neglected are immediately suspended or placed in a position that does not allow access to residents, pending the investigation.

A copy of the reviewed Policy #LTC-630 Zero Tolerance of Abuse and Neglect is to be submitted to Gillian Chamberlin, Long-Term Care Homes Inspector. Ministry of Health and Long-Term Care, gillian.chamberlin@ontario.ca by April 30, 2015.

The licensee is hereby ordered to comply with Policy #VI-30 Narcotics and Controlled Drugs (review date June 28, 2010) specifically to the following

sections but not limited to only them:

#1- Narcotics and controlled medication will be stored under double lock.

#6- The "Narcotic Key" is always carried by the Charge Registered Staff.

The licensee is hereby ordered to comply with Policy #VI-80 Expired / Discontinued Medications Policy (review date June 28, 2010) specifically to the following sections but not limited to only them:

• Medications or substances no longer in use, or those past expiry date, will be removed from use and disposed of according to Federal or Provincial law or returned to Rexal pharmacy, as required.

The licensee is hereby ordered to comply with Policy #VI-10 Medication Administration (review date May 21, 2010) specifically to the following sections but not limited to only them:

#4- Evaluation of the resident's condition after the medication is administered and the effectiveness of the drug.

#12- The efficacy of the P.R.N medication must be charted on PRN sheet or the PRN med sheet or the progress notes.

#13- Chart all P.R.N narcotics on PRN sheet or progress notes. The efficacy of the P.R.N narcotic must be charted on the progress notes.

Grounds / Motifs :

1. The licensee has failed to ensure that policies are complied with and are implemented in accordance with applicable requirements under the Act.

A review of the home's policy #LTC-630: Zero Tolerance of Abuse and Neglect dated December 5, 2012 found that the policy states that persons who have abused/neglected or alleged to have abused/neglected and should the allegation of abuse be found to be factual, the person will be immediately suspended pending the results of the investigation and as such, the home's policy allows for staff members who have abused or alleged to have abused a resident to continue to work in the home providing direct care, pending the results of the investigation. This policy is not in compliance with sections under the Act s.20.

A Critical Incident was submitted to the Ministry of Health and Long-Term Care in relation to reported abuse by a staff member towards several residents in the home. Two staff members presented a letter to the ADOC with concerns that their co-worker #s-112 was rough when providing resident care and yelled at residents. After the home completed their investigation, the outcome resulted in written discipline for #s-112 with mandatory attendance in the Employee Assistance Program (EAP) and completion of the CNO module, Abuse Prevention: One is One Too Many and signing off on the home's policy: Zero Tolerance of Abuse and Neglect.

During an interview with Inspector #593 January 08, 2015, the home's ADOC #s-100 advised that accused #s-112 continued to work in the home during the investigation into the abuse allegations. This was a decision made with the HR department as they felt that the residents in the home were not at risk and that they would not be alone while working. After the investigation was completed, #s-112 was issued a written discipline.

A Critical Incident was submitted to the Ministry of Health and Long-Term Care, in relation to reported physical restraining of a resident with responsive behaviours. The Administrator received a phone call from #s-103 reporting that they did not agree with how #s-115 was dealing with a resident with responsive behaviours, in order to provide care. According to #s-103, four staff members including #s-115 physically restrained resident #012 to provide care. Later that day, it was reported that #s-115 held resident #012's arms so that another staff member could provide care.

During an interview with Inspector #593 January 08, 2015, the Administrator advised that the incident of staff to resident abuse was reported to them as the ADOC was away. This was a Friday afternoon before a weekend and therefore they did not commence the investigation until four days later on the Tuesday when the ADOC returned. During these four days, the accused #s-115 continued to work as confirmed by progress note charting for resident #012. The investigation commenced four days after it was reported, #s-115 also worked this day and provided care for resident #012.

The home has failed to suspend both staff members during the abuse investigations who have abused or alleged to have abused a resident or residents in the home. It is not documented in the policy that the home are to

suspend suspected staff members during an investigation into abuse or alleged abuse and therefore the policy is not in compliance with sections under the Act s.20. As such, the licensee has failed to ensure that policies are in compliance with and is implemented in accordance with applicable requirements under the Act. [s. 8. (1) (a)]
(593)

2. The licensee has failed to ensure that policies are put in place and complied with.

On January 6 and 7, 2015, Inspector #603 observed the medication cart unattended and unlocked in the unlocked medication room beside the nursing station. Inspector #603 interviewed #s-103 and #s-104 who both stated that they do not lock the medication cart at all times. #S-104 explained that as long as the narcotic box is locked in the medication cart, it is ok to leave the medication cart unlocked. #S-103 and #s-104 also explained that there is usually someone at the nursing station and if not, then the medication room's door will be closed and locked.

The home's Narcotics and Controlled Drugs policy # VI-30 revised June 28, 2010 indicated that #1. Narcotics and controlled medication will be stored under double lock. The Home's Narcotics & Controlled Drugs policy # VI-30 indicated that #6. The "Narcotic Key" is always carried by the Charge Registered Staff. Inspector #603 observed that the narcotic key was shared between the Charge Registered Nurse and the Registered Practical Nurses who administered medications. There was no sign off for when the narcotic key was exchanged.

Inspector #603 interviewed #s-101 and #s-104 who explained that the narcotic key usually stays with the Registered Practical Nurse who is in charge of administering medications. The Charge Registered Staff only gets the narcotic key if needed.

The Home's Narcotics & Controlled Drugs policy # VI-30 referred in general that only Registered Nurses administer residents narcotics when in fact both Registered Nurses and Registered Practical Nurses administered narcotics.

The Home's Narcotics & Controlled Drugs policy # VI-30 Revised June 28, 2010 was not complied with.

On January 5 and 6, 2015, Inspector #603 conducted an audit of the medication cart and the medication room for expired drugs. In the medication cart, Inspector #603 noted one bottle of Soflax 100mg exp. 12/14. In the medication room, Inspector #603 noted six bottles of Soflax 100mg exp. 12/14, Depomedrol 40mg per ml exp. 8/14, Flovent HFA 250mcg exp. 8/14.

Inspector #603 interviewed #s-103 and the staff member was not aware of any process for removing expired drugs. #S-104 explained that the RNs on night shift are to check for expired drugs but this does not get done regularly. #S-104 also explained that there is no schedule or formal process in place to check for expired drugs.

#S-101 was not aware who checks for expired drugs however, when giving different medication, they check for expiry dates. While observing #s-101 and #s-103 administering medications, both staff members did not check for expiry dates including resident treatments such as puffers.

The Home's Expired/Discontinued Medications policy # VI-80 revised June 28, 2010 indicated that medications or substances no longer in use, or those past expiry date, will be removed from use and disposed of according to Federal or Provincial Law or returned to Rexal Pharmacy, as required.

The Home's Expired/Discontinued Medications policy # VI-80 was not complied with.

On January 5 and 6, 2015, Inspector #603 observed #s-101 and #s-103 administer PRN medications. Both staff explained that when PRN medications are given, they go back to assess residents and document the effectiveness of medication on the PRN Medication Administration Record (MAR) or in Point Click Care (PCC). Inspector #603 reviewed resident #016 PRN MAR and progress notes in PCC and there was no documentation on the effectiveness of Hydromorph 2mg given on January 1, 2015 at 1730 and for Tylenol 650mg given on January 2, 2015 at 2230. Inspector #603 reviewed resident #015's PRN MAR and progress notes in PCC and there was no documentation on the effectiveness of Toradol 30mg IM given on October 5, 2014 at 1915.

The Home's Standards of Medication Administration policy # I-10 dated May 21, 2010 indicated that #4. Nurses evaluate resident outcomes following medication administration and take appropriate steps for follow up. The Home's Drug

Administration policy # V-10 dated June 28, 2010 indicated #4. Evaluation of the resident's condition after the medication is administered and the effectiveness of the drug. The Home's Medication Charting Procedure #IV-40 reviewed 01-11-30 indicated #12. The efficacy of the P.R.N. medication must be charted on the PRN sheet or the PRN med sheet or the progress notes. #13. Chart all P.R.N. narcotics on PRN sheet or progress notes. The efficacy of the P.R.N. narcotic must be charted on the progress notes.

The Home's Standards of Medication Administration policy # I-10 dated May 21, 2010, the Home's Drug Administration policy # V-10 dated June 28, 2010, and the Home's Medication Charting Procedure #IV-40 reviewed 01-11-30 were not complied with. [s. 8. (1) (b)] (603)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 12, 2015

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant: 2014_281542_0014, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:

1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Order / Ordre :

The licensee is required to prepare, submit and implement a plan for achieving compliance under s.110. (2) 6 of the regulations. This plan is to include:

• An education plan for registered staff regarding the evaluation requirements when residents are restrained by a physical device.

• Strategies to ensure that assessment of resident's condition and effectiveness of the restraint are evaluated at least every 8 hours or more often if required by a member of the registered nursing staff.

• Adherence to documentation of the assessment and evaluation by a member of the registered nursing staff.

This plan is to be submitted to Gillian Chamberlin, Long-Term Care Homes Inspector. Ministry of Health and Long-Term Care, gillian.chamberlin@ontario.ca by May 15, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident's condition has been reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

On January 5, 2015 at 1630, Inspector #603 observed resident #013 sitting in in the home. The resident had a physical device applied. Inspector #603 reviewed care plan and there was no mention of the physical device as the inspector observed. Inspector #603 interviewed #s-101 who explained that the resident needs the device to make sure the resident is safe. #S-101 stated that the resident was not able to remove the device. On January 8, 2015 at 0930, Inspector #603 requested #s-103 to ask the resident to remove the device and the resident was unable to remove the device.

Inspector #603 reviewed resident #013's Medication Administration Record (MAR) and there was no documentation of reassessment and effectiveness of the restraints by Registered Staff for at least the last two and half months.

Inspector interviewed #s-101 and they were not aware that Registered Staff were to document on the resident's condition and effectiveness of the restraint every 8 hours. #S-101 also confirmed that the resident's MAR did not refer to the device. [s. 110. (2) 6.] (603)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 12, 2015

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
Performance Improvement and Compliance 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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
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
Direction de l'amélioration de la performance et de la conformité
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 27th day of April, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Gillian Chamberlin

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