Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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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
Jun 30, 2016	2016_327570_0011	012598-16	Resident Quality Inspection

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

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

SAMI JAROUR (570), BAIYE OROCK (624), DENISE BROWN (626), JULIET MANDERSON-GRAY (607), SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 09-13 and 16-20, 2016

During this Resident Quality Inspection (#012598-16), the following intakes were reviewed and inspected upon concurrently #014307-16, 012466-16 , 014783-16, 011394-16 , 035971-15 , 019352 and 021252- 15.
Summary of the Intakes:
1) Log #014307-16 - Complaint, related to staff to resident alleged verbal abuse and neglect;
2) Log #012466-16 - Complaint, related to resident's care areas and communication with the home;
3) Log #014783-16 - Complaint, related to resident's care areas;
4) Log #011394-16 - Critical Incident Report, related to fall and transfer to hospital;
5) Log #035971-15 - Critical Incident Report, related to fall and transfer to hospital;
6) Log #019352 -16 - Critical Incident Report, related to resident to resident alleged sexual abuse; and
7) Log #021252- 15 - Critical Incident Report, related to improper/incompetent treatment of a resident that results in harm or risk to a resident.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, the Resident Council President, Administrator, Director of Care (DOC), Assistants Director of Care (ADOC), Environmental Services Manager (ESM), Housekeeping staff, Environmental Services Supervisor, Director of Social Services, Personal Care Providers (PCP), Registered Practical Nurses (RPN), Registered Nurses (RN), Physiotherapist (PT), Occupational Therapist (OT), Physiotherapy Assistant, Program Manager and Recreation Aides.

The Inspectors also toured the home, observed staff to resident interactions during the provision of care, observed meal services, observed medication administration and infection control practices, reviewed clinical health records, reviewed admission package, reviewed maintenance log binders, reviewed licensee's investigation documentation and the licensee's policies related to infection control, falls prevention, skin and wound program, resident safety and risk management, responsive behaviours, and resident abuse prevention program.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007 s.19. (1) by failing to protect residents #048, #041 from abuse and or neglect.

Definitions:

Under O. Reg 79/10 s. 2 (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" means, (a) subject to subsection (3), any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or (b) 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;

Under O. Reg 79/10 s. 2 (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "verbal abuse" means, (a) 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.

Under O. Reg 79/10 s.2 (5) For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

As per the licensee's policy "Resident Abuse – Abuse Prevention Program – Whistle-Blowing Protection", No: LTC-CA-ALL-100-05-02 revised October 9, 2014, Sexual Abuse means : "Non-consensual sexual physical touching of a resident; such behaviours include but is not limited to:
- Non-consensual sexual intercourse
- Non-consensual touching of a sexual nature of the resident including kissing
- Behaviour or remarks of a sexual nature towards the resident, which are unwanted by the resident and are sexually demeaning, humiliating, exploitative or derogatory"

Related to log # 019352-15 for resident #048 and resident #047:

The home submitted Critical Incident Report (CIR) on an identified date for an incident related to resident to resident alleged sexual abuse. The critical incident was as follows: On an identified date resident #047 was witnessed straddling resident #048 who was sitting in wheelchair. Resident #047 was leaning over and inappropriately touching resident #048. Resident #048 appeared to be trying to move their head away. The CIR indicates that resident #047 does have a history of attempts to touch co-residents in a

sexual manner. As per CIR, resident #047's behaviour had been well managed, but recent escalation and targeting of particular resident has occurred.

Resident #047 and resident # 048 were admitted to the home on identified dates. On admission, resident #048 was ambulatory but his/her condition deteriorated and now uses a wheelchair for mobility. Both residents are cognitively impaired and resided in the same home area until resident #048 was moved to a different home area following the reported incident as indicated in the CIR.

A review of the progress notes of resident # 047 for sixteen months period revealed multiple incidents of responsive behaviours of a sexual nature by resident #047 directed toward resident #048. The incidents were documented in resident #047's progress notes as follows:

On an identified date, Personal Care Provider (PCP) staff found resident #047 inappropriately touching resident #048's face and cheek area in the dining room before breakfast. RN #151 explained to resident #047 that he/she can't continue to do this. Explained that resident #048's family member would not like that and reminded resident #047 that resident #048 does have a close friend that comes to visit and they wouldn't like that either.

On an identified date, staff noted resident #047 was sitting in chair near info desk after dinner; when resident #048 walked by resident #047, resident #047 reached out and slapped resident #048's buttock. RPN #151 explained to resident #047 that resident #048 has a close friend and they would not like resident #048 to be touched in that manner; resident #047 was asked to go to own room to reflect.

On an identified date, recreational staff reported to RPN #136 that resident #047 was seen inappropriately touching resident #048. Resident #047 was spoken to and planned activity was taken away this evening. RPN reminded resident #047 of "No touching policy".

On an identified date, PCP staff reported to RPN #151 that resident #047 was witnessed leaning over top of resident #048 and inappropriately touching resident #048. PCP explained that resident #047 cannot do that, and reminded resident #047 that resident #048's family member had spoken to him/her to stop touching resident #048 as the resident has a close friend.

On an identified date, housekeeping staff stated that after resident #047 left the dining room from an identified meal, he/she noticed resident #047 in the family room hugging resident #048. Resident #047 was redirected to another area and reminded that caring or providing care to others is not his/her responsibility and resident walked away.

On an identified date, two PCP staff reported to RPN #149 that they saw resident #047 inappropriately touching resident #048 on the forehead, PCP staff intervened by stopping resident #047. RPN #149 reminded resident #047 that this behaviour was inappropriate, that despite liking someone, he/she is not allowed to kiss them. RPN #149 asked resident #047 to go to his/her room and take some time to think about this inappropriate behaviour.

On an identified date, critical incident report (CIR) was submitted stating resident #047 was witnessed straddling resident #048 who was sitting in wheelchair. Resident #047 was leaning over and inappropriately touching resident #048. Resident #048 appeared to be trying to move his/her head away. Resident #047 was sent to his/her room and was told to stay in room until further notice. Physician was notified of incident and ordered to increase identified medication and referral for assessment.

On an identified date, resident #047 walked out of restorative/exercise room and went into family room on identified home area where resident #048 was sitting in wheelchair and inappropriately touched resident #048. RPN #149 separated the two residents and asked resident #047 to go back and continue with exercises. (Note: this incident occurred after resident #048 was moved to a different home area from where both residents resided until the incident that was reported in the CIR on an identified date).

Interviews with RPNs #136, 149, and 151, all agreed that resident #048 is cognitively impaired and does not have the capacity to give consent to sexual activity. RPN #151 informed the inspector that for the four identified incidents, he/she is very certain the incidents were reported to the Nurse Manager but this was not documented. RPN #136 indicated he/she has no recollection of the incident he/she documented on a specified date but said he/she must have reported it to the Nursing Manager but was unsure. For the two incidents on identified dates documented by RPN #149, he/she indicated the expectation is to report to the Nursing Manager which he/she did for one identified incident. The other incident on an identified date, RPN #149 indicated that the incident was witnessed by him/her and the Nursing Manager and they both concluded that it was consensual as resident #048 did not show any indication that he/she did not like the touching from resident #047.

Interview with the DOC indicated to the inspector, in relation to the incidents of sexual behaviour by resident #047 directed toward resident #048, that there was either no indication the touching behaviours were non-consensual or of a sexual nature or that the documentation was unclear to indicate abuse. Therefore, they were not looked upon as sexual abuse and as such were not reported.

The DOC went further to explain that, the bottom line is that the CIR report was submitted for an identified incident as this was the first time that resident #048 had indicated not wanting the kissing. The DOC also stated that they are doing everything to manage resident #047's behaviour. The DOC stated that resident #047's sexual behaviours were assessed and after the transfer of resident #048 out of the unit, resident #047's sexual behaviours have improved. The DOC also stated that residents have a right to form relationships and the home cannot interfere with that right.

On whether resident #048 has the capacity to consent to sexual activity, the DOC indicated: "Legally, not. However, if he/she is not opposing, it will be implied consent". As per the DOC resident #048, at the present moment, is capable of moving his/her arms, legs and head to indicate disinterest.

Apart from the one incident that was reported to the Director and interventions put in place to protect resident #048 (including transfer to another unit), a review of the health records for both residents did not indicate any additional interventions specific to sexual behaviours other than redirecting and re-orientation of resident #047. The redirection and re-orientation interventions had been in effect before the first incident of inappropriate touching involving resident #048. A review of resident #048's progress notes did not indicate entries related to four identified incidents of inappropriate touching, all involving resident #047. Given that both residents are cognitively impaired and lack the capacity to consent to sexual activity and considering the definition of sexual abuse as per Ontario Regulations and the licensee's abuse policy, the licensee failed to protect resident #048 from repeated sexual abuse by resident #047.

The licensee also failed to comply with:
1. LTCHA 2007, s. 6 (7) and s.6 (11) (b) whereby the licensee did not ensure that care set out in the plan of care for resident #047 related to constant monitoring of the resident when off the secured unit was provided to the resident as specified in the plan; and the licensee did not ensure when interventions specific to resident #047's sexually responsive behaviours were ineffective, that the resident's plan of care was revised to

include different approaches. (Refer to WN #2)

2. LTCHA 2007, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. (Refer to WN #5)

3. LTCHA 2007, 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. (Refer to WN #6)

4. LTCHA 2007, 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: 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. (Refer to WN #7)

5. O. Reg 79/10 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 wellbeing. (Refer to WN #12) (624)

Related to Log #014307-16 for resident #041:

An interview during this inspection with resident #041 indicated that there is a personal care provider (PCP) #103 who swears at him/her and slams his/her bedroom door. Resident #041 stated that this was reported in writing to RN #102 on an identified date. Resident #041 indicated that to date he/she has never received a response from the home as to the outcome of their investigation. Resident #041 indicated that PCP #103 still works in the home and cares for him/her and stated being "fearful of PCP #103 and would prefer that PCP #103 did not look after him/her".

During an interview, the DOC indicated being aware of this complaint and that there was an investigation. This complaint was received in writing by the licensee on an identified date and it was treated as a verbal complaint. The DOC stated that investigation notes

indicated that the outcome was unfounded. The DOC confirmed that there is a written statement in the investigation file from resident #041 that is written on his/her behalf. The DOC indicated that the paper states: "PCP #103 slammed the door and swore in the room when resident #041 was on the phone with a family member. PCP #103 kept swearing and the resident was left on the commode for 1.5 hours". The DOC stated that this accusation could never be confirmed because no one could verify this. The DOC indicated that during the investigation, other staff that were interviewed indicated that they did not witness any swearing. The DOC revealed that the investigation notes state that the Administrator was supposed to follow up with the resident but there is no confirmation that this ever happened.

A review of the written statement on an identified date indicated that PCP #103 swearing and talking back to resident #041, PCP#103 was angry because resident #041 had diarrhea. Resident #041 was left on the commode for 1.5 hours on same identified date of the written statement.

During an interview, the DOC confirmed that the nature of the written statement would be considered an allegation of abuse and neglect and that this complaint was not treated as such therefore the incident was not immediately reported to the Director.

During an interview, the Administrator confirmed that he/she did not follow up with resident #041 after the internal investigation into the complaint was completed. The Administrator indicated that he/she first spoke with resident #041 on an identified date (one week following the incident) after receiving a phone call from the resident stating that PCP #103 was caring for him/her. The Administrator confirmed that the home's policy #LTC-CA-WQ-100-05-08 Complaints; was not followed.

The licensee did not protect resident #041 from alleged neglect and verbal abuse by not taking actions as follows:
- The staff member involved PCP #103 continued to provide care for the resident despite the complaint brought forward by the resident.
- The allegation of abuse and neglect was not immediately reported to the director;
- The home did not inform resident #041 of the outcome of the outcome of the investigation.

The licensee also failed to comply with:
1. LTCHA 2007, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written

policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. (Refer to WN #5).

2. LTCHA 2007, 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: 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. (Refer to WN #7)

3. O. Reg. 79/10, s. 8 (1) (b), 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 is complied with, specific to complaints policy. (Refer to WN #3)

4. O. Reg. 79/10, s. 101 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. (Refer to WN #13)

5. O. Reg. 79/10, s. 103 (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). (Refer to WN #14)

6. O. Reg. 79/10, s. 104 (2) The licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. (Refer to WN #15) (623)

The decision to issue a Compliance Order was based on the severity and scope of the incidents noted specifically:

Severity – minimal harm and potential for actual harm to resident #041 who remains fearful of PCP #103 and concerned that the licensee did not address resident #041's

complaint including an allegation of verbal abuse and neglect when the complaint was brought forward on an identified date and the fact that PCP #103 continued to care for the resident despite the resident's complaint. Also, minimal harm or potential for actual harm to resident #048 by being repeatedly targeted by resident #047 on eight occasions during an identified period including once after resident #048 was moved to another home area.

Scope – multiple incidents of alleged resident to resident sexual abuse involving residents #047 and 048 and an allegation of staff to resident verbal abuse and neglect involving resident #041 were identified by inspectors and were not reported to the Director.

The licensee failed to protect residents #041 and 048 from abuse and neglect, therefore a Compliance Order is warranted. [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. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan.

Related to Logs #012466-16 and 014783-16 for resident #015:

A review of a complaint made to the Central Intake Assessment Triage Team (CIATT) on identified dates by the substitute decision maker (SDM) of resident #015 indicated that staff of the home found resident #015 arguing with another resident and the other resident had a red mark on the cheek. The SDM believes the home thinks resident #015 hit another resident, which SDM said, could be true, because lately resident #015 has been throwing things and becoming aggressive. SDM said staff uses distraction as an intervention to address resident #015's responsive behaviours and does not know if there are other interventions in place in resident #015's plan of care.

A review of resident #015's plan care revealed that the following interventions were in place related to responsive behaviours:
1. Staff to approach in am, if the resident is co-operative care will be completed
2. If refusing, staff to turn on lights, open curtains (staff will not open curtains if the resident is removing clothing)
3. Turn music or Television on
4. Report refusals to registered staff
5. Continue to re-approach
6. Administer medication as ordered, report refusal to Medical Director during rounds
7. Use stop and go approach
8. Contact Behaviour Support Observation (BSO) RPN or PCP to assist with care
9. When indicators of refusal occur, ensure the resident is safe before leaving and re-approach in 20 minutes. Family are ok with resident sleeping in late.

A review of clinical records, in the home's electronic record of Point Click Care (PCC) revealed the following documentation in relation to resident #015:
- "on an identified date, writer went into resident's room, turned on all lights and pulled off resident's blankets."
- "on identified date and time, writer went into room and pulled off resident's blankets to try and wake resident. Resident became agitated and started telling writer to get out. Writer explained that they need to get out of bed."
- "on an identified date, writer went in, pulled back the covers, told resident it was time to get up"

Interview with RPN #145 and PCP #144 revealed that when waking resident #015 up, they turn the lights on, open the curtains and use the stop and go approach. An interview

with RPN #115 revealed that there is no documentation in the resident's plan of care indicating that resident blankets should be pulled back as an intervention of waking the resident up and the plan of care was not followed.

Therefore, the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

2. The Licensee failed to ensure that care set out in the plan of care for resident #047 was provided to the resident as specified in the plan.

Related to Log #019352-15 for resident #047:

Refer to Written Notification (WN) #1 of this report for background information related to log #019352-15 for residents #047 and 048.

A review of the progress notes of resident #047 related to sexual behaviour revealed that on an identified date, resident #047 was taken to an identified home area (where resident #048 was moved to and currently resides following a previous incident of inappropriate touching by resident #047) to take part in an activity in the restorative/exercise room. RPN #149 documented that while he/she and the Nurse Manager were working on the home area, resident #047 was witnessed walking out of restorative/exercise room and went into family room where resident #048 was sitting in wheelchair. Resident #047 went really close to resident #048's face talking and inappropriately touched resident #048. Both residents were separated by RPN #149 who redirected resident #047 back to the restorative/exercise room to continue his/her activity. In an interview with RPN #149 indicated to the inspector that the staff member who had brought resident #047 up from a different home area had stepped aside to bring another resident to the restorative/exercise room when the resident wandered to the family room.

A review of the care plan of resident #047 related to recreation stated that "Monitor while off the home area due to wandering". In an interview with PCPs #133, 152, RPNs #149 and 151, all working on identified unit where resident #047 resides, all reported that "Monitor while off the home area due to wandering" means when the resident is off the unit, as resident #047 does for activities, the accompanying staff member needs to ensure that they keep an eye on the resident constantly and ensure that the resident does not wander off. The DOC and ADOC #150 both confirmed that the statement means constant monitoring while off the home area.

The staff member, who accompanied the resident the home area where resident #048 resides, did not provide care as specified in the care plan when they left resident #047 unattended in the restorative/exercise room. [s. 6. (7)]

3. The Licensee failed to ensure that when interventions specific to resident #047's sexually responsive behaviours were ineffective, that the resident's plan of care was revised to include different approaches.

Related to Log # 019352-15 for resident #047:

Refer to WN #1 of this report for background information related to log #019352-15 for residents #047 and 048.

A review of the progress notes of resident #047 for a period of sixteen months revealed multiple incidents of sexual responsive behaviours by resident #047 directed toward resident #048. The incidents were documented in resident #047's progress notes (Refer to WN #1).

During an identified period of six months, there were seven incidents of alleged sexual abuse of resident #048 by resident #047. A review of resident #047's plan of care specific to intimacy and sexually inappropriate behavior revealed that despite repeated inappropriate touching behaviours exhibited by resident #047, the resident's plan of care was not revised and no new approaches were considered until after the seventh incident which was reported to the Director when new interventions were put in place to protect resident #048 from abuse. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
- the care set out in the plan of care for residents #015 and #047 is provided to the residents as specified in the plan; and
- resident #047's plan of care is revised to include different approaches when interventions specific to resident #047's sexually responsive behaviours were ineffective, to be implemented voluntarily.

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 failed to comply with O. Reg. 79/10, s. 8 (1) (b), by not ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specific to dealing with complaints.

Under LTCHA, 2007, s. 21. Every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints.

Related to Log #014307-16 for resident #041:

Review of the licensee's policy for complaints revealed the following;

Policy#LTC-CA-WQ-100-05-08-Complaints (revision date January 2016)
- Verbal complaints that take longer than 24 hours to resolve require written documentation of the investigation and written documentation of the communication associated with the complaint and the investigation. The written investigation report does not have to be sent to the Ministry.
Procedures:
#6. Verbal complaints that cannot be resolved within 24 hours after receipt will be;
i. Fully investigated with the written investigation report and complaint communication log being completed and
ii. Logged in the home's complaint log workbook.

Upon receiving a written complaint:
1. The person receiving the written complaint must immediately forward the written complaint to the Department Manager.
2. The Department Manager will:
i. Inform the Administrator,
ii. Initiate the investigation form for the complaint,
iii. Log all communication with the person who made the complaint with the persons response on the complaint communication log,
iv. Contact the person who filed the complaint acknowledging receipt of the complaint and if necessary obtain additional information to assist with the investigation,
v. Initiate an investigation into the complaint within 24 hours of receipt of the complaint; the complaint will be fully investigated by the Manager - this may include contacting the author of the complaint for further information.
vi. Document the results of your investigation on the investigation report form.
vii. Forward the form to the Administrator for response to the author of the complaint.

An interview during this inspection with resident #041 indicated that there is a personal care provider (PCP) #103 who swears at him/her and slams his/her bedroom door. Resident #041 stated that this was reported in writing to RN #102 on an identified date. Resident #041 indicated that to date he/she has never received a response from the home as to the outcome of their investigation. Resident #041 indicated that PCP #103 still works in the home and cares for him/her and stated being "fearful of PCP #103 and would prefer that PCP #103 did not look after him/her".

Review of the homes internal investigation into the complaint received on an identified date from resident #041 revealed that the initial complaint was received in writing from the resident. The complaint contained allegations of verbal abuse and neglect towards

resident #041 by PCP #103. The home immediately began an initial investigation into the complaint.
- The investigation is recorded on the homes "Complaint Investigation Form". In the "Summary of Investigation box" it is noted "not written - recorded as resident #041 cannot write due to a medical condition and has trouble forming his/her thoughts - written to capture what the concern was, not as an actual written complaint".
- The investigation package does not contain any written statements from the resident interview, any witness statements, any staff on duty that may be related to the allegation, the abuser.
- There is no evidence of written documentation of the physical and emotional status of the resident allegedly abused.
- All written documentation within the investigation package fails to include a date and time of recording as well as a signature of the author.
- The home's Complaint Investigation Form indicated that PCP #103 was on vacation from the home on the date complaint brought forward and returned to regular duties a week after that date from vacation. An investigation interview was conducted by the DOC on an identified date after the PCP had already worked a shift on the same home area including caring for resident #041.

-The internal investigation form failed to reveal that a follow up with the complainant was completed immediately following the investigation.
- The complaint investigation form fails to reveal that it was submitted to the Director.
- The complaint investigation form fails to reveal that this complaint was immediately reported to the Director as required under section 24 of the Long-Term Care Homes Act (LTCHA) 2007.

Therefore the licensee failed to comply with their Policy #LTC-CA-WQ-100-05-08-Complaints. [s. 8. (1) (b)]

2. The licensee failed to comply with O. Reg. 79/10, s. 8 (1) (b), by not ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specific to Falls Prevention and Management.

Under O. Reg. 79/10, s.48(1)1 every licensee of a long-term care home shall ensure that the following interdisciplinary program is developed and implemented in the home: a falls prevention and management program to reduce the incidence of falls and the risk of injury.

Related to Logs #012466-16 and 014783-16 for resident #015:

A review of the licensee's policy titled resident falls, policy #07 – Resident Safety and risk Management revealed the following:
Post Fall Analysis
1. Following a resident fall, Registered Staff will review the residents fall history to determine how many falls the resident has had in the month and how many falls the resident had in the quarter combined with the level of risk related to falls, Registered staff will use the number of falls in the month and quarter to determine if a Post Fall Analysis is to be completed.
2. The interdisciplinary team is responsible for meeting and completing the Post Fall Analysis. Further they are responsible for implementation and subsequent evaluation of interventions implemented as result of the analysis.

A review of a complaint made to the Central Intake Assessment Triage Team (CIATT) on two identified dates by the substitute decision maker (SDM) of resident #015 identified that SDM is concerned because resident #015 has "slid out of the wheelchair" numerous times in the past.

A review of progress notes for resident #015 revealed that the resident had falls on four identified dates.

Interview with personal care provider (PCP) #144 revealed that the resident self-propels wheelchair as well as self-transfer from wheelchair to bed which contributed to his/her falls. The PCP also identified that when the resident self-propels in wheelchair, the resident often slips forward in the wheelchair and often has to be repositioned.

A review of clinical records revealed that resident #015 is at high risk for falls and the inspector could not locate a referral or documentation that the resident was referred to the Physiotherapist (PT) or the Occupational Therapist (OT) for an assessment in relation to the resident's falls and positioning in wheelchair.

A review of the post fall analysis completed falls on two identified dates, revealed that a post fall analysis was completed and only the nursing team was present, and there was no indication that a referral was sent to the OT or PT or that they were involved in the post fall analysis.

An interview with the Physiotherapist (PT) #153 revealed that he/she has not received a

referral in relation to resident #015's falls on the above identified dates.

Interview with DOC confirmed that the names of who participated in post fall analysis should be included in the assessment, and it does not appear that interdisciplinary team participated in the post fall analysis assessment for resident #015.

Therefore the falls prevention policy was not complied with when the physiotherapist and or the occupational therapist did not participate as part of the interdisciplinary team in completing the post fall analysis assessment for resident #015. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
- the licensee's complaints policy; and
- falls policy in relation to interdisciplinary post fall analysis are complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 15 (2) (c), by not ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following observations were made during the dates of May 09, 2016 through to May 13, 2016:

- Tub – MacLaughlin Bay Spa Room (#169) – acrylic finishing on tub (inside) surface is chipped in two areas allowing water to seep in through two small holes.

- Walls – scuffed, scraped/gouged, paint chipping and areas with visible damage (holes in wall, or steel corners exposed) in identified resident room(s) and washroom (s) located on Lakeview Park, Samac Trail, Purple Woods, Collins Path, MacLaughlin Bay, Lynde Creek, Spa Room(s) #169, and #366; Family room #267, Living room #267A located on Lakeview Park home area and Family room #378 located on Samac Trail home area.

- Vanity Counters – laminate (veneer) missing or chipped on washroom vanities exposing wood surface in identified resident room(s) located on Lakeview Park, Samac Trail, Purple Woods and MacLaughlin Bay.

- Doors – rooms/bathroom doors – chipped/scuffed paint or black marks in identified resident rooms located on Samac Trail, Lakeview Park, Collins Path, and MacLaughlin Bay.

- Baseboard heaters – scraped paint/black marks on radiator heaters in identified resident room(s) located on Collins Path, Samac Trail and Purple Woods.

The home's Maintenance Log binders located on Residents Home Areas were reviewed for the period of March 01 to May 18, 2016. The logs indicated most of the above areas requiring repair were not identified.

The Environmental Services Manager (ESM) and the Environmental Services Supervisor both indicated being aware of most of the above areas requiring repair or replacement. The ESM and Environmental Services Supervisor also indicated that the home does have a painting program in place and that professional painters were brought in last year and painted all shower and tub rooms. The ESM indicated that the majority of resident rooms have been painted during the last year; The Environmental Services Supervisor indicated that Tuesday of each weak is designated for painting residents rooms. The ESM indicated that two tubs have been replaced in the second floor and that the home is replacing one tub every year. [s. 15. (2) (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 home, furnishings and equipment including walls in residents' rooms and the tub in Spa room #169 are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: 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 comply with LTCHA, 2007, s. 20 (1), by not ensuring the written policy that promotes zero tolerance of abuse and neglect is complied with.

A review of a complaint made to the Central Intake Assessment Triage Team (CIATT) on two identified dates by the substitute decision maker (SDM) of resident #015 indicated that resident #015 hit another resident and there was a red mark on the other resident's face. The SDM of resident #015 was not told about the incident until the next day.

A review of the clinical records for both resident #015 and #052 indicated that there was a physical altercation between the two residents on an identified date.

A review of the home's policy titled Risk Management – Resident to resident Abuse-Abuse prevention, Policy # LTC-CA-ALL-100-05-02 revealed that when there is an alleged abuse the supervisor/ designate is responsible to:
iii. Complete a Resident incident Report form as applicable to the home.

A review of the clinical records and interview with RN #109 confirmed that an incident report was not completed in relation to the altercation between resident #015 and #052. [s. 20. (1)]

2. Related to Log #019352-15 for residents #047 and 048:

According to the Licensee's policy "Resident Abuse – Abuse Prevention Program – Whistle-Blowing Protection, policy No LTC-CA-ALL-100-05-02" revised October 9, 2014, "all staff members are required to report any abuse, suspected abuse or allegation of abuse immediately to their respective supervisor".

Refer to WN #1 of this report for background information related to Log #019352-15 for residents #047 and 048.

A review of the progress notes of resident #047 for a period of sixteen months revealed multiple incidents of sexual responsive behaviours by resident #047 directed toward resident #048. The incidents were documented in resident #047's progress notes. (Refer to WN #1)

Apart from one incident on an identified date that was reported to the Director, immediately investigated and the resident's SDM notified immediately, there were no records to indicate that the RPNs followed their policy by immediately reporting these incidents to their immediate supervisor.

In interviews with RPNs #136, 149, and 151, to whom the allegation of abuse were reported to, all said when an allegation of abuse is reported to the RPN, the expectation is to report to the immediate supervisor (i.e. the Nursing Manager during business hours or Manager on call, if incident occurs after business hours). All three RPNs indicated they must have reported all the incidents to their supervisors but unfortunately they had no documentation to support that. Regarding the one incident on an identified date, RPN #149 indicated that it was witnessed by him/her and the Nursing manager and they both concluded that it was consensual as resident #048 did not show any indication that he/she did not like the inappropriate touching from resident #047.

In an interview with the DOC indicated to the inspector, in relation to the incidents of sexual behaviour by resident #047 directed toward resident #048, that there was either no indication the inappropriate touching behaviours were non-consensual or of a sexual nature or that the documentation was unclear to indicate abuse. Therefore, they were not

looked upon as sexual abuse and as such were not reported. [s. 20. (1)]

3. Related to Log #014307-16 for resident #041:

Review of the home's policy for Resident Abuse revealed the following;

Policy #LTC-CA-ALL-100-05-02 (revision date October 9, 2014) Resident Abuse-Abuse prevention Program-Whistle Blowing Protection
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If the alleged abuser is a:
a) An employee:
i. the employee may be sent home or removed to an alternative area pending completion of the investigation based on the situation.

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Investigation Process
1. After safety is ensured, the supervisor responsible/designate completing the allegation investigation must:
a) Immediately request and/or obtain written signed and dated (including time) statements immediately from:
- the person or staff member reporting the incident.
- any witnesses
- any staff on duty that may peripherally be related to the allegation prior to their departure from shift; in the event the staff have departed from duty prior to the onset of the investigation, staff who may be involved are to be contacted and interviewed.
- the resident; if the resident is unable to complete a written statement, an interview with the resident statement written by a designate, read back to the resident, signed by the resident including date and time;
- if it is safe to do so, the alleged abuser;
- as an alternate to written statements, video-taped statements including the day, time and name of person reporting the information may be used.
- written documentation of the physical and emotional status of the resident allegedly abused.

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d) Ensure:
- all written documentation is signed and dated with the time of recording
- complete a review of all written information including resident incident report form (in

PCC and or paper) and observations for completeness,
- update and complete the provincial/regulatory body's incident report as required under provincial regulations or use the Chartwell Incident Form,
- review the information/findings of the investigation
- discuss the findings with the respective Director, Regional Operations/Designates and make recommendations.
e) Ensure:
- to report to the required provincial authority if applicable;
- complete/review/update/submit and the designated provincial form as applicable to the province/sector (i.e. MOHTLC/AB Health Authroity, RHRA) as per established timelines, copy to file.

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Post Investigation:
1. After the investigation is completed, the supervisor/designate will contact the resident and POA to offer an appointment to provide debrief of the investigation IMMEDIATELY upon the conclusion of the investigation.

An interview during this inspection with resident #041 indicated that there is a personal care provider (PCP) #103 who swears at him/her and slams his/her bedroom door. Resident #041 stated that this was reported in writing to RN #102 on an identified date. Resident #041 indicated that to date he/she has never received a response from the home as to the outcome of their investigation. Resident #041 indicated that PCP #103 still works in the home and cares for him/her.

The DOC confirmed that there is a written statement in the investigation file from resident #041 that is written on behalf of the resident. The DOC indicated that the paper states: "PCP #103 slammed the door and swore in the room when resident #041 was on the phone with a family member. PCP #103 kept swearing and the resident was left on the commode for 1.5 hours". The DOC stated that this accusation could never be confirmed because no one could verify this. The DOC indicated that during the licensee's investigation, other staff that were interviewed indicated that they did not witness any swearing. The DOC revealed that the investigation notes state that the Administrator was supposed to follow up with the resident but there is no confirmation that this ever happened.

A review of the written statement on an identified date indicated that PCP #103 swearing and talking back to resident #041, PCP#103 was angry because resident #041 had

diarrhea. Resident #041 was left on the commode for 1.5 hours on same identified date of the written statement.

During an interview, the DOC confirmed that the nature of the written statement would be considered an allegation of abuse/neglect and that this complaint was not treated as such therefore the incident was not immediately reported to the Director.

During an interview, the Administrator confirmed that he/she did not follow up with resident #041 after the internal investigation into the complaint was completed. The Administrator indicated that he/she first spoke with resident #041 on an identified date (one week following the incident) after receiving a phone call from the resident stating that PCP #103 was caring for him/her.

Review of the home's internal investigation into the complaint received on an identified date in 2016 from resident #041 revealed that the initial complaint was received in writing from the resident on an identified date. The complaint contained allegations of verbal abuse and neglect towards resident #041 by PCP #103. The home immediately began an initial investigation into the complaint.
- The investigation is recorded on the home's "Complaint Investigation Form". In the "Summary of Investigation box" it is noted "not written - recorded as resident #041 has trouble forming his/her thoughts - written to capture what the concern was, not as an actual written complaint".
- The investigation package does not contain any written statements from the resident interview, any witness statements, any staff on duty that may be related to the allegation, the abuser.
- There is no evidence of written documentation of the physical and emotional status of the resident allegedly abused.
- All written documentation within the investigation package fails to include a date and time of recording as well as a signature of the author.
- The home's Complaint Investigation Form indicated that PCP #103 was on vacation and returned to regular duties after one week from the incident. An investigation interview was conducted by the DOC on an identified date, one day after the PCP had already worked a shift on the same home area including caring for resident #041.
-The internal investigation form failed to reveal that a follow up with the complainant was completed immediately following the investigation.
- The complaint investigation form fails to reveal that this complaint involving allegations of abuse and neglect was immediately reported to the Director as required under section 24 of the Act.

Therefore the licensee failed to comply with policy#LTC-CA-ALL-100-05-02 (revision date October 9, 2014) Resident Abuse-Abuse prevention Program-Whistle Blowing Protection. (623) [s. 20. (1)]

WN #6: 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 failed to immediately investigate allegations of sexual abuse of resident #048 by resident #047.

Related to Log # 019352-15 for residents #047 and 048:

Refer to WN #1 of this report for background information related to Log #019352-15 for residents #047 and 048.

A review of the progress notes of resident #047 for sixteen months period revealed eight incidents of sexual responsive behaviours by resident #047 directed toward resident #048 on identified dates. The incidents were documented in resident #047's progress notes. (Refer to WN #1)

Apart from one incident on identified date that was reported to the Director and immediately investigated, there were no records to indicate that any of the other incidents were immediately investigated.

In interviews with RPNs #136, 149, and 151 who had documented the incidents, they reported that the expectation as per the licensee's abuse policy is for them, upon becoming aware of resident to resident abuse, to separate and provide care to the residents and then report to the immediate supervisor who then starts an investigation. As per all three RPNs, they reported being sure all incidents were reported to the Nursing Manager but that they had no documentation to indicate that was the case. In an Interview with ADOC #150 regarding one incident on an identified date, he/she indicated the incident will definitely be abuse but was unsure why it was not immediately investigated or reported to the Director.

Interview with the DOC indicated to the inspector, in relation to the incidents of sexual behaviour by resident #047 directed toward resident #048, that there was either no indication the inappropriate touching behaviours were non-consensual or of a sexual nature or that the documentation was unclear to indicate abuse. Therefore, they were not looked upon as sexual abuse and as such were not reported. (Refer to WN #1)

The DOC went further to explain that, the bottom line is that the report was made for one incident on an identified date as this was the first time that resident #048 had indicated not wanting the inappropriate touching. As per DOC, the incidents are even more complicated as resident #048, at one point was very independent and always touching other residents but not in a sexual nature. [s. 23. (1) (a)]

WN #7: 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 ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director?
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Related to Log #014307-16 for resident #041:

Refer to WN #1 of this report for background information related to Log #014307-16 for resident #041.

As per WN #1, the allegation of verbal abuse and neglect was not reported to the Director as required when resident #041 brought forward a written complaint with allegations of verbal abuse and neglect by personal care provider (PCP) #103.

During an interview, the DOC confirmed that the nature of the written statement from resident #041 reported to RN #102 would be considered an allegation of abuse and neglect and that this complaint was not treated as such therefore the incident was not immediately reported to the Director.

During an interview, ADOC #105 stated that he/she was aware of the complaint

submitted by resident #041 but was not involved at all in the investigation or outcome.

During an interview, the Administrator confirmed that he/she did not follow up with resident #041 after the internal investigation into the complaint was completed. The Administrator indicated that he/she first spoke with resident #041 on an identified date (one week following the incident) after receiving a phone call from the resident stating that PCP #103 was caring for him/her.

The Administrator, the DOC, ADOC #105 and RN #102, all were aware of the nature of the complaint brought forward by resident #041and yet the Director was not immediately notified of the allegations of abuse and neglect until a later date when the issue was brought forward by inspector #623. [s. 24. (1)]

2. The Licensee failed to immediately report allegations of sexual abuse of resident #048 by resident # 047.

Related to Log # 019352-15 for resident #047:

Refer to WN #1 of this report for background information related to Log #019352-15 for residents #047 and 048.

A review of the progress notes of resident #047 for sixteen months period revealed eight incidents of sexual responsive behaviours by resident #047 directed toward resident #048 on identified dates. The incidents were documented in resident #047's progress notes. (Refer to WN #1)

Apart from one incident on identified date that was reported to the Director and immediately investigated, there were no records to indicate that any of the other incidents were immediately reported.

In an Interview with ADOC #150 regarding one incident on an identified date, he/she indicated the incident will definitely be abuse but was unsure why it was not immediately investigated or reported to the Director.

Interview with the DOC indicated to the inspector, in relation to the incidents of sexual behaviour by resident #047 directed toward resident #048, that there was either no indication the inappropriate touching behaviours were non-consensual or of a sexual

nature or that the documentation was unclear to indicate abuse. Therefore, they were not looked upon as sexual abuse and as such were not reported. [s. 24. (1)]

3. The licensee failed to comply with LTCHA, 2007, s. 24. (1) 1, by not ensuring that a person who had reasonable grounds to suspect that an improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident immediately reported the suspicion and the information upon which it is based to the Director.

Related to Log #021252-15 for resident #051

Critical Incident Report (CIR) was submitted to the Director on an identified date and time. The CIR indicated that on an identified date and time, personal care provider (PCP) #138 was assisting resident #051 with bathing when the resident stood up holding the railing and fell sideways. Resident #051 hit a specified area of the body, sustained a small injury and complained of pain to a specified.

Review of clinical records and interview with the DOC indicated that on an identified date resident #051 was transferred with the assistance of one staff contrary to the resident's assessed transfer status of two staff assist.

Interview with the DOC indicated that the incident was not immediately reported as required to the MOHLTC and that the CIR was submitted the next day when the investigation of the incident was completed. The DOC indicated that charge nurse at the time of the incident was educated that the manager on call should have been contacted and that this incident should have been called in to the MOHLTC using the after hours pager number. [s. 24. (1) 1.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (2) The licensee shall ensure that each resident receives assistance, if required, to insert dentures prior to meals and at any other time as requested by the resident or required by the resident's plan of care. O. Reg. 79/10, s. 34 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident receives assistance, if required, to insert dentures prior to meals and at any time when requested by the resident or required by the resident's plan of care.

Related to Logs #012466-16 and 014783-16 for resident #015:

A review of complaint made to the Central Intake Assessment Triage Team (CIATT) on two identified dates by the substitute decision maker (SDM) of resident #015 identified that on an identified resident #015 was eating and did not have dentures in place.

A review of the progress notes for the period of six months revealed that resident #015 did not have dentures in place on the day shifts on two occasions. The dentures were found in the medication cart but there was no documentation on the above mentioned day shifts indicating that resident #015 had refused to have dentures in place.

A review of the plan of care indicated that the resident had partial dentures, requires extensive assistance and staff are to ensure dentures are stored in the medication cart in the evenings and returned to the resident every morning.

An interview with RPN #115 confirmed that he/she had worked on two identified day shifts when the resident did not have dentures in place. RPN #115 could not locate documentation indicating that the resident refused to have dentures nor could he/she remember that the resident had the dentures in place. RPN #115 further indicated that the plan of care was not followed for resident #015 in relation to having dentures in place. [s. 34. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The Licensee has failed to comply with O.Reg 79/10, s. 36, by not ensuring that staff use safe transferring and positioning devices or techniques when assisting residents.

Related to Log # 021252-15 for resident #051

On an identified date, personal care provider (PCP) #138 was assisting resident #051 with bathing when the resident stood up holding the railing and fell sideways. Resident #051 hit a specified area of the body, sustained a small injury and complained of pain to a specified area.

Review of resident #051's plan of care in effect at time of the incident indicated the resident requires extensive assistance by two staff for transferring and bathing.

Review of the home's investigation notes and interview with the DOC indicated at the time of the incident the resident's plan of care indicated resident #051 required two staff assist with transferring and bathing.

Review of clinical records and interview with the DOC indicated that on an identified date, resident #051 was transferred with the assistance of one staff contrary to the resident's assessed transfer status. [s. 36.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are monitored during meals, including residents eating in locations other than dining areas.

Related to Logs #012466-16 and 014783-16 for resident #015:

A review of a complaint made to the Central Intake Assessment Triage Team (CIATT) on two identified dates by the substitute decision maker (SDM) of resident #015 identified that there had been occasions when resident #015's food was left on the table beside bed. The SDM indicated that the home contacted him/her on an identified date asking to sign a consent form for resident #015 to have all meals in bedroom, unsupervised.

A review of the progress notes on two identified dates revealed that the resident had choking episodes and had to receive abdomen thrust to clear airway.

On May 17, 2016, the following observations were made:
- 1039 hours - resident #015 in bedroom sitting in wheelchair in bedroom having continental breakfast, a cup of tea/coffee and cookies, no staff supervising
- 1108 hours - the resident was in bedroom sitting in wheelchair with an over the bed table in front of the resident having continental breakfast, with a cup of coffee/tea and cookies, no staff supervising
- 1110 hours - resident in bedroom sitting in wheelchair with an over the bed table in front of the resident with a cup of coffee/tea and cookies, no staff supervising.

A review of the plan of care, revealed that the resident is on regular diet, regular texture, regular fluids and has swallowing problems; Staff are to provide level of assistance/supervision during meals and encourage the resident to come to dining room.

A review of the progress notes on an identified date documented by the dietitian revealed that the staff have been given direction that the resident cannot eat alone in bedroom, and staff are to take a tray and stay with the resident to supervise for meals.

An interview with PCPs #119 and 138 revealed that the resident sleeps in and receives continental breakfast each morning in bedroom.

An interview with the Registered Dietitian and the Nutritional Manager confirmed that it is the expectation that the resident be supervised during meals and snacks, as resident #015 is at risk for swallowing difficulties, unless the resident had a negotiated risk agreement signed.

Therefore, the licensee failed to ensure the resident was monitored during meals, including when eating in locations other than dining areas. [s. 73. (1) 4.]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)
(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 78 (2)
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained; 2007, c. 8, s. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges; 2007, c. 8, s. 78 (2)
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with

respect to the supply of drugs; 2007, c. 8, s. 78 (2)
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents; 2007, c. 8, s. 78 (2)
(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package; 2007, c. 8, s. 78 (2)
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations; 2007, c. 8, s. 78 (2)
(q) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2)
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 78. (2) (g), by not ensuring that the admission package include the home's policy on minimizing the restraining of residents and how to obtain a copy of the policy.

Review of the Licensee Confirmation Checklist Admission Process, completed by the Administrator on May 09, 2016, indicated that the admission package did not include the home's policy on minimizing the restraining of residents and how to obtain a copy of the policy.

Review of an admission package provided to inspector indicated the home's policy on minimizing the restraining of residents and how to obtain a copy of the policy was not included in the package.

On May 16, 2016, interview with the Administrator and the DOC, both confirmed that the home's restraint policy was not included in the admission package. The DOC indicated resident care file has all required documents related to restraints to be completed by registered nursing staff if restraining of the resident is required on admission day. Both the Administrator and DOC indicated that the home's restraints policy will be included in the admission package.

On May 16, 2016, interview with substitute decision maker (SDM) of resident #050 who has been admitted this day, indicated that he/she had received the admission package with information related to abuse, whistle blower policies and complaint process but no information or explanation was received related to the home's restraints policy. [s. 78. (2) (g)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee failed to immediately notify resident # 048's substitute decision-maker (SDM) about several incidents of alleged sexual abuse.

Related to Log # 019352-15

The home submitted Critical Incident Report (CIR) on an identified date for an incident related to resident to resident alleged sexual abuse. The critical incident was as follows: On an identified date resident #047 was witnessed straddling resident #048 who was sitting in wheelchair. Resident #047 was leaning over and inappropriately touching resident #048. Resident #048 appeared to be trying to move their head away. The CIR indicates that resident #047 does have a history of attempts to touch co-residents in a sexual manner. As per CIR, resident #047's behaviour had been well managed, but recent escalation and targeting of particular resident has occurred.

A review of the progress notes of resident #047 for sixteen months period revealed eight incidents of sexual responsive behaviours by resident #047 directed toward resident #048 on identified dates. The incidents were documented in resident #047's progress notes. (Refer to WN #1)

Apart from one incident that was reported to the Director and immediately investigated and the resident's SDM notified immediately, there were no records to indicate that resident's 048's SDM was specifically notified of any of the other incidents of alleged sexual abuse (refer to WN #1).

Interview with the DOC indicated to the inspector, in relation to the incidents of sexual behaviour by resident #047 directed toward resident #048, that there was either no indication the inappropriate touching behaviours were non-consensual or of a sexual nature or that the documentation was unclear to indicate abuse. Therefore, resident #048's SDM was not notified. [s. 97. (1) (a)]

2. The licensee has failed to ensure that the resident's substitute decision maker (SDM) and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

A review of a complaint made to the Central Intake Assessment Triage Team (CIATT) on two identified dates by the SDM of resident #015 indicated that resident #015 hit another resident and there was an injury to a specified body part of the other resident. The SDM was not told about the incident until next day.

A review of the clinical records for both resident #015 and #052 indicated that there was a physical altercation between the two residents on an identified date. A review of the documentation records could not locate that the SDMs of both residents were notified of the above identified altercation.

Interview with RN #109 and DOC confirmed that both SDMs were not notified and the expectation is that staff notifies the SDM within 12 hours of an incident. [s. 97. (1) (b)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident of operation of the home: that a response is provided within 10 business days of receipt of the complaint.

Related to Log #014307-16 for resident #041:

An interview during this inspection with resident #041 indicated that there is a personal care provider (PCP) #103 who swears at him/her and slams his/her bedroom door. Resident #041 stated that this was reported in writing to RN #102 on an identified date. Resident #041 indicated that to date he/she has never received a response from the home as to the outcome of their investigation.

During an interview, the DOC indicated being aware of this complaint and that there was an investigation. This complaint was received on an identified date and it was treated as a verbal complaint, the investigation notes indicated that the outcome was unfounded. The DOC revealed that the investigation notes state that the Administrator was supposed to follow up with the resident but there is no confirmation that this ever happened.

During an interview, the Administrator confirmed that he/she did not follow up with resident #041 after the internal investigation into the complaint was completed. The Administrator indicated that he/she first spoke with resident #041 on an identified date (one week following the incident) after receiving a phone call from the resident stating that PCP #103 was caring for him/her. The Administrator confirmed that the home's policy #LTC-CA-WQ-100-05-08 Complaints; was not followed. [s. 101. (1) 1.]

2. The licensee has failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or the operation of the home, has a response to the person who made the complaint indicating:
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

As per the above information, the home did not respond back to resident #041 regarding the resident's concerns involving PCP #103. [s. 101. (1) 3.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

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

s. 103. (2) The licensee shall comply with subsection (1) immediately upon completing the licensee's investigation into the complaint, or at an earlier date if required by the Director. O. Reg. 79/10, s. 103 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a copy of the written complaint that was received relating to a matter that the licensee reports (or reported) to the Director under section 24 of the Act, and a corresponding written report documenting the response the licensee made to the complainant?

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:
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.

Related to resident #041:

As per WN #1, the allegation of verbal abuse and neglect was not reported to the director as required when resident #041 brought forward a complaint with written statements including allegations of verbal abuse and neglect by personal care provider (PCP) #103.

During an interview, the DOC confirmed being aware of the complaint from resident #041 and that there was an investigation. This complaint was received by the licensee on an identified date and it was treated as a verbal complaint, the DOC stated that investigation notes indicated the outcome was unfounded. This verbal complaint was not resolved in

24 hours and never submitted to the Director as this is not the home's policy.

The DOC confirmed that the nature of the written statement would be considered an allegation of abuse and neglect but this complaint was not treated as such and the incident was not submitted as a CIR to the Director.

During an interview, the Administrator confirmed that the initial complaint that was received from resident #041 on an identified date should have been handled as a written complaint and forwarded to the Director with a written response; Also, considering the nature of the complaint that contained allegations of verbal abuse and neglect, it required immediate reporting to the Director and a Critical Incident Report to the Ministry of Health. The Administrator confirmed that this was not done.

As indicated in WN #7, the Director was not immediately notified of the allegations of abuse and neglect until a specified date when the issue was brought forward by inspector #623. [s. 103. (1)]

2. The licensee has failed to ensure that for written complaints related to section 24 of the Act, that the licensee submit a report documenting the response the licensee made to the complainant immediately upon completing the licensee's investigation into the complaint.

Related to resident #041:

As per the above information, the home did not send a copy of resident #041's complaint with allegations of abuse and neglect involving personal care provider (PCP) #103 to the Director. The home did not respond immediately to the complainant when the investigation into the complaint was completed. [s. 103. (2)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date is required by the Director.

Related to Log #014307-16 for resident #041:

An interview with DOC on May 10, 2016 confirms receipt of the complaint from resident #041 on an identified date which included allegations of verbal abuse and neglect. The DOC confirmed that the licensee did not report this to the Director within 10 days.

A Critical Incident Report (CIR) was submitted on an identified date after approximately two months from date the complaint was received.

Therefore the licensee failed to ensure that a report to the Director was made within 10 days of becoming aware of allegations of verbal abuse and neglect. [s. 104. (2)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that there was monitoring and documentation of resident #045's response and the effectiveness of the antibiotic drug being taken during two identified periods.

During the RQI it was identified that resident #045 had a change in condition related to being treated for an infection with specified symptoms on two identified periods.

On an identified date, the Physician ordered that resident #045 to receive a specified antibiotic by mouth twice daily for seven days, and on later identified date a specified antibiotic by mouth four times daily times daily for ten days.

A review of the progress notes for one identified period indicated that there was no monitoring of symptoms or the effectiveness of the antibiotic for a total of fifteen shifts.

A review of the progress notes for another identified period indicated that there was no monitoring of symptoms for a total of seven shifts.

During an interview, RPN #129 indicated the monitoring of resident #045's health status and the effectiveness of the antibiotic should have been documented in the resident's health record for the full course of receiving the antibiotics.

An interview with the DOC revealed that the expectation is that staff document symptoms as long as the resident has symptoms.

Therefore, there was no evidence that there was monitoring and documentation of resident #045's response and the effectiveness of the antibiotic drug being taken on fifteen shifts during an identified and seven shifts during the other identified period [s. 134. (a)]

Issued on this 4th day of July, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SAMI JAROUR (570), BAIYE OROCK (624), DENISE BROWN (626), JULIET MANDERSON-GRAY (607), SARAH GILLIS (623)
Inspection No. / No de l'inspection :	2016_327570_0011
Log No. / Registre no:	012598-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 30, 2016
Licensee / Titulaire de permis :	Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner 100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1
LTC Home / Foyer de SLD :	THE WYNFIELD 451 Woodmount Drive, OSHAWA, ON, L1G-8E3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sharol Henry

To Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a corrective action plan to ensure the following:

- Members of the management team including all registered staff and Nurse Managers receive formal training on the licensee's abuse policy "Resident Abuse – Abuse Prevention Program – Whistle-Blowing Protection, policy No: LTC-CA-ALL-100-05-02".
- Members of the management team including all registered staff and Nurse Managers receive formal training on the Long-Term Care Homes Act (LTCHA) 2007 and Ontario Regulations (O. Reg.) 79/10, specifically the following sections:
LTCHA, 2007, s. 23.
LTCHA, 2007, s. 24.
O. Reg 79/10 s. 97.
O. Reg 79/10 s.101.
O. Reg 79/10 s.103.
O. Reg 79/10 s.104.
- All staff receive formal training on the definition of all types of abuse with specific emphasis on sexual abuse and how to identify and report all types of abuse specifically sexual abuse.
- A system is developed whereby the Director of Care and/or delegate is reviewing all communication from the front line staff at least daily to determine the presence of suspected/alleged incidents of resident abuse.
- A system is developed whereby when there are reasonable grounds to suspect that abuse has occurred, the licensee shall immediately investigate and ensure that all legislative requirements have been fulfilled.

In addition to the above order, the licensee shall immediately ensure each resident currently exhibiting responsive behaviours of a sexual nature is assessed, the plan of care is reviewed and revised to include different approaches when current interventions are ineffective.

The corrective action plan shall be submitted by July 15, 2016 to Sami Jarour via email to OttawaSAO.MOH@ontario.ca.

Grounds / Motifs :

1. The licensee failed to comply with LTCHA 2007 s.19. (1) by failing to protect residents #048, #041 from abuse and or neglect.

Definitions:

Under O. Reg 79/10 s. 2 (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" means, (a) subject to subsection (3), any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or (b) 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;

Under O. Reg 79/10 s. 2 (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "verbal abuse" means, (a) 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.

Under O. Reg 79/10 s.2 (5) For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

As per the licensee's policy "Resident Abuse – Abuse Prevention Program – Whistle-Blowing Protection", No: LTC-CA-ALL-100-05-02 revised October 9, 2014, Sexual Abuse means : "Non-consensual sexual physical touching of a resident; such behaviours include but is not limited to:
- Non-consensual sexual intercourse
- Non-consensual touching of a sexual nature of the resident including kissing
- Behaviour or remarks of a sexual nature towards the resident, which are unwanted by the resident and are sexually demeaning, humiliating, exploitative or derogatory"

Related to log # 019352-15 for resident #048 and resident #047:

The home submitted Critical Incident Report (CIR) on an identified date for an incident related to resident to resident alleged sexual abuse. The critical incident was as follows:
On an identified date resident #047 was witnessed straddling resident #048 who

was sitting in wheelchair. Resident #047 was leaning over and inappropriately touching resident #048. Resident #048 appeared to be trying to move their head away. The CIR indicates that resident #047 does have a history of attempts to touch co-residents in a sexual manner. As per CIR, resident #047's behaviour had been well managed, but recent escalation and targeting of particular resident has occurred.

Resident #047 and resident # 048 were admitted to the home on identified dates. On admission, resident #048 was ambulatory but his/her condition deteriorated and now uses a wheelchair for mobility. Both residents are cognitively impaired and resided in the same home area until resident #048 was moved to a different home area following the reported incident as indicated in the CIR.

A review of the progress notes of resident #047 for sixteen months period revealed multiple incidents of responsive behaviours of a sexual nature by resident #047 directed toward resident #048. The incidents were documented in resident #047's progress notes as follows:

On an identified date, Personal Care Provider (PCP) staff found resident #047 inappropriately touching resident #048's face and cheek area in the dining room before breakfast. RN #151 explained to resident #047 that he/she can't continue to do this. Explained that resident #048's family member would not like that and reminded resident #047 that resident #048 does have a close friend that comes to visit and they wouldn't like that either.

On an identified date, staff noted resident #047 was sitting in chair near info desk after dinner; when resident #048 walked by resident #047, resident #047 reached out and slapped resident #048's buttock. RPN #151 explained to resident #047 that resident #048 has a close friend and they would not like resident #048 to be touched in that manner; resident #047 was asked to go to own room to reflect.

On an identified date, recreational staff reported to RPN #136 that resident #047 was seen inappropriately touching resident #048. Resident #047 was spoken to and a planned activity was taken away this evening. RPN reminded resident #047 of "No touching policy".

On an identified date, PCP staff reported to RPN #151 that resident #047 was

witnessed leaning over top of resident #048 and inappropriately touching resident #048. PCP explained that resident #047 cannot do that, and reminded resident #047 that resident #048's family member had spoken to him/her to stop touching resident #048 as the resident has a close friend.

On an identified date, housekeeping staff stated that after resident #047 left the dining room from an identified meal, he/she noticed resident #047 in the family room hugging resident #048. Resident #047 was redirected to another area and reminded that caring or providing care to others is not his/her responsibility and resident walked away.

On an identified date, two PCP staff reported to RPN #149 that they saw resident #047 inappropriately touching resident #048 on the forehead, PCP staff intervened by stopping resident #047. RPN #149 reminded resident #047 that this behaviour was inappropriate, that despite liking someone, he/she is not allowed to touch them inappropriately. RPN #149 asked resident #047 to go to bedroom and take some time to think about this inappropriate behaviour.

On an identified date, critical incident report (CIR) was submitted stating resident #047 was witnessed straddling resident #048 who was sitting in wheelchair. Resident #047 was leaning over and inappropriately touching resident #048. Resident #048 appeared to be trying to move his/her head away. Resident #047 was sent to his/her room and was told to stay in room until further notice. Physician was notified of incident and ordered to increase identified medication and referral for assessment.

On an identified date, resident #047 walked out of restorative/exercise room and went into family room on identified home area where resident #048 was sitting in wheelchair and inappropriately touched resident #048. RPN #149 separated the two residents and asked resident #047 to go back and continue with exercises. (Note: this incident occurred after resident #048 was moved to a different home area from where both residents resided until the incident that was reported in the CIR on an identified date).

Interviews with RPNs #136, 149, and 151, all agreed that resident #048 is cognitively impaired and does not have the capacity to give consent to sexual activity. RPN #151 informed the inspector that for the four identified incidents, he/she is very certain the incidents were reported to the Nurse Manager but this was not documented. RPN #136 indicated he/she has no recollection of the

incident he/she documented on a specified date but said he/she must have reported it to the Nurse Manager but was unsure. For the two incidents on identified dates documented by RPN #149, he/she indicated the expectation is to report to the Nursing Manager which he/she did for one identified incident. The other incident on an identified date, RPN #149 indicated that the incident was witnessed by him/her and the Nursing Manager and they both concluded that it was consensual as resident #048 did not show any indication that he/she did not like the touching from resident #047.

Interview with the DOC indicated to the inspector, in relation to the incidents of sexual behaviour by resident #047 directed toward resident #048, that there was either no indication the kissing and touching behaviours were non-consensual or of a sexual nature or that the documentation was unclear to indicate abuse. Therefore, they were not looked upon as sexual abuse and as such were not reported.

The DOC went further to explain that, the bottom line is that the CIR report was submitted for an identified incident as this was the first time that resident #048 had indicated not wanting the kissing. The DOC also stated that they are doing everything to manage resident #047's behaviour. The DOC stated that resident #047's sexual behaviours were assessed and after the transfer of resident #048 out of the unit, resident #047's sexual behaviours have improved. The DOC also stated that residents have a right to form relationships and the home cannot interfere with that right.

On whether resident #048 has the capacity to consent to sexual activity, the DOC indicated: "Legally, not. However, if he/she is not opposing, it will be implied consent". As per the DOC resident #048, at the present moment, is capable of moving his/her arms, legs and head to indicate disinterest.

Apart from the one incident that was reported to the Director and interventions put in place to protect resident #048 (including transfer to another unit), a review of the health records for both residents did not indicate any additional interventions specific to sexual behaviours other than redirecting and re-orientation of resident #047. The redirection and re-orientation interventions had been in effect before the first reported incident of inappropriate touching involving resident #048. A review of resident #048's progress notes did not indicate entries related to four identified incidents of inappropriate touching, all involving resident #047. Given that both residents are cognitively impaired and

lack the capacity to consent to sexual activity and considering the definition of sexual abuse as per Ontario Regulations and the licensee's abuse policy, the licensee failed to protect resident #048 from repeated sexual abuse by resident #047.

The licensee also failed to comply with:
1. LTCHA 2007, s. 6 (7) and s.6 (11) (b) whereby the licensee did not ensure that care set out in the plan of care for resident #047 related to constant monitoring of the resident when off the secured unit was provided to the resident as specified in the plan; and the licensee did not ensure when interventions specific to resident #047's sexually responsive behaviours were ineffective, that the resident's plan of care was revised to include different approaches. (Refer to WN #2)

2. LTCHA 2007, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. (Refer to WN #5)

3. LTCHA 2007, 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. (Refer to WN #6)

4. LTCHA 2007, 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: 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. (Refer to WN #7)

5. O. Reg 79/10 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 wellbeing. (Refer to WN #12) (624)

Related to Log #014307-16 for resident #041:

An interview during this inspection with resident #041 indicated that there is a personal care provider (PCP) #103 who swears at him/her and slams his/her bedroom door. Resident #041 stated that this was reported in writing to RN #102 on an identified date. Resident #041 indicated that to date he/she has never received a response from the home as to the outcome of their investigation. Resident #041 indicated that PCP #103 still works in the home and cares for him/her and stated being "fearful of PCP #103 and would prefer that PCP #103 did not look after him/her".

During an interview, the DOC indicated being aware of this complaint and that there was an investigation. This complaint was received in writing by the licensee on an identified date and it was treated as a verbal complaint. The DOC stated that investigation notes indicated that the outcome was unfounded. The DOC confirmed that there is a written statement in the investigation file from resident #041 that is written on his/her behalf. The DOC indicated that the paper states: "PCP #103 slammed the door and swore in the room when resident #041 was on the phone with a family member. PCP #103 kept swearing and the resident was left on the commode for 1.5 hours". The DOC stated that this accusation could never be confirmed because no one could verify this. The DOC indicated that during the investigation, other staff that were interviewed indicated that they did not witness any swearing. The DOC revealed that the investigation notes state that the Administrator was supposed to follow up with the resident but there is no confirmation that this ever happened.

A review of the written statement on an identified date indicated that PCP #103 swearing and talking back to resident #041, PCP#103 was angry because resident #041 had diarrhea. Resident #041 was left on the commode for 1.5 hours on same identified date of the written statement.

During an interview, the DOC confirmed that the nature of the written statement would be considered an allegation of abuse and neglect and that this complaint was not treated as such therefore the incident was not immediately reported to the Director.

During an interview, the Administrator confirmed that he/she did not follow up with resident #041 after the internal investigation into the complaint was completed. The Administrator indicated that he/she first spoke with resident #041 on an identified date (one week following the incident) after receiving a

phone call from the resident stating that PCP #103 was caring for him/her. The Administrator confirmed that the home's policy #LTC-CA-WQ-100-05-08 Complaints; was not followed.

The licensee did not protect resident #041 from alleged neglect and verbal abuse by not taking actions as follows:
- The staff member involved PCP #103 continued to provide care for the resident despite the complaint brought forward by the resident.
- The allegation of abuse and neglect was not immediately reported to the director;
- The home did not inform resident #041 of the outcome of the outcome of the investigation.

The licensee also failed to comply with:
1. LTCHA 2007, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. (Refer to WN #5).

2. LTCHA 2007, 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: 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. (Refer to WN #7)

3. O. Reg. 79/10, s. 8 (1) (b), 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 is complied with, specific to complaints policy. (Refer to WN #3)

4. O. Reg. 79/10, s. 101 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. (Refer to WN #13)

5. O. Reg. 79/10, s. 103 (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). (Refer to WN #14)

6. O. Reg. 79/10, s. 104 (2) The licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. (Refer to WN #15) (623)

The decision to issue a Compliance Order was based on the severity and scope of the incidents noted specifically:

Severity – minimal harm and potential for actual harm to resident #041 who remains fearful of PCP #103 and concerned that the licensee did not address resident #041's complaint including an allegation of verbal abuse and neglect when the complaint was brought forward on an identified date and the fact that PCP #103 continued to care for the resident despite the resident's complaint. Also, minimal harm or potential for actual harm to resident #048 by being repeatedly targeted by resident #047 on eight occasions during an identified period including once after resident #048 was moved to another home area.

Scope – multiple incidents of alleged resident to resident sexual abuse involving residents #047 and 048 and an allegation of staff to resident verbal abuse and neglect involving resident #041 were identified by inspectors and were not reported to the Director.

The licensee failed to protect residents #041 and 048 from abuse and neglect, therefore a Compliance Order is warranted. [s. 19. (1)] (570)

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

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 30th day of June, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sami Jarour

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