Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 15, 2020	2020_782736_0008	023728-19, 024056-19, 004127-20, 004522-20, 007535-20	Critical Incident System

Licensee/Titulaire de permis

Mill Creek Care Centre
286 Hurst Drive BARRIE ON L4N 0Z3

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

Mill Creek Care Centre
286 Hurst Drive BARRIE ON L4N 0Z3

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

AMANDA BELANGER (736)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 9-13, 2020, and May 26 and 27, 2020. Off site inspection activities took place March 16-18, 2020; as well as, May 13-14, and May 19-21, 2020.

The following intakes were inspected during the course of this inspection:
-three logs related to reports submitted to the Director related to allegations of staff to resident abuse; and,
-two logs related to resident falls with injury.

A Complaint Inspection #2020_782736_0007 was conducted concurrently with this inspection.

PLEASE NOTE: Non-compliance of a Compliance Order (CO) related to s. 24 (1) of the LTCHA 2007, was identified in this inspection and has been issued in Inspection Report, #2020_782736_0007, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Nurse Managers (NM), Nursing Consultant, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the Inspector(s) reviewed internal investigation notes, relevant resident health records, relevant staff files, licensee policies and observed the provisions of care.

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

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

5 WN(s)
2 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	Légende 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of a resident was complied with.

A Critical Incident (CI) report was submitted to the Director on a specified date in 2019, related to an allegation of abuse and neglect towards resident #002 by Personal Support Worker (PSW) #106. The CI report indicated that PSW #107 had brought forward allegations that PSW #106 had neglected resident #002 that had taken place months earlier. The CI report was amended to indicate that based on the home's internal investigation, it concluded that PSW #106 had neglected resident #002 on two separate occasions, as well as had verbally abused resident #002 on a third occasion.

For the purpose of the Act and this Regulation, "physical abuse" is defined as the use of physical force by anyone other than a resident that causes physical injury or pain. (O.Reg. 79/10, s 2).

For the purpose of the Act and this Regulation, "verbal abuse" is defined as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes the resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident. (O.Reg. 79/10, s 2).

For the purposes of the Act and this Regulation, "neglect" is defined as 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. (O.Reg. 79/10, s.5).

The home's internal policy, "Abuse and Neglect Policy", Index ID P-10, last reviewed May 3, 2019, indicated that all residents were to be treated with dignity and respect. The abuse or neglect of a resident would not be tolerated by the Home and any such conduct on the part of a staff member will result in disciplinary action, up to and including termination, as well as other potential action.

The home's same policy also indicated that when a staff member had reason to believe that a resident had suffered harm or is at risk of harm due to abuse or neglect, improper or incompetent treatment or care, or unlawful conduct, they were to immediately report their suspicion and the information upon which it is based, to the Home, and to the Director appointed under the Long Term Care Homes Act, 2007.

a) The Inspector reviewed the home's internal investigation package related to PSW #106's interactions with resident #002. The investigation package indicated that on two separate occasions, PSW #106 had video taped themselves interacting with resident #002, and the videos were sent to a third party, who was not employed by the home or related to the resident. The Director of Care (DOC) and Executive Director (ED) reviewed the videos and made notes that indicated both videos showed that PSW #106 had neglected resident #002 on two separate dates.

In an interview with the ED, they indicated that the allegations of abuse and neglect towards resident #002, by PSW #106 were founded, and therefore, PSW #106 did not comply with the home's policy related to zero tolerance of abuse and neglect.

b) In the same internal investigation package, the Inspector noted that PSW #107, had been made aware of the allegations of physical abuse, verbal abuse and neglect towards resident #002 and resident #008 by PSW #106, from a member of the community on specific date in 2019, however, did not immediately bring forward the concerns. According to the investigation notes, PSW #107 brought forward the allegation of physical abuse towards resident #008 one day later, and brought forward the allegation of verbal abuse and neglect towards resident #002 eight days later.

In separate interviews with the DOC and ED, they indicated that PSW #107 become aware of allegations of staff to resident abuse from a member of the community; however, PSW #107 did not immediately bring the concerns forward, and should have. Both the DOC and ED indicated that PSW #107 did not comply with the home's zero tolerance of abuse policy, as they did not immediately bring forward the allegations.

c) In the home's internal investigation notes, it noted that PSW #104 had previously witnessed PSW #106 verbally abuse resident #002; however, had not reported the incident when it had taken place.

In an interview with PSW #104, they indicated to the Inspector that they had not complied with the home's zero tolerance of abuse policy, as they had witnessed PSW #106 be verbally abusive to a resident and did not immediately report the incident.

In separate interviews with the DOC and ED, they indicated that PSW #104 should have immediately come forward after witnessing PSW #107 be abusive towards a resident. Both the DOC and ED indicated, that by not immediately reporting the resident abuse, PSW #104 did not comply with the home's zero tolerance of abuse policy. [s. 20. (1)]

2. A CI report was submitted to the Director on a specified date in 2020, related to the allegation of physical abuse towards resident #009 by PSW #117. The CI report decribed that PSW #117 was witnessed by RPN #111 using physical force with resident #009.

An additional CI report was submitted to the Director on specified date in 2020, six days after the initial CI report was submitted, related to allegations of physical, and verbal abuse by PSW #117 towards residents #010, #011, #012, and #013.

a) The Inspector reviewed the home's internal investigation notes related to the allegation of physical abuse by PSW #117 towards resident #009. It described RPN #111 observing the physical force PSW #117 used with resident #009.

In separate interviews with the DOC, and ED, they both indicated to the Inspector that the allegation of physical abuse towards resident #009 by PSW #117 was founded, and therefore, the PSW did not comply with the home's zero tolerance of abuse policy. The DOC also indicated to the Inspector that there was no reason to believe that the allegations of abuse towards residents #010, #011, #012, and #013 did not occur, and therefore, also meant that PSW #117 did not comply with the home's zero tolerance of abuse policy related to those incidents.

b) The Inspector reviewed the home's internal investigation notes related to the allegations of physical abuse by PSW #117 towards residents #010, #011 and #012. It was documented that on a specified date in 2020, PSW #118 brought forward allegations of staff to resident abuse to Registered Nurse (RN) #114. PSW #118 alleged that on

multiple occasions they had witnessed PSW #117 be verbally, and physically abusive towards residents #010, #011, and #012.

PSW #118 alleged that they witnessed PSW #117 engage in threatening communication with resident #010, sometime in the summer of 2019. PSW #118 also alleged that they witnessed PSW #117 provide care to resident #011 using physical force, sometime in the fall 2019. Lastly, PSW #118 alleged that they witnessed PSW #117 use physical force resident #012 sometime in the winter 2020.

The Inspector reviewed PSW #118's employee file and noted a letter dated after the CI report was submitted to the Director, which indicated that they had reported abuse incidents both verbal and physical, however, reported them late, months after they had occurred.

In an interview with PSW #118, they indicated to the Inspector, that they had not complied with the home's zero tolerance of abuse policy, as they had not immediately reported staff to resident abuse that they had witnessed.

In separate interviews with the DOC, and ED, they both indicated to the Inspector that PSW #118 had not complied with the home's zero tolerance of abuse policy, as they did not immediately report allegations of resident abuse, and should have.

c) The Inspector reviewed the home's internal investigation notes into the allegations of verbal and physical abuse by PSW #117, and noted that RPN #105, had on two separate occasions, noted PSW #117 be emotionally abusive towards resident #012, however, could not recall the dates of the incidents. RPN #105 described the form of verbal communication that PSW #117 used with a resident.

The Inspector reviewed RPN #105's employee file and noted a letter dated after the CI report was submitted to the Director, which indicated that during an investigation, it was identified that they failed to report incidents of verbal abuse.

In separate interviews with the DOC, and ED, they both indicated to the Inspector that RPN #105 had not complied with the home's zero tolerance of abuse policy, as they did not immediately report allegations of resident abuse, and should have.

d) The Inspector reviewed the home's internal investigation notes into the allegations of verbal and physical abuse by PSW #117, and noted that PSW #119 had witnessed PSW

#117 use a form of verbal communication with resident #013 while providing care, on an undetermined date.

The Inspector reviewed PSW #119's employee file and noted a letter dated after the CI report was submitted to the Director, which indicated that it was identified that during an investigation, the PSW failed to report incidents of verbal abuse.

In separate interviews with the DOC, and ED, they both indicated to the Inspector that PSW #119 had not complied with the home's zero tolerance of abuse policy, as they did not immediately report allegations of resident abuse, and should have. [s. 20. (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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that an allegation of resident abuse was immediately investigated.

During a review of the home's internal investigation of an allegation of abuse by PSW #106 to resident #001, Inspector #736 noted an allegation of physical abuse towards resident #008 by PSW #106. Please see Written Notice (WN) #1 for further details.

The Inspector reviewed an email that was sent on a specified date, to the DOC and Nurse Manager (NM) #109, from NM #102. The email indicated that PSW #107 had information that indicated that PSW #106 had physically abused resident #008 while providing care.

The Inspector was unable to locate any information within the investigation package related to the allegation of abuse towards resident #008 from PSW #106.

The Inspector confirmed with the DOC and ED that the home did not begin to investigate the allegation of physical abuse towards resident #008 immediately.

A review of the home’s internal policy, titled "Abuse and Neglect Policy", #P-10, last reviewed May 3, 2019, indicated that the home would immediately investigate any allegations of harm or potential harm to a resident, including as caused by abuse or neglect.

In an interview with the ED, they indicated to the Inspector that they were unaware of the email allegation of physical abuse towards resident #008 until the Inspector requested it. The ED indicated, that based on the email that was sent to the DOC and NM #109, from NM #102, there was an allegation of physical abuse towards resident #008, and that the home should have immediately began an investigation, and did not. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that allegations of resident abuse are immediately investigated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that after a resident has fallen, they were assessed using a post fall assessment tool.

A CI report was submitted to the Director on a specified date in 2019, related to resident #001 who sustained a fall with injury.

The home's policy titled "Falls Prevention Program", last revised April 2019, defined a fall as, "an event that resulted in the resident coming to rest inadvertently on the ground, or other lower level, or hitting an object like a chair or stair with or without injury". The home's same policy also indicated that an assessment of a fall was to be done immediately following the fall, by the registered staff. The assessments and actions taken post assessment were to be documented in the electronic interdisciplinary notes using the falls assessment (Risk Incident Management-RIM).

a) Inspector #736 completed a review of resident #001's progress notes and noted that the resident was documented as having "near misses" in relation to a fall on two different dates in 2020.

The Inspector was unable to locate corresponding post fall assessments for the falls on the two different dates in 2020.

In an interview with RN #114, the RN reviewed the progress notes for resident #001 for both dates. RN #114 indicated that based on the progress notes, the resident had sustained a fall, and that a post fall assessment should have been completed under the "Risk Management" tab of Point Click Care (PCC). The RN was unable to locate

corresponding post fall assessments for resident #001 for either date.

In an interview with the DOC, they indicated that based on the progress notes for resident #001, the resident had possibly intentionally placed themselves one location to another, and thus, it would not have met the home's definition of a fall and not required a post fall assessment.

b) The Inspector reviewed resident #005's progress notes and noted that the resident was documented as having a "near miss" on two separate dates in 2020.

The Inspector was unable to locate corresponding post fall assessments for resident #005 on either date.

In an interview with the DOC, they indicated that after a resident had sustained a fall, the registered staff were to complete a post fall assessment in the RIM on PCC. Together, the DOC and Inspector reviewed the progress notes for resident #005 related to the two separate dates. The DOC identified that both progress notes indicated that the resident had sustained a fall. The DOC was unable to locate any post fall assessment in the RIM for the two fall dates. The DOC indicated that a post fall assessment should have been completed for resident #005 on both dates. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has sustained a fall, a clinically appropriate post fall assessment is completed, to be implemented voluntarily.

WN #4: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and completed each other.

During a review of an alleged staff to resident abuse of resident #002, Inspector #736 reviewed the care plan and fall risk assessment for resident #002. The Inspector noted that on specific date in 2020, the resident had a fall risk assessment completed, which indicated the resident was at a specific risk of falls.

The Inspector reviewed the resident's plan of care for the same time period, and noted that the resident was listed as a different risk for falls.

In an interview with RN #114, they indicated to the Inspector that a resident's plan of care and fall risk assessment should match and be consistent with each other. Together, the RN and Inspector reviewed resident #002's care plan and fall risk assessment; the RN indicated that the assessment and care plan did not match and were not consistent with each other.

In an interview with the DOC, they indicated to the Inspector that a resident's plan of care and fall risk assessment should have be consistent with each other. Together, the DOC and Inspector reviewed resident #002's plan of care and fall risk assessment; the DOC indicated that the assessment and care plan were not consistent related to the fall risk assessment level. [s. 6. (4) (a)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when there was an allegation of resident abuse, with no signs of injury or distress, that the Substitute Decision Maker (SDM) was notified within 12 hours of the allegation.

A CI report was submitted to the Director related to the allegation of physical abuse from a staff member towards resident #002. The CI report indicated that there was an allegation that PSW #106 had physically abused and neglected resident #002 on a specific date in 2019.

During a review of an alleged staff to resident abuse of resident #002, Inspector #736 reviewed the home's internal investigation package, and noted an allegation of physical abuse towards resident #008 by PSW #106. Please see WN #1 for further details.

The Inspector reviewed resident #008's electronic documentation and was unable to locate any progress notes, or any other indications to state that the resident's SDM had been notified of the allegation of physical abuse that was made on a later date in 2019.

A review of the home's policy titled "Abuse and Neglect Policy", #P-10, last reviewed May 3, 2019, indicated that that the Executive Director/designate would ensure that the Resident's SDMs, if any, and any other person specified by the Resident were notified within 12 hours upon the Home becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of a Resident.

In an interview with the DOC, they indicated that they were unsure if the SDM of resident #008 had been notified after the allegation of physical abuse was made. The DOC further indicated that if there was no documentation of the SDM being made aware in the resident's chart, that they assumed that it had not taken place. The DOC indicated that resident #008's SDM should have been notified of the allegation of physical abuse towards the resident.

In an interview with the ED, they indicated to the Inspector that they were unsure if the SDM of resident #008 had been notified after the allegation of physical abuse had been made. The ED indicated that the resident's SDM should have been notified of the allegation of abuse. [s. 97. (1) (b)]

Issued on this 18th day of June, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	AMANDA BELANGER (736)
Inspection No. / No de l’inspection :	2020_782736_0008
Log No. / No de registre :	023728-19, 024056-19, 004127-20, 004522-20, 007535-20
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 15, 2020
Licensee / Titulaire de permis :	Mill Creek Care Centre 286 Hurst Drive, BARRIE, ON, L4N-0Z3
LTC Home / Foyer de SLD :	Mill Creek Care Centre 286 Hurst Drive, BARRIE, ON, L4N-0Z3
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Jenny Douma

To Mill Creek Care Centre, you are hereby required to comply with the following order (s) by the date(s) set out below:

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

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 # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 20(1) of the LTCHA.

Specifically, the licensee must:

a) ensure that all staff comply with the "Zero Tolerance of Abuse and Neglect" policy related to ensuring that residents are not abused or neglected by staff;

b) ensure that all staff comply with the "Zero Tolerance of Abuse and Neglect" policy related to reporting allegations of abuse and/or neglect;

c) retrain all direct care staff, including the management team, on the policy related to Zero Tolerance of Abuse and Neglect;

d) keep records related to staff training, including the date the training was provided, who provided the training, what was covered, and who attended the training.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of a resident was complied with.

A Critical Incident (CI) report was submitted to the Director on a specified date in 2019, related to an allegation of abuse and neglect towards resident #002 by Personal Support Worker (PSW) #106. The CI report indicated that PSW #107 had brought forward allegations that PSW #106 had neglected resident #002

that had taken place months earlier. The CI report was amended to indicate that based on the home's internal investigation, it concluded that PSW #106 had neglected resident #002 on two separate occasions, as well as had verbally abused resident #002 on a third occasion.

For the purpose of the Act and this Regulation, "physical abuse" is defined as the use of physical force by anyone other than a resident that causes physical injury or pain. (O.Reg. 79/10, s 2).

For the purpose of the Act and this Regulation, "verbal abuse" is defined as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes the resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident. (O.Reg. 79/10, s 2).

For the purposes of the Act and this Regulation, "neglect" is defined as 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. (O.Reg. 79/10, s.5).

The home's internal policy, "Abuse and Neglect Policy", Index ID P-10, last reviewed May 3, 2019, indicated that all residents were to be treated with dignity and respect. The abuse or neglect of a resident would not be tolerated by the Home and any such conduct on the part of a staff member will result in disciplinary action, up to and including termination, as well as other potential action.

The home's same policy also indicated that when a staff member had reason to believe that a resident had suffered harm or is at risk of harm due to abuse or neglect, improper or incompetent treatment or care, or unlawful conduct, they were to immediately report their suspicion and the information upon which it is based, to the Home, and to the Director appointed under the Long Term Care Homes Act, 2007.

a) The Inspector reviewed the home's internal investigation package related to PSW #106's interactions with resident #002. The investigation package

indicated that on two separate occasions, PSW #106 had video taped themselves interacting with resident #002, and the videos were sent to a third party, who was not employed by the home or related to the resident. The Director of Care (DOC) and Executive Director (ED) reviewed the videos and made notes that indicated both videos showed that PSW #106 had neglected resident #002 on two separate dates.

In an interview with the ED, they indicated that the allegations of abuse and neglect towards resident #002, by PSW #106 were founded, and therefore, PSW #106 did not comply with the home's policy related to zero tolerance of abuse and neglect.

b) In the same internal investigation package, the Inspector noted that PSW #107, had been made aware of the allegations of physical abuse, verbal abuse and neglect towards resident #002 and resident #008 by PSW #106, from a member of the community on specific date in 2019, however, did not immediately bring forward the concerns. According to the investigation notes, PSW #107 brought forward the allegation of physical abuse towards resident #008 one day later, and brought forward the allegation of verbal abuse and neglect towards resident #002 eight days later.

In separate interviews with the DOC and ED, they indicated that PSW #107 become aware of allegations of staff to resident abuse from a member of the community; however, PSW #107 did not immediately bring the concerns forward, and should have. Both the DOC and ED indicated that PSW #107 did not comply with the home's zero tolerance of abuse policy, as they did not immediately bring forward the allegations.

c) In the home's internal investigation notes, it noted that PSW #104 had previously witnessed PSW #106 verbally abuse resident #002; however, had not reported the incident when it had taken place.

In an interview with PSW #104, they indicated to the Inspector that they had not complied with the home's zero tolerance of abuse policy, as they had witnessed PSW #106 be verbally abusive to a resident and did not immediately report the incident.

In separate interviews with the DOC and ED, they indicated that PSW #104 should have immediately come forward after witnessing PSW #107 be abusive towards a resident. Both the DOC and ED indicated, that by not immediately reporting the resident abuse, PSW #104 did not comply with the home's zero tolerance of abuse policy. (736)

2. 2. A CI report was submitted to the Director on a specified date in 2020, related to the allegation of physical abuse towards resident #009 by PSW #117. The CI report decribed that PSW #117 was witnessed by RPN #111 using physical force with resident #009.

An additional CI report was submitted to the Director on specified date in 2020, six days after the initial CI report was submitted, related to allegations of physical, and verbal abuse by PSW #117 towards residents #010, #011, #012, and #013.

a) The Inspector reviewed the home's internal investigation notes related to the allegation of physical abuse by PSW #117 towards resident #009. It described RPN #111 observing the physical force PSW #117 used with resident #009.

In separate interviews with the DOC, and ED, they both indicated to the Inspector that the allegation of physical abuse towards resident #009 by PSW #117 was founded, and therefore, the PSW did not comply with the home's zero tolerance of abuse policy. The DOC also indicated to the Inspector that there was no reason to believe that the allegations of abuse towards residents #010, #011, #012, and #013 did not occur, and therefore, also meant that PSW #117 did not comply with the home's zero tolerance of abuse policy related to those incidents.

b) The Inspector reviewed the home's internal investigation notes related to the allegations of physical abuse by PSW #117 towards residents #010, #011 and #012. It was documented that on a specified date in 2020, PSW #118 brought forward allegations of staff to resident abuse to Registered Nurse (RN) #114. PSW #118 alleged that on multiple occasions they had witnessed PSW #117 be verbally, and physically abusive towards residents #010, #011, and #012.

PSW #118 alleged that they witnessed PSW #117 engage in threatening

communication with resident #010, sometime in the summer of 2019. PSW #118 also alleged that they witnessed PSW #117 provide care to resident #011 using physical force, sometime in the fall 2019. Lastly, PSW #118 alleged that they witnessed PSW #117 use physical force resident #012 sometime in the winter 2020.

The Inspector reviewed PSW #118's employee file and noted a letter dated after the CI report was submitted to the Director, which indicated that they had reported abuse incidents both verbal and physical, however, reported them late, months after they had occurred.

In an interview with PSW #118, they indicated to the Inspector, that they had not complied with the home's zero tolerance of abuse policy, as they had not immediately reported staff to resident abuse that they had witnessed.

In separate interviews with the DOC, and ED, they both indicated to the Inspector that PSW #118 had not complied with the home's zero tolerance of abuse policy, as they did not immediately report allegations of resident abuse, and should have.

c) The Inspector reviewed the home's internal investigation notes into the allegations of verbal and physical abuse by PSW #117, and noted that RPN #105, had on two separate occasions, noted PSW #117 be emotionally abusive towards resident #012, however, could not recall the dates of the incidents. RPN #105 described the form of verbal communication that PSW #117 used with a resident.

The Inspector reviewed RPN #105's employee file and noted a letter dated after the CI report was submitted to the Director, which indicated that during an investigation, it was identified that they failed to report incidents of verbal abuse.

In separate interviews with the DOC, and ED, they both indicated to the Inspector that RPN #105 had not complied with the home's zero tolerance of abuse policy, as they did not immediately report allegations of resident abuse, and should have.

d) The Inspector reviewed the home's internal investigation notes into the

allegations of verbal and physical abuse by PSW #117, and noted that PSW #119 had witnessed PSW #117 use a form of verbal communication with resident #013 while providing care, on an undetermined date.

The Inspector reviewed PSW #119's employee file and noted a letter dated after the CI report was submitted to the Director, which indicated that it was identified that during an investigation, the PSW failed to report incidents of verbal abuse.

In separate interviews with the DOC, and ED, they both indicated to the Inspector that PSW #119 had not complied with the home's zero tolerance of abuse policy, as they did not immediately report allegations of resident abuse, and should have.

The severity of this issue was determined to be a two, as there was actual harm or actual risk to the residents. The scope of the issue was a level three, widespread. The home had a level three compliance history, as they had related non-compliance with this section of the Ontario Regulation 79/10 that included:
-a Voluntary Plan of Correction (VPC) issued October 10, 2018 (2018_745690_0010), and,
-a CO issued January 4, 2018 (2017_420643_0022).
(736)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 07, 2020

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 15th day of June, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amanda Belanger

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