Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

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


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

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

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Aug 24, 2018 | 2018_508137_0008 | 004608-18 | Complaint |

### Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

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

Caressant Care Fergus Nursing Home
450 Queen Street East FERGUS ON N1M 2Y7

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

MARIAN MACDONALD (137), SHARON PERRY (155)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): March 7-9, 12-15, 19-23, 26 -29, April 3-6 and 9-13, 2018**

**The following inspections were conducted concurrently during this Complaint inspection:**
**Log #004799-18, Follow up to an immediate compliance order related to Director of Nursing qualifications; Log #001151-18, CIS #2603-000006-18; Log #002325-18, CIS #2603-000015-18; Log #004224-18, IL-55740-LO and Log #004889-18, IL-NC-55402 related to alleged staff to resident abuse.**

**PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA,2007,c.8,s.19(1) and a Written Notification and Compliance Order related to LTCHA,2007,c.8,s.23(1) identified in a concurrent inspection #2018_508137_0006 (Log #002325-18, CIS #2603-000006-18) were issued in this report.**
**PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, s.8, s. 23(1), identified in a concurrent inspection #2018_448155_0005 (Log #001151-18, CIS #2603-000006-18) were issued in this report.**

**During the course of the inspection, the inspector(s) spoke with Regional Manager/Nurse Consultant, Executive Director, current and former Directors of Care, current and former Resident Care Coordinators, acting Directors of Care, former Resident Assessment Instrument (RAI) Coordinator, External Nurse Consultant, Nurse Practitioner, Food Service Manager, Office Manager, Maintenance, Director of Environmental Services - Corporate, Activity Coordinator, Nurse Clerks, Registered Staff, Personal Support Workers, family members and residents.**

**The Inspectors also also toured the home, reviewed resident clinical records, staff education records, employee files, relevant policies and procedures, internal investigative notes, staffing schedules, observed staff to resident interactions, provision of care, the general maintenance and cleanliness of the home.**

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

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

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 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.

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

Ontario Regulation 79/10 s.2 (2) (a) defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain".

A)The home submitted a Critical Incident System (CIS) report #2603-000015-18 to the Ministry of Health and Long Term Care (MOHLTC) on a specific date, related to an incident of alleged staff to resident abuse that occurred on a specific date, during the night – early morning. Staff member #115 noticed an injury to an identified resident and asked the resident what happened. The resident reported that two staff members entered their room during the night and were rough. Staff member #115 reported this to staff members #119 and #139. Staff member #119 interviewed the resident and was told the staff were so rough and observed injuries to the resident.

A review of the staff sign in sheets showed that staff members #127 and #140 worked on the shift of the alleged incident.

There was no documented evidence that the incident of alleged staff to resident abuse was immediately investigated and that appropriate action was taken in response to the incident involving the identified resident.

B) Nineteen days later, the home became aware of another incident of alleged staff to resident abuse, involving staff member #127. An identified resident told staff member

#106 that they are scared during the night as staff member #127 was rough and not telling them what they were doing. Staff member #106 observed an injury to the resident and reported the incident to staff member #104, who interviewed the resident. The resident told staff member #104 the same concerns. Staff member #104 reported the concerns to staff member #119, who also interviewed the resident. The resident told staff member #119 that they tried to fight back and it still hurt. The resident was visibly upset and asked that staff member #127 no longer provide their care. Staff member #119 informed Administrator #107, Regional Manager #100 and External Consultant #138 on a specific date, by email. Staff member #127 was not interviewed about the incident until six days after the alleged incident occurred. Staff member #127 continued to work in the home from the time the incident was reported until staff member #127 was interviewed. Staff member #127 denied the allegation and no further action was taken.

During an interview on a specific date, Inspector #137 asked Administrator #107 what was done to protect the resident from abuse by anyone, during the six days from when the incident was reported until staff member #127 was interviewed, as staff member #127 continued to work in the home. The Administrator said there was a protocol that if an incident was reported and if it was considered necessary for the person to be put on administrative leave, then that would be exercised. Administrator #107 said the allegation could not be substantiated as the resident could not provide the name of staff member #127 and basically in terms of what was identified, they did not feel the resident was at risk.

C) One day later, the home became aware of a third incident of alleged staff to resident abuse, involving staff member #127. The incident was reported to staff members #104 and #119. Staff member #119 interviewed an identified resident and was told that staff member #127 entered the room and was rough with an identified resident. The resident told staff member #127 to "stop". The identified resident was able to describe and identify staff member #127. It was requested that staff member #127 no longer provide their care.
Staff member #119 informed Administrator #107, Regional Manager #100 and External Consultant #138 on a specific date, by email. Staff member #127 was not interviewed untl five days after the home became aware of the alleged incident. Staff member #127 continued to work in the home from the time the incident was reported until staff member #127 was interviewed. Staff member #127 denied the allegation and no further action was taken.

During an interview on a specific date, Inspector #137 asked Administrator #107 what

was done to protect the identified resident from abuse by anyone, during the five days from when the incident was reported until staff member #127 was interviewed, as staff member #127 continued to work in the home. The Administrator said there was a protocol that if an incident was reported and if it was considered necessary for the person to be put on administrative leave, then that would be exercised. Administrator #107 said the allegation could not be substantiated as the identified resident was not reliable, there were some inconsistencies in terms of the time of the event and basically in terms of what was identified, they did not feel the resident was at risk.

The licensee has failed to ensure that residents were protected from abuse by anyone and that residents were not neglected by the licensee or staff. [s. 19. (1)]

***Additional Required Actions:***

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

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**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 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 every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knew of, or that was reported was immediately investigated and that appropriate action was taken in response to every such incident.

A)The home submitted a Critical Incident System (CIS) report #2603-000015-18 to the Ministry of Health and Long Term Care (MOHLTC) on a specific date, related to an incident of alleged staff to resident abuse that occurred on a specific date, during the night – early morning. Staff member #115 noticed an injury to an identified resident and asked the resident what happened. The resident reported that two staff members entered their room during the night and were rough. Staff member #115 reported this to staff members #119 and #139. Staff member #119 interviewed the resident and was told the staff were so rough and observed injuries to the identified resident.

On a specific date, Regional Manager #100 was requested to provide the investigative notes to Inspector #137 for CIS 2603-000015-18, as Administrator #107 was off site, attending an education session.
The following day, Administrator #107 was also requested to provide the investigative notes for CIS 2603-000015-18.
Regional Manager #100 provided a sheet of paper, written by a former staff member, that said:
"Policy & Procedure - Abuse & Neglect (North)".
The names of two staff members were written on the sheet with their respective signatures. Regional Manager #100 said this was all they could find related to the investigative notes involving the identified resident.

A review of the staff sign in sheets showed that staff member #127 and #140 worked on the shift of the alleged incident.

On a specific date, the Centralized Intake Assessment Triage Team (CIATT) requested an amendment of the CIS related to the outcome of the home's internal investigation, the action taken to address staff performance and to prevent reoccurrence. To date, there was no documented evidence that a CIS amendment was submitted.

There was no documented evidence that the incident of alleged staff to resident abuse was immediately investigated and that appropriate action was taken in response to the incident involving the identified resident.

B) The home became aware of an incident of alleged staff to resident abuse on a specific date, involving an identified resident. The resident told staff member #106 that they were scared during the night as staff member #127 was rough with them and not telling them what they were doing. Staff member #106 observed an injury to the resident and reported the incident to staff member #104, who interviewed the resident. The resident told staff member #104 the same concerns. Staff member #104 reported the concerns to staff member #119, who also interviewed the resident. The resident told staff member #119 that they tried to fight back and it still hurt. The resident was visibly upset and asked that staff member #127 no longer provide their care. Staff member #119 informed Administrator #107, Regional Manager #100 and External Consultant #138 on a specific date, by email. Staff member #127 was not interviewed until six days after the alleged incident occurred. Staff member #127 continued to work in the home from the time the incident was reported until staff member #127 was interviewed. Staff member #127 denied the allegation and no further action was taken. Staff members #104, #106, #119 and #139, with knowledge of the incident, were not interviewed by Administrator #107, during the investigation.
Administrator #107 said the allegation could not be substantiated as the resident could not provide the name of staff member #127.

During an interview on a specific date, the resident was able to recall the incident and told Inspector #137 that a staff member came into the room at night and was rough. The resident told staff member #127 to “stop” and the resident was scared.

During an interview on a specific date, Administrator #107 said the delay in interviewing staff member #127 was because there had to be union representation. A review of the staff sign in sheets showed that a union steward was available and working on specific

dates, prior to the interview of staff member #127.

During an interview on a specific date, Inspector #137 asked Regional Manager #100 what their involvement was, related to the alleged staff to resident abuse incident, as they were copied on the email. Regional Manager #100 said they had nothing to do with it and incidents were dealt with at the home level by Administrator #107.

The incident of alleged, suspected or actual staff to resident abuse was not reported to the Ministry of Health and Long Term Care (MOHLTC) after-hours pager and a CIS report was not submitted to the MOHLTC.

There was no documented evidence that the incident of alleged staff to resident abuse was immediately investigated and that appropriate action was taken in response to the incident involving the identified resident.

C) The home became aware of an incident of alleged staff to resident abuse on a specific date, involving an identified resident. The incident was reported to staff members #104 and #119. Staff member #119 interviewed an identified resident and was told that staff member #127 entered the room and was rough with an identified resident. The resident told staff member #127 to "stop". The identified resident was able to describe and identify staff member #127. It was requested asked that staff member #127 no longer provide their care.
Staff member #119 informed Administrator #107, Regional Manager #100 and External Consultant #138 on a specific date, by email. Staff member #127 was not interviewed about the incident until five days after the home became aware of the alleged incident. Staff member #127 continued to work in the home from the time the incident was reported until staff member #127 was interviewed. Staff member #127 denied the allegation and no further action was taken. Staff members #104 and #119, with knowledge of the incident, were not interviewed by Administrator #107, during the investigation. Administrator #107 said the allegation could not be substantiated as the identified resident was not reliable.

During an interview on a specific date, the identified resident was able to recall the incident and told Inspector #137 that staff member #127 just pulled the covers off and was rough.

During an interview on a specific date, Administrator #107 said the delay in interviewing staff member #127 was because there had to be union representation. A review of the

staff sign in sheets showed that a union steward was available and working on specific dates, prior to the interview of staff member #127.

During an interview on a specific date, Inspector #137 asked Regional Manager #100 what their involvement was, related to the alleged staff to resident abuse incident, as they were copied on the email. Regional Manager #100 said they had nothing to do with it and incidents were dealt with at the home level by Administrator #107.

The incident of alleged, suspected or actual staff to resident abuse was not reported to the Ministry of Health and Long Term Care (MOHLTC) after-hours pager and a CIS report was not submitted to the MOHLTC.

There was no documented evidence that the incident of alleged staff to resident abuse was immediately investigated and that appropriate action was taken in response to the incident involving the identified resident.

The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knew of, or that was reported was immediately investigated and that appropriate action was taken in response to every such incident. [s. 23. (1)]

2. PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, s.8, s. 23(1), identified in a concurrent inspection #2018_448155_0005 (Log #001151-18, CIS #2603-000006-18) were issued in this report.

The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported is immediately investigated.

On a specific date, during stage one of the Resident Quality Inspection, an identified resident told Inspector #155 that a Personal Support Worker (PSW) was abusive to them. Inspector #155 reported this to the former Director of Nursing #142 and they submitted a Critical Incident Report (CIS #2603-000006-18) on a specific date.

The CIS states that the former Director of Nursing #142 met with the identified resident and reported that the alleged incident took place on a day shift during a week day, that a PSW was transferring them and hit them on the hand. As a result of this, the identified resident sustained an injury. Resident reported that the employee still worked in the

home. The CIS also indicated that they would follow up with the employees and that the long-term actions planned to correct this situation and prevent recurrence would be implemented upon completion of the investigation.

On a specific date, Inspector #155 asked Executive Director #107 for investigative notes regarding CIS 2603-000006-18. Executive Director #107 brought Inspector #155 a copy of CIS 2603-000006-18 report. They stated that they got the report from their CIS binder but that there were no other investigation notes or documents in the CIS binder. Executive Director #107 stated that this incident happened on a specific date, when the previous Director of Nursing #142 was not always available in the home and then resigned. Executive Director #107 could not explain what the investigation consisted of, what PSW staff were interviewed regarding the alleged incident of abuse or the outcome of the investigation. There was no documented evidence that the investigation was completed and the CIS report was not amended.

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

***Additional Required Actions:***

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

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**WN #3: 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 comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director
Specifically failed to comply with the following:

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

Findings/Faits saillants:
The licensee has failed to ensure that a person who had reasonable grounds to suspect that 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 had occurred, immediately reported the

suspicion and the information upon which it was based to the Director.

A)The home became aware of an incident of alleged staff to resident abuse on a specific date, involving an identified resident. The resident told staff member #106 that they were scared during the night as staff member #127 was rough with them and not telling them what they were doing. Staff member #119 informed Administrator #107, Regional Manager #100 and External Consultant #138 on a specific date, by email.

The incident of alleged, suspected or actual staff to resident abuse was not reported to the Ministry of Health and Long Term Care (MOHLTC) after-hours pager and a Critical Incident System (CIS) report was not submitted to the MOHLTC. Staff member #119 informed Administrator #107 on a specific date, via email, that they were locked out of the CIS for security reasons and was unable to submit a CIS. Administrator #107 had knowledge of the incident and did not submit a CIS.

B) The home became aware of an incident of alleged staff to resident abuse on a specific date, involving an identified resident. Staff member #119 interviewed an identified resident and was told that staff member #127 entered the room and was rough with an identified resident. The resident told staff member #127 to "stop". The identified resident was able to describe and identify staff member #127. It was requested that staff member #127 no longer provide their care.
Staff member #119 informed Administrator #107, Regional Manager #100 and External Consultant #138 on a specific date, by email.

The incident of alleged, suspected or actual staff to resident abuse was not reported to the Ministry of Health and Long Term Care (MOHLTC) after-hours pager and a CIS report was not submitted to the MOHLTC. Staff member #119 informed Administrator #107 on a specific date, via email, that they were locked out of the CIS for security reasons and was unable to submit a CIS. Administrator #107 had knowledge of the incident and did not submit a CIS.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that 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 had occurred, immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

***Additional Required Actions:***

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

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 26. Whistle-blowing protection**

**Findings/Faits saillants :**

1. The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.26. Whistle-blowing protection.

Specifically failed to comply with the following:

s.26(1) No person shall retaliate against another person, whether by action or omission, or threaten to do so because,
(a) anything has been disclosed to an inspector

s.26(2) 1. Dismissing a staff member.
4. Intimidating, coercing or harassing any person

s.26(5)1. None of the following shall do anything that discourages, is aimed at discouraging or that has the effect of discouraging a person from doing anything mentioned in clauses (1) (a) to (c):
1. The licensee of a long-term care home or a person who manages a long-term care home pursuant to a contract.

The licensee retaliated against another person, whether by action, omission or threat to do so, because anything had been disclosed to an Inspector.
(2) Without in any way restricting the meaning of the word "retaliate", the following constitute retaliation for the purposes of subsection (1):
- Dismissing a staff member.
- Intimidating, coercing or harassing any person.

(5) None of the following persons shall do anything that discourages, is aimed at discouraging or that has the effect of discouraging a person from doing anything

mentioned in clause (1)(a).
1. The licensee of a long-term care home or a person who manages a Long-term care home pursuant to a contract.

During this Complaint Inspection, information was gathered from several staff interviews and showed that the licensee's representatives, Regional Manager/Nurse Consultant (RM/NC) #100 and Executive Director (ED) #107, retaliated against staff member #119, for disclosing information to an inspector. The staff member was also intimidated and/or harassed and was dismissed from their employment.

On March 1, 2018, staff member #119 contacted the Ministry of Health and Long-Term Care (Ministry) INFOLINE and reported complaints about two incidents of alleged staff to resident abuse, as well as retaliation.

Staff member #119 was an employee of Caressant Care Nursing Home in Fergus, Ontario.
As part of their complaints to the Ministry, staff member #119 stated that their employment at the Long-Term Care (LTC) home was terminated on February 26, 2018 and the Executive Director (ED) #107 allegedly told staff member #124 that staff member #119 was terminated because they told Ministry Inspectors too much, during the Resident Quality Inspection (RQI), at the LTC home. The RQI was conducted between January 8 and 31, 2018.

During the RQI, on January 30, 2018, staff member #119 approached Inspectors #137, #155, #523 and #532, to inquire about an incident of alleged financial abuse. Staff member #119 asked to sit in the corner of the room, out of visual sight, as they said they were afraid to be seen speaking to Inspectors and they would likely be fired for speaking to the Ministry. When staff member #119 finished speaking to the Inspectors, Inspector #137 checked the hallway to ensure there was no one present who may have witnessed staff member #119 leaving the room.

This Complaint was inspected concurrently with other Complaint, Critical Incident System (CIS) and Follow-up inspections.

During an interview on March 20, 2018, staff member #119 said they had been questioned different times, during the RQI, by Executive Director (ED) #107, about how the Ministry knew about an incident involving an identified resident, which occurred while inspectors were in the home. ED #107 told member #119 that only staff member #104

and themselves were questioned on January 22 and 23, 2018 by the Ministry Inspectors and staff member #104 did not inform the inspectors about the incident involving an identified resident. Staff member #119 responded to ED #107 that they did not know and ED #107 kept asking who would give the Ministry this information. Staff member #119 replied again that they did not know as Ministry Inspectors had spoken to a number of people, during the RQI.

On a specific date, the Ministry became aware of an incident, involving an identified resident, from a call made to the Spills Action Centre (SAC) by the (former) Director of Nursing (DON) #142. The home was requested, by a Triage Inspector with the Centralized Intake Assessment Triage Team (CIATT), to complete a Critical Incident System (CIS) report which was submitted on January 22, 2018, by staff member #119.

During the interview, on March 20, 2018, staff member #119 provided various e-mails for Inspector #137 and Inspector #155 to review:

• On January 19, 2018 at 1509 hours, while Inspectors were in the home, staff member #119 sent an email to DON and copied ED #107, RM/NC #100 and External Consultant related to three concerns about Personal Support Worker (PSW) #146. On January 22, 2018, staff member #119 was interviewed by Inspector #137 related to responsive behaviours and the plan of care for an identified resident. On January 25, 2018, ED #107 told staff member #119 not to be forthcoming when speaking to the Ministry and answer only what the Ministry asked.
Staff member #119 said that approximately a week or two after the RQI, they noticed a change in how they were being treated and spoken to by ED #107 and RM/NC #100. Some of their regular duties had been assigned to other registered staff and ED #107 and RM/NC #100 were constantly checking up on the duties performed by staff member #119, such as audits. Staff member #119 said that practice had not occurred, prior to the Ministry visiting in the home and that ED #107 had no prior interest in reviewing the duties performed by staff member #119.
Approximately, one week before staff member #119 was terminated, they observed ED #107 giving a tour of the home to possibly a new employee. ED #107 pointed out the Resident Care Coordinator (RCC) office as they passed by. Staff member #119 was told that the person hired for the RCC position, after staff member #119 was terminated, matched the description of the person who was given the tour of the home.
• January 22, 2018 at 1514 hours – RM/NC #100 sent an email to ED #107 and staff member #124, copied to staff member #119, DON #142, External Consultant and Vice President of Operations related to Safety Equipment Audit Process. RM/NC #100 stated

"From what I have now been told is that the MOH wants a process on inventory. This is not a mandated requirement and we are not going to start developing more processes in the home when we can't accomplish the ones we already have. At NO time is this process as outlined below to be shared with the MOH".
• During an interview on May 7, 2018, staff member #119 was asked if they ever felt intimidated, coerced or harassed, they said all the time by RM/NC #100, especially after staff member #119 spoke to the Ministry.

During an interview on March 20, 2018, staff member #124 said the ED #107 told them that staff member #119 was terminated because the Ministry brought forward concerns about the competency of staff member #119 and that red flags were raised during interactions between staff member #119 and the Ministry. At no time did Ministry Inspectors bring forward concerns to ED #107 related to the competency of staff member #119.

During an interview on March 23, 2018, ED #107 said staff member #119 was terminated as they were not a perfect fit for the organization and that their concerns about staff member #119 were from an attitudinal perspective. ED #107 said staff member #119 did not have any performance reviews completed, which DON #142 was responsible for but failed to do it.

The following phone call and e-mails to Inspector #155 demonstrate that, only a few weeks prior to their termination, the licensee was confident to have staff member #119 assist with DON support until a new DON was hired. This did not support the licensee's concerns regarding the competency and attitudinal concerns of staff member #119:
• February 8, 2018 at 1550 hours – Inspector #155 called ED #107 regarding DON coverage. ED #107 shared that RM/NC #100 was there today and that they were in the recruitment process for a DON. They have done some interviewing but have not secured anyone yet. Staff member #119 was onsite providing coverage.
• February 12, 2018 at 1500 hours – email sent to Inspector #155, copied to RM/NC #100 - "Recruitment for the DON position is ongoing.
The Acting DON #118 will be supported by RM/NC #100, who will be in the home two days per week, Healthcare Consultant, also in the home one day per week and staff member #119 five days per week".
• February 14, 2018 at 1004 hours – email sent to Inspector #155 and copied to RM/NC #100 and VP of Operations– "The management of Caressant Care has arranged to have RM/NC #100 and Healthcare Consultant for Caressant Care Fergus (both BSCN with multiple years of managerial nursing experience) to be in the home three to four days per

week to support the DON position. In addition, staff members #119 and #124 will also be available in the home throughout the week. Both of these individuals are also Registered Nurses and both also have multiple years of managerial nursing experience working within LTC homes. Both of these individual are also in the home throughout the week and available to assist the acting DON on an ongoing basis".

Staff member #119 was asked about their working relationship with the Regional Manager/Nurse Consultant (RM/NC) #100 and described them as a bit of a bully, never gave positive reinforcement, only negative and staff referred to them as the "barracuda". After the resignation of the DON, effective February 9, 2018, staff member #119 was asked by ED #107 to fill in as the DON but refused due to lack of support. They said that no one wanted to fill in as they did not want to work with RM/NC #100.

During an interview on April 13, 2018, RM/NC #100 said staff member #119 was terminated for performance issues and inability to follow direction, as given. RM/NC #100 said there were no documented concerns and no performance reviews completed. There were no formal disciplinary actions as they were a probationary employee.

During an interview on April 26, 2018, Resident Care Coordinator (RCC) #122 said they were contacted by RM/NC #100 on January 25, 2018 to set up an interview for the RCC position. They were interviewed by RM/NC #100 and ED #107 on February 2 and February 20, 2018 for the RCC position. They said that they did not apply for the DON position and was not interviewed for the DON position. Staff member #119 was still employed in the RCC position during the time when the interviews were conducted. A review of the employee file for RCC #122 showed an Offer of Employment from ED #107 dated February 26, 2018 which was the same day that staff member #119 was terminated.

During an interview on May 2, 2018, DON #142 verified that they had did not deliver any discipline or complete any performance review related to staff member #119, from the time that staff member #119 started employment and until DON #142 resigned their employment on February 9, 2018.

Inspector #137 reviewed the employee file for staff member #119 which contained a resume, references, offer of employment, Police Vulnerable Sector Check and a termination letter dated February 26, 2018, which stated the cause for termination was" your management style does not align with our expectations. This being the case, your probationary period will end unsuccessfully and your employment with Caressant Care

will end effective the date of this letter. You will receive one week's pay in lieu of notice". There was no documented evidence of completed orientation, any disciplinary action or any performance reviews in the employee file for staff member #119.
Related to Termination, the Offer of Employment, dated October 13, 2017 stated: "Your employment may be terminated at any time for cause. If your employment is terminated without cause, you will receive either working notice or payment in lieu of notice in compliance with the provisions of applicable employment legislation".

During an interview, ED #107 said RM/NC #100 expressed concerns about staff member #119, approximately one month before they were terminated. Ministry inspectors were in the home conducting the Resident Quality Inspection (RQI) and other inspections, at that time. On January 22, 2018, staff member #119 was interviewed by Inspector #137 related to responsive behaviours and the plan of care for an identified resident. Staff member #119 had been questioned by RM/NC #100 and ED #107 as to how Ministry Inspectors were getting their information and about sharing information with Inspectors. On January 25, 2018, ED #107 told staff member #119 not to be forthcoming when speaking to the Ministry and answer only what the Ministry asked. Shortly thereafter, the home had initiated and conducted an interview for the position of Resident Care Coordinator (RCC), which staff member #119 had currently held.

There was no documented evidence, in the employee file of staff member #119, of completed orientation, any disciplinary action, performance reviews, or of any concerns about their work performance. RM/NC #100 and ED #107 said staff member #119 had not received any discipline and no performance reviews were completed.

During this Complaint Inspection, documentation and information was gathered from several staff interviews and showed that the licensee, through RM/NC #100 and ED #107, retaliated against staff member #119, for disclosing information to an inspector.
A review of documentation and information gathered, throughout the inspection, supports that staff member #119 was retaliated against and terminated for disclosing information to the Ministry Inspectors, during the RQI.

"Discouraging Reporting"

The licensee failed to ensure that none of the following persons shall discourage, is aimed at discouraging or that has the effect of discouraging a person from doing anything mentioned in clause (1)(a).
1. The licensee of a long-term care home or a person who manages a Long-term care home pursuant to a contract.

After speaking to Ministry of Health Inspectors, staff members #104 and #119 on January 26, 2018, #112 on March 13, 2018 and #121 on March 27, 2018 were spoken to by the Executive Director (ED) #107 and/or the Regional Manager, Nurse Consultant (RM/NC) #100, which left staff members feeling intimidated, threatened and fearful which was discouraging, was aimed at discouraging or had the effect of discouraging the staff members to disclose any information to inspectors.

During an interview with Inspectors #137 and #155, on January 23, 2018, staff member #104 shared concerns related to care provision of residents by newly hired Personal Support Workers (PSWs), as well as a recent incident of alleged neglect by a PSW.
On January 26, 2018, staff member #104 was questioned by ED #107 and RM/NC #100 about talking to inspectors and dealing with issues internally, rather than sharing the information with the Ministry.
During an interview on March 23, 2018, staff member #104 said they were questioned by ED #107 and RM/NC #100 about why they talked to the Inspectors and was spoken to about confidentiality, as they should not be saying things about what goes on in the home. ED #107 said "We are throwing people under the bus. If we didn't say anything to the Ministry, we would pass compliance". Staff member #104 said they felt bullied, threatened and intimidated by the RM/NC #100.
Staff member #104 told Inspectors #137 and #155 that RM/NC #100 had issues with staff talking to the Ministry and said RM/NC #100 would likely pick on them now as they knew staff member #104 talked to the Ministry. These actions were aimed at or had the effect of discouraging staff to provide information to an inspector.

During an interview on March 23, 2018, staff member #129 said some staff went to them because they had been approached by RM/NC #100 after speaking to Inspectors during this inspection and RM/NC #100 demanded to know what had been said and told them that the RM/NC needed to be present when they speak to Inspectors. Staff member #129 said the staff were a little scared now to come forward so it was promised not to provide their names to the inspectors. Staff member #129 said the staff members felt intimidated and that the behaviour of RM/NC #100 were aimed at or had the effect of

discouraging staff to provide information to an inspector.
On March 12, 2018, staff member #112 was interviewed by Inspector #155 related to continence care products and the use of agency staff. On March 13, 2018, staff member #112 approached Inspectors #137 and #155 and said that, after speaking to Inspector #155, they were told by RM/NC #100 to stick directly to the questions and not to offer any information to the inspectors. RM/NC #100 said this is the problem that people are talking to the Ministry and we are in this mess.

During an interview on March 26, 2018, staff member #112 said they were questioned by the RM/NC #100 as to what the Inspector was asking them and was instructed how to answer the Inspectors. Staff member #112 said they "felt really intimidated as RM/NC #100 had a threatening tone, and just puts you in your place by their tone of voice". ED #107 told staff member #112 they did not know why anyone would be talking to the Ministry. ED #107 said "we were the problem and the home would be open to admissions if we were not all tattling to the Ministry". ED said staff member #112 did not understand and did not realize their job could be in jeopardy.
Staff member #112 asked to sit in the corner of the room, out of visual sight, as they said they were afraid to be seen speaking to Inspectors. These actions, by RM/NC #100 and ED #107, were aimed at or had the effect of discouraging staff to provide information to an inspector.

On March 8, 2018, staff member #121 approached Inspector #137 in Central Hallway about information missing from a document. Inspector #137 asked if the missing information contained Personal Information (PI) or Personal Health Information (PHI) related to residents and staff member #121 said it did. Inspector #137 encouraged staff member #121 to report it to ED #107. Staff member #121 informed ED #107 at "huddle" on March 8, 2018.
During an interview on March 26, 2018, staff member #121 said to the Inspectors that they reported to ED #107 that information was missing from a document and they did not want to be blamed for taking them. Staff member #121 was approached the next day by ED #107 and was told "you know there could be some fall out from this". When staff member #121 asked what they meant, ED did not really say. Staff member #121 showed inspectors that there were no entries in the document from January 29 to March 7, 2018 and said there should have been but the pages were torn out. Staff member #121 felt intimidated and threatened by ED #107.
Staff member #121 asked to sit in the corner of the room, out of visual sight, as they said they were afraid to be seen speaking to Inspectors. These actions were aimed at or had the effect of discouraging staff to provide information to an inspector.

During an interview on April 13, 2018, when RM/NC #100 was asked about questioning staff after speaking with Inspectors, they said they did not know what staff the Inspectors were referring to. RM/NC #100 shared it was not uncommon for them to ask what Inspectors were looking at, it is a general question. They did ask staff what the Ministry was asking so they knew what the general issues were that ministry was looking at so they can be aware of them.
They said that they have never threatened the staff or questioned the staff about what they had said. They cannot control what was said and what staff perceive.

During an interview on April 27, 2018, ED #107 said many staff had a bullying fear of RM/NC #100 and they could get that RM/NC #100 was intimidating.

During an interview on May 2, 2018, DON #142 said RM/NC #100 led by fear and provided no support for a home with lots of issues. RM/NC #100 never had a lot of involvement with the staff but some had a fear of RM/NC #100.

On January 22, 2018, staff member #119 was interviewed by Inspector #137 related to responsive behaviours and the plan of care for an identified resident.
On January 25, 2018, ED #107 told staff member #119 not to be forthcoming when speaking to the Ministry and answer only what the Ministry asked.
During an interview on May 7, 2018, staff member #119 was asked if they ever felt intimidated, coerced or harassed, they said all the time by RM/NC #100, especially after staff member #119 spoke to the Ministry. RM/NC #100 said you follow what you are directed to do. They were a hard ball and intimidating. These actions were aimed at or had the effect of discouraging staff to provide information to an inspector.

During the Resident Quality Inspection (RQI), Inspector #563 was questioned by ED #107 and DON #142 on January 29, 2018, as to where the Inspectors were getting their information about concerns related to care and who was telling them that information. Inspector #563 did not disclose this information.

On April 3, 2018, External Consultant #138 approached Inspectors #137 and #155 and said that when RM/NC #100 saw staff member #112 speaking to Inspector #155, they said "you need to shut them down". When External Consultant #138 asked what they meant, RM/NC #100 said they "wanted to shut staff member #121 down from talking to Inspectors". External Consultant #138 told RM/NC #100 that they would not be talking to staff member #121 about that. The action of RM/NC #100 was aimed at or had the effect

of discouraging staff to provide information to an inspector.

During this Complaint Inspection, information was gathered from several staff interviews and showed that the actions of the licensee, through RM/NC #100 and ED #107, were discouraging, aimed at discouraging or had the effect of discouraging staff members #104, #112, #119 and #121 to provide information to an inspector.

The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.26. Whistle-blowing protection.

Specifically failed to comply with the following:

s.26(1) No person shall retaliate against another person, whether by action or omission, or threaten to do so because,
(a) anything has been disclosed to an inspector

s.26(2)1. Dismissing a staff member.
4. Intimidating, coercing or harassing any person

s.26(5)1. None of the following shall do anything that discourages, is aimed at discouraging or that has the effect of discouraging a person from doing anything mentioned in clauses (1) (a) to (c):
1. The licensee of a long-term care home or a person who manages a long-term care home pursuant to a contract. [s. 26.]

***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 s.(26(1) no person shall retaliate against another person, whether by action or omission, or threaten to do so because, (a) anything has been disclosed to an inspector, s.26(2)1 dismiss a staff member or Intimidate, coerce or harass any person and s.26(5)1 none of the following shall do anything that discourages, is aimed at discouraging or that has the effect of discouraging a person from doing anything mentioned in clauses (1) (a) to (c): 1. The licensee of a long-term care home or a person who manages a long-term care home pursuant to a contract, to be implemented voluntarily.***

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**Issued on this 27th day of August, 2018**

**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

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|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | MARIAN MACDONALD (137), SHARON PERRY (155) |
| **Inspection No. / No de l'inspection :** | 2018_508137_0008 |
| **Log No. / No de registre :** | 004608-18 |
| **Type of Inspection / Genre d'inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Aug 24, 2018 |
| **Licensee / Titulaire de permis :** | Caressant-Care Nursing and Retirement Homes Limited<br>264 Norwich Avenue, WOODSTOCK, ON, N4S-3V9 |
| **LTC Home / Foyer de SLD :** | Caressant Care Fergus Nursing Home<br>450 Queen Street East, FERGUS, ON, N1M-2Y7 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Penny Silva |

To Caressant-Care Nursing and Retirement Homes Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 001

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

**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 must be compliant with s.19(1) of the LTCHA.

Specifically the licensee must:
• Ensure that residents #001, #005 and #006 are protected from abuse by anyone and that residents are not neglected by the licensee or staff, as outlined in the LTCHA, 2007 S.O. 2007, c.8, s. 19(1), of the Long Term Care Home Act.

**Grounds / Motifs :**

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

Ontario Regulation 79/10 s.2 (1) (a) defines physical abuse, subject to subsection (2), as "the use of physical force by anyone other than a resident that causes physical injury or pain".

A)The home submitted a Critical Incident System (CIS) report #2603-000015-18 to the Ministry of Health and Long Term Care (MOHLTC) on a specific date, related to an incident of alleged staff to resident abuse that occurred on a specific date, during the night – early morning. Staff member #115 noticed an injury to an identified resident and asked the resident what happened. The resident reported that two staff members entered their room during the night and were rough. Staff member #115 reported this to staff members #119 and #139. Staff member #119 interviewed the resident and was told the staff were so rough and observed injuries to the resident.

A review of the staff sign in sheets showed that staff members #127 and #140 worked on the shift of the alleged incident.

There was no documented evidence that the incident of alleged staff to resident abuse was immediately investigated and that appropriate action was taken in response to the incident involving the identified resident.

B) Nineteen days later, the home became aware of another incident of alleged staff to resident abuse on February 14, 2018, involving staff member #127. An identified resident told staff member #106 that they are scared during the night as staff member #127 was rough with them and not telling them what they were doing. Staff member #106 observed an injury to the resident and reported the incident to staff member #104, who interviewed the resident. The resident told staff member #104 the same concerns. Staff member #104 reported the concerns to staff member #119, who also interviewed the resident. The resident told staff member #119 that they tried to fight back and it still hurt.The resident was visibly upset and asked that staff member #127 no longer provide their care. Staff member #119 informed Administrator #107, Regional Manager #100 and External Consultant #138 on a specific date, by email. Staff member #127 was not interviewed about the incident until six days after the alleged incident occurred. Staff member #127 continued to work in the home from the time the incident was reported until staff member #127 was interviewed. Staff member #127 denied the allegation and no further action was taken.

During an interview on a specific date, Inspector #137 asked Administrator #107 what was done to protect the resident from abuse by anyone, during the six days from when the incident was reported until staff member #127 was interviewed, as staff member #127 continued to work in the home. The Administrator said there was a protocol that if an incident was reported and if it was considered necessary for the person to be put on administrative leave, then that would be exercised. Administrator #107 said the allegation could not be substantiated as the resident could not provide the name of staff member #127 and basically in terms of what was identified, they did not feel the resident was at risk.

C) One day later, the home became aware of a third incident of alleged staff to resident abuse, involving staff member #127.The incident was reported to staff members #104 and #119. Staff member #119 interviewed an identified resident and was told that staff member #127 entered the room and was rough with an identified resident. The resident told staff member #127 to "stop". The identified resident was able to describe and identify staff member #127. It was requested

that staff member #127 no longer provide their care.
Staff member #119 informed Administrator #107, Regional Manager #100 and External Consultant #138 on a specific date, by email. Staff member #127 was not interviewed about the incident until five days after the home became aware of the alleged incident. Staff member #127 continued to work in the home from the time the incident was reported until staff member #127 was interviewed. Staff member #127 denied the allegation and no further action was taken.

During an interview on a specific date, Inspector #137 asked Administrator #107 what was done to protect resident #006 from abuse by anyone, during the five days from when the incident was reported until staff member #127 was interviewed, as staff member #127 continued to work in the home. The Administrator said there was a protocol that if an incident was reported and if it was considered necessary for the person to be put on administrative leave, then that would be exercised. Administrator #107 said the allegation could not be substantiated as the identified resident was not reliable, there were some inconsistencies in terms of the time of the event and basically in terms of what was identified, they did not feel the resident was at risk.

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

This area of non-compliance was determined to have a severity level of three, actual harm/risk, the scope was a level three, widespread, as three of three (100 per cent) of residents were affected and compliance history of five, multiple non-compliances with at least one related to the current area of concern.

The home does have a history of non-compliance in this subsection of the Legislation.
It was issued as a:
Written Notification, Compliance Order and a Director's Referral on August 24, 2017, under Inspection # 2017_508137_0018, during a Follow up Inspection;
Written Notification and a Compliance Order on November 3, 2016, under Inspection # 2016_262523_0040, during a Complaint Inspection;
Written Notification and a Voluntary Plan of Correction on June 15, 2016, under Inspection #2016_325568_0015, during a Resident Quality Inspection (RQI).

(137)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Sep 07, 2018

**Order # / Ordre no :** 002

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) appropriate action is taken in response to every such incident; and
(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).

**Order / Ordre :**

The licensee must be compliant with s.23(1) of the LTCHA.

Specifically the licensee must:
• a) Ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knew of, or that was reported is immediately investigated and that appropriate action is taken in response to every such incident.
• b) Documentation pertaining to investigations and appropriate actions taken in response to every such incident shall be retained and kept in the home.

**Grounds / Motifs :**

1. On a specific date, during stage one of the Resident Quality Inspection, an identified resident told Inspector #155 that a Personal Support Worker(PSW) was abusive to them. Inspector #155 reported this to the former Director of Nursing #142 and they submitted a Critical Incident Report (CIS #2603-000006-18) on a specific date.

The CIS states that the former Director of Nursing #142 met with the identified

resident and reported that the alleged incident took place on a day shift during a week day, that a PSW was transferring them and hit them on the hand. As a result of this, the identified resident sustained an injury. Resident reported that the employee still worked in the home. The CIS also indicated that they would follow up with the employees and that the long-term actions planned to correct this situation and prevent recurrence would be implemented upon completion of the investigation.

On a specific date, Inspector #155 asked Executive Director #107 for investigative notes regarding CIS 2603-000006-18. Executive Director #107 brought Inspector #155 a copy of CIS 2603-000006-18 report. They stated that they got the report from their CIS binder but that there were no other investigation notes or documents in the CIS binder. Executive Director #107 stated that this incident happened on a specific date, when the previous Director of Nursing #142 was not always available in the home and then resigned. Executive Director #107 could not explain what the investigation consisted of, what PSW staff were interviewed regarding the alleged incident of abuse, or the outcome of the investigation. There was no documented evidence that the investigation was completed and the CIS report was not amended.

The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported is immediately investigated and that appropriate action was taken in response to every such incident.

(155)

2. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knew of, or that was reported was immediately investigated and that appropriate action was taken in response to every such incident.

A)The home submitted a Critical Incident System (CIS) report #2603-000015-18 to the Ministry of Health and Long Term Care (MOHLTC) on a specific date, related to an incident of alleged staff to resident abuse that occurred on a specific date, during the night – early morning. Staff member #115 noticed an injury to an identified resident and asked resident what happened. The resident reported that two staff members entered their room during the night and were rough. Staff member #115 reported this to staff members #119 and #139. Staff

member #119 interviewed the resident and was told the staff were so rough and observed injuries to the identified resident.

On a specific date, Regional Manager #100 was requested to provide the investigative notes to Inspector #137 for CIS 2603-000015-18, as Administrator #107 was off site, attending an education session.
The following day, Administrator #107 was also requested to provide the investigative notes for CIS 2603-000015-18.
Regional Manager #100 provided a sheet of paper, written by a former staff member, that said:
"Policy & Procedure - Abuse & Neglect (North)".
The names of two staff members were written on the sheet with their respective signatures. Regional Manager #100 said this was all they could find related to the investigative notes involving the identified resident.
A review of the staff sign in sheets showed that staff member #127 and #140 worked on the shift of the alleged incident.
On a specific date, the Centralized Intake Assessment Triage Team (CIATT) requested an amendment of the CIS related to the outcome of the home's internal investigation, the action taken to address staff performance and to prevent reoccurrence. To date, there was no documented evidence that a CIS amendment was submitted.

There was no documented evidence that the incident of alleged staff to resident abuse was immediately investigated and that appropriate action was taken in response to the incident involving resident #001.

B) The home became aware of an incident of alleged staff to resident abuse on a specific date, involving an identified resident. The resident told staff member #106 that they were scared during the night as staff member #127 was rough with them and not telling them what they were doing. Staff member #106 observed an injury to the resident and reported the incident to staff member #104, who interviewed the resident. The resident told staff member #104 the same concerns. Staff member #104 reported the concerns to staff member #119, who also interviewed the resident. The resident told staff member #119 that they tried to fight back and it still hurt. The resident was visibly upset and asked that staff member #127 no longer provide their care. Staff member #119 informed Administrator #107, Regional Manager #100 and External Consultant #138 on a specific date, by email. Staff member #127 was not interviewed about the incident until six days after the alleged incident occurred. Staff member #127

continued to work in the home from the time the incident was reported until staff member #127 was interviewed. Staff member #127 denied the allegation and no further action was taken. Staff members #104, #106, #119 and #139, with knowledge of the incident, were not interviewed by Administrator #107, during the investigation.
Administrator #107 said the allegation could not be substantiated as the resident could not provide the name of staff member #127.

During an interview on a specific date, the resident was able to recall the incident and told Inspector #137 that a staff member came into the room at night and was rough. The resident told staff member #127 to "stop" and the resident was scared.

During an interview on a specific date, Administrator #107 said the delay in interviewing staff member #127 was because there had to be union representation. A review of the staff sign in sheets showed that a union steward was available and working on specific dates, prior to the interview if staff member #127.

During an interview on a specific date, Inspector #137 asked Regional Manager #100 what their involvement was, related to the alleged staff to resident abuse incident, as they were copied on the email. Regional Manager #100 said they had nothing to do with it and incidents were dealt with at the home level by Administrator #107.

The incident of alleged, suspected or actual staff to resident abuse was not reported to the Ministry of Health and Long Term Care (MOHLTC) after-hours pager and a CIS report was not submitted to the MOHLTC.

There was no documented evidence that the incident of alleged staff to resident abuse was immediately investigated and that appropriate action was taken in response to the incident involving the identified resident.

C) The home became aware of an incident of alleged staff to resident abuse on a specific date, involving an identified resident. The incident was reported to staff members #104 and #119. Staff member #119 interviewed an identified resident and was told that staff member #127 entered the room and was rough with an identified resident. The resident told staff member #127 to "stop". The identified resident was able to describe and identify staff member #127. POA for resident

#006 requested asked that staff member #127 no longer provide their care. Staff member #119 informed Administrator #107, Regional Manager #100 and External Consultant #138 on a specific date, by email. Staff member #127 was not interviewed about the incident until five days after the home became aware of the alleged incident. Staff member #127 continued to work in the home from the time the incident was reported until staff member #127 was interviewed. Staff member #127 denied the allegation and no further action was taken. Staff members #104 and #119, with knowledge of the incident, were not interviewed by Administrator #107, during the investigation. Administrator #107 said the allegation could not be substantiated as resident #006 was not reliable.

During an interview on a specific date, the identified resident was able to recall the incident and told Inspector #137 that staff member #127 just pulled the covers off and was rough.

During an interview on a specific date, Administrator #107 said the delay in interviewing staff member #127 was because there had to be union representation. A review of the staff sign in sheets showed that a union steward was available and working on specific dates, prior to the interview if staff member #127.

During an interview on a specific date, Inspector #137 asked Regional Manager #100 what their involvement was, related to the alleged staff to resident abuse incident, as they were copied on the email. Regional Manager #100 said they had nothing to do with it and incidents were dealt with at the home level by Administrator #107.

The incident of alleged, suspected or actual staff to resident abuse was not reported to the Ministry of Health and Long Term Care (MOHLTC) after-hours pager and a CIS report was not submitted to the MOHLTC.

There was no documented evidence that the incident of alleged staff to resident abuse was immediately investigated and that appropriate action was taken in response to the incident involving the identified resident.

The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knew of, or that was reported was immediately investigated and that appropriate action was taken in response to every such incident.

This area of non-compliance was determined to have a severity level of three, actual harm/risk, the scope was a level three, widespread, as four of four (100 per cent) of residents were affected and compliance history of five, multiple non-compliances with at least one related to the current area of concern.

The home does have a history of non-compliance in this subsection of the Legislation.
It was issued as a:
Written Notification and a Voluntary Plan of Correction on January 8, 2018, under Inspection #2018_448155_0001, during a Resident Quality Inspection (RQI);
Written Notification and a Voluntary Plan of Correction on June 15, 2016, under Inspection #2016_325568_0015, during a Resident Quality Inspection (RQI).
(137)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Sep 07, 2018

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 :** 003

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

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

The licensee must be compliant with s.24(1) of the LTCHA.

Specifically the licensee must:
a) Ensure that a person who has reasonable grounds to suspect that 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 has occurred or may occur, immediately report the suspicion and the information upon which it is based to the Director.

**Grounds / Motifs :**

1. 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).

The licensee has failed to ensure that a person who had reasonable grounds to suspect that 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 had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A)The home became aware of an incident of alleged staff to resident abuse on a specific date, involving an identified resident. The resident told staff member #106 that they were scared during the night as staff member #127 was rough with them and not telling them what they were doing. Staff member #119 informed Administrator #107, Regional Manager #100 and External Consultant #138 on a specific date, by email.

The incident of alleged, suspected or actual staff to resident abuse was not reported to the Ministry of Health and Long Term Care (MOHLTC) after-hours pager and a Critical Incident System (CIS) report was not submitted to the MOHLTC. Staff member #119 informed Administrator #107 on a specific date, via email, that they were locked out of the CIS for security reasons and was unable to submit a CIS. Administrator #107 had knowledge of the incident and did not submit a CIS.

B) The home became aware of an incident of alleged staff to resident abuse on a specific date, involving an identified resident. Staff member #119 interviewed and identified resident and was told that staff member #127 entered the room and was rough with an identified resident. The resident told staff member #127 to "stop". It was requested that staff member #127 no longer provide their care. Staff member #119 informed Administrator #107, Regional Manager #100 and External Consultant #138 on a specific date, by email.

The incident of alleged, suspected or actual staff to resident abuse was not reported to the Ministry of Health and Long Term Care (MOHLTC) after-hours

pager and a CIS report was not submitted to the MOHLTC. Staff member #119 informed Administrator #107 on a specific date, via email, that they were locked out of the CIS for security reasons and was unable to submit a CIS. Administrator #107 had knowledge of the incident and did not submit a CIS.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that 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 had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

This area of non-compliance was determined to have a severity level of three, actual harm/risk, the scope was a level three, widespread, as two of two (100 per cent) of residents were affected and compliance history of five, multiple non-compliances with at least one related to the current area of concern.

The home does have a history of non-compliance in this subsection of the Legislation.
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Written Notification and a Voluntary Plan of Correction on June 15, 2016, under Inspection #2016_325568_0015, during a Resident Quality Inspection (RQI).

(137)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Sep 07, 2018

## 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 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, 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
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 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 de la Santé et 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)
151, rue Bloor Ouest, 9e étage
Toronto ON  M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et 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 24th day of August, 2018**

**Signature of Inspector /**
**Signature de l'inspecteur :**

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

**Name of Inspector /**
**Nom de l'inspecteur :** MARIAN MACDONALD

**Service Area Office /**
**Bureau régional de services :** Central West Service Area Office