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 prévue 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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Nov 19, 2019	2019_727695_0029 (A1)	012863-19, 017070-19, 017788-19, 018102-19, 019872-19	Critical Incident System

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

Amended by MARIA MCGILL (728) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Extension of compliance due date.

Issued on this 19th day of November, 2019 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Amended Public Copy/Copie modifiée du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 19, 2019	2019_727695_0029 (A1)	012863-19, 017070-19, 017788-19, 018102-19, 019872-19	Critical Incident System

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

Amended by MARIA MCGILL (728) - (A1)

Amended 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): October 15, 16, 17, 18, 22, and 23, 2019.

The following Inspector also participated in this inspection: Daniela Lupu (758)

During the course of the inspection, the following Critical Incident intakes were inspected:

Intake #019872-19, CI #2603-000051-19, related to alleged resident to resident sexual abuse

Intake #018102-19, CI #2603-000048-19, related to an improper transfer of a resident

Intake #017788-19, CI #2603-000047-19, related to alleged resident to resident sexual abuse

Intake #017070-19, CI #2603-000042-19, related to alleged staff to resident physical abuse

The following follow-up to a Compliance Order was conducted:

Intake #012863-19, related to the Policy to Promote Zero Tolerance, Compliance Order #001 issued under Inspection #2019_755728_0010

This Inspection was conducted concurrently with Complaint Inspection #2019_727695_0030.

During the course of the inspection, the inspector(s) spoke with residents, family members, personal support workers (PSW), registered practical nurses (RPN), registered nurses (RN), Behavioural Support Ontario (BSO) RPN, Resident Clinical Coordinators (RCCs), former Nurse Manager, the Director of

Care (DOC), and Responsive Health Management- Director of Operations (RHM-DOO).

The inspectors also toured the home, observed the provision of care and services, reviewed relevant documents including but not limited to: clinical records, investigation notes, training records, and policies and procedures.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **3 WN(s)**
- **1 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 :

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

1) A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) stating Personal Support Worker (PSW) #120 provided rough

and improper care to resident #005, on a specific day in September 2019.

The home's policy titled Abuse & Neglect – Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff, directed the Director of Care (DOC) and/or Executive Director to interview all parties and maintain a written record using the Abuse – Resident Incident Report (Appendix A) and directed the Director of Care (DOC), or in his/her absence, the Charge Nurse, to complete a Head to Toe Assessment of the resident and document the same.

A review of the home's internal investigation records and progress notes, in Point Click Care (PCC), showed there was no documented evidence that resident #005 was interviewed and there was no record of an Abuse – Resident Incident Report having been completed. DOC #108 said they were not there on the day of the incident and if resident #005 had been interviewed, the report would be included in the investigative package.

A review of the progress notes in PCC for the date of the incident showed an entry by former Nurse Manager #100 that a head to toe and pain assessment had been completed by Registered Practical Nurse (RPN) #112.

A review of the assessments and progress notes in PCC showed there was no documented evidence that a head to toe or pain assessment had been completed for resident #005.

RPN #112 said they did not complete either assessment at the time of the incident. [137]

2) A CIS report was submitted to the MLTC on a specific date in September 2019, stating that two days earlier, resident #002 and resident #001 were found exhibiting sexual behaviours.

a) The home's policy titled, "Abuse & Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff," directed staff to immediately report an alleged/actual act of abuse, as outlined, to their immediate supervisor.

According to the home's investigation notes, Agency RPN #102, who witnessed the incident, was interviewed, however, there were no questions regarding why the incident was not reported. In addition, there was no interview with RN #109.

The former Nurse Manager stated that they only became aware of the incident after it occurred and that it was never reported to management. They spoke with Agency RPN #102 who stated they reported the incident immediately to RN #109. They did not follow up with RN #109 regarding late reporting as they believed that the DOC was going to follow up.

The DOC stated that they did not interview RN #109 or any other staff regarding the late reporting of this incident. They acknowledged that management in the home became aware of the incident two days after it occurred.

b) The home's policy titled, "Abuse & Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff," directed staff to ensure that the immediate needs of the resident(s) were attended to and to provide medical treatment as needed.

The former Nurse Manager confirmed that the sexually inappropriate behaviour was substantiated in relation to this CIS report. They referred resident #001 to the social worker for follow up. They also stated that a head to toe assessment was expected to be completed after an incident of sexual abuse and it should to be documented in the electronic record, under assessments.

Review of the assessments showed that a head to toe assessment was not completed for resident #001. A progress note from two days after the incident, by the former Nurse Manager, stated "social work referral" and directed the social worker to review the BSO RPN's note regarding the incident. There were no progress notes by the social worker after the incident. The social worker referral binder was reviewed and there was no referral for resident #001 in regards to this incident.

The social worker stated they did not receive a referral for resident #001 regarding sexual abuse in regards to this incident.

The DOC acknowledged that there was no evidence of follow up by the social worker and no evidence the head to toe assessment was completed for resident #001. They acknowledged that both of these should have been completed after an incident of sexual abuse. [695]

3) A CIS report was submitted to the MLTC related to an incident in October

2019, where resident #003 was found exhibiting sexual behaviours towards resident #004.

a) The home's policy titled, "Abuse & Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff," directed staff to immediately notify the police of any alleged, suspected or witnessed incident of abuse or neglect of a resident that may constitute a criminal offence.

The home's investigation notes for this CIS report checked off "No" where it asked if police were notified of the incident.

The DOC acknowledged that the abuse was substantiated as resident #004 was not cognitive. They said the police were not contacted and should have been at the time of the incident.

The home failed to ensure that the abuse policy was followed by failing to notify the police when an incident of sexual abuse occurred.

b) The home's policy titled, "Abuse & Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff," directed staff to take measures such as heightened monitoring and behaviour support (BSO) services to ensure residents involved in abuse of other residents will be hindered from entering other resident rooms unattended.

After the incident of alleged sexual abuse in October 2019, the CIS report stated that a BSO referral was made and staff were to redirect the residents as per the plan of care.

Review of resident #003's plan of care showed that there was no update in regards to the residents new sexual behaviours, triggers, or interventions in place. There was no evidence that the interventions were being implemented. In addition, the Dementia Observation System (DOS), that was initiated for resident #003 and required the staff to monitor them every 30 minutes, was incomplete.

A progress note from three days after the incident stated that resident #003 was found in resident #004's room.

The DOC stated that after the incident occurred, staff were expected to provide heightened monitoring and redirect the residents away from one another. The

trigger and interventions for resident #003's behaviour were also identified after the incident.

The DOC acknowledged that the DOS was incomplete after the incident, and there was no update to resident #003's plan of care in regards to their new sexual behaviour, triggers or interventions.

c) The home's policy titled, "Abuse & Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff," directed staff to interview both residents involved (if appropriate) to determine the cause of the behaviour, evaluating the events preceding the incident.

According to the CIS report, the incident of alleged sexual abuse in October 2019, between resident #003 and #004 was a one-time incident and neither of the residents involved had contact prior to the incident.

The DOC stated that the general practice of the home was to interview the residents and any witnesses of an alleged abuse incident.

The Investigation notes were reviewed for the CIS report and there were no interviews with the residents. Resident #006, who was in the room during the incident, was not interviewed. A written statement was taken from PSW #104, who stated they were called into the room by resident #006 when they saw resident #003 and #004 engaged in sexual activity.

Resident #006 informed Inspector #695 that they saw resident #004 and resident #003 in the same room a week before the CI as well. They also observed resident #003 attempting to enter resident #004's room two days after the incident. A progress note from three days after the incident, stated that resident #003 was found in resident #004's room.

The DOC acknowledged they did not attempt to interview the two residents involved in the incident because they were not cognitive and they did not interview resident #006 as they did not believe they were in the room at the time of the incident. [695]

The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with. Specifically they failed to: report an incident immediately to management, interview all the

necessary individuals, conduct head to toe assessments, provide victim support, notify the police and provide behavioural monitoring as needed after an alleged or suspected abuse. [s. 20. (1)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 001

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

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the report to the Director included the names of any staff members or other persons who were present at or discovered the incident.

a) A CIS report was submitted to the MLTC related to an alleged incident of resident to resident sexual abuse that occurred on a specific date in August 2019. It stated that a PSW helped separate resident #001 and #002 from one another. The name of the PSW who witnessed the incident and responded to it was not written in full on the CIS report.

The DOC acknowledged that the name of the PSW who witnessed and responded to the incident was not written in the CIS report.

b) A CIS report was submitted to the MLTC related to an alleged incident of resident to resident sexual abuse that occurred on a specific date in September 2019. It stated that a PSW witnessed the incident. The CIS report did not indicate which PSW witnessed the incident.

The DOC acknowledged that the name of the PSWs who witnessed and responded to the incident were not written in the CIS report.

The licensee failed to ensure that the report to the Director included the names of any staff members or other persons who were present at or discovered the incident. [s. 104. (1) 2.]

2. The licensee has failed to ensure that the report to the Director included the following actions taken in response to the incident, specifically, the home provided inaccurate information regarding an action taken as a result of the incident.

A CIS report stated that after the incident of alleged sexual abuse on a specific date in October 2019, a head to toe assessment was conducted on resident #004. Another CIS report stated that a head toe assessment was conducted on resident #001 after an incident of alleged sexual abuse on a specific date in September 2019.

A review of progress notes and assessments showed that there was no head to toe assessment conducted for both resident #004 and #001, during the time period of their respective incidents.

The DOC was interviewed and acknowledged that there was no evidence that a head to toe assessment was completed for the residents involved in the identified incidents.

The licensee has failed to ensure that the report to the Director was accurate regarding the action taken in relation to the incidents in both CIS reports. [s. 104. (1) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance To ensure that the CIS report includes all the names of any staff members or other persons who were present at or discovered the incident, and
to ensure that the report to the Director is accurate regarding the actions taken as a result of the incident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The following is further evidence to support compliance order #006 issued on October 7, 2019, during inspection # 2019_727695_0025 to be complied December 20, 2019.

a) For the purposes of the Act and this Regulation, "sexual abuse" means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A CIS report stated that on a specific date in September 2019, resident #002 and resident #001 were found exhibiting sexual behaviours. Another CIS report stated that on a specific date in August 2019, resident #002 was found exhibiting sexual behaviours towards resident #001.

Resident #002 stated that when they think back to the incident in September 2019, they believed resident #001 did not consent to the activity.

The home's investigation notes for the CIS report from the incident in August 2019 were reviewed and there was no evidence that the residents involved or the PSW that witnessed the incident were interviewed. In addition, there was no referral to the BSO RPN or to the social worker. The home's investigation notes for the second CIS report had an interview with RPN #102, the RPN who witnessed the incident, stating that they observed the incident as reported in the CI.

The former Nurse Manager stated that the day they found out about the second incident, from September 2019, was when they interviewed resident #001 and determined that they did not want to be involved with resident #002.

The former Nurse Manager acknowledged that the incident of abuse in September 2019 was substantiated. They stated that they were not part of the investigation for the previous incident from August 2019. The DOC also stated that they did not do the investigation for this incident and believed it was the former Nurse Manager. They acknowledged that they could not find any interviews or investigation notes and therefore did not know whether abuse was substantiated for the first incident.

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

A CIS report was submitted to the MLTC on a specific date in September 2019, stating PSW #120 provided rough and improper care to resident #005.

A review of the home's internal investigation records showed resident #005 was upset and said that PSW #120 hurt them during care provision. Resident #005 expressed discomfort, was visibly upset and emotional support was provided. There was documented evidence on the electronic Medication Administration

Record (eMAR) that the resident's pain level was higher later that day and scheduled analgesics were administered by Registered Practical Nurse (RPN) #112.

When Nurse Manager #100 interviewed PSW #121, they said that PSW #120 told them they did not provide care to the resident according to their plan of care.

PSW #120 was sent home, removed from the schedule and no longer provided services to the home.

Resident #005 was able to recall the details of the incident to Inspector #137 and said that the PSW was rough. Resident #005 said they were in pain afterwards and feared that they had a more serious injury.

Registered Practical Nurse (RPN) #112 said PSW #120 was expected to follow the home's policy and procedures regarding resident care provision but failed to do so.

The licensee has failed to ensure that resident #001 was protected from sexual abuse by resident #002 and that resident #005 was protected from physical abuse by the licensee or staff in the home. [s. 19. (1)]

Issued on this 19th day of November, 2019 (A1)

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

Ministère de la Santé et 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 Homes Division
Long-Term Care Inspections Branch

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by MARIA MCGILL (728) - (A1)
Inspection No. / No de l'inspection :	2019_727695_0029 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	012863-19, 017070-19, 017788-19, 018102-19, 019872-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 19, 2019(A1)
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	Caressant Care Fergus Nursing Home 450 Queen Street East, FERGUS, ON, N1M-2Y7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Debbie Boakes

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

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:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_755728_0010, CO #001;

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) Comply with the home's zero tolerance of abuse and neglect policy and related procedures.
b) Ensure that all staff, including agency staff, are educated and aware of their responsibility in relation to the incidents of alleged, suspected, or witnessed abuse or neglect. This includes their responsibility to immediately report the incident, contact the police, conduct a head to toe assessment and other assessments (with documented evidence), refer to victim support, and conduct behavioural monitoring as needed. A record should be kept of the education material, sign in sheets, and a tracking sheet to confirm that all staff have received the education.
c) Ensure that there is a designated lead from the management team for every investigation related to suspected abuse or neglect. The lead's name should be written on the critical incident report and they will be responsible to ensure that the policy is followed and the investigation is complete. The investigation should follow the policy and include the following items as needed: a review of the assessments and interventions completed, whether they were documented and whether follow up occurred as required, interviews with the residents and staff who were involved and witnessed the incident, and a conclusion of whether the incident was substantiated and actions taken. Documentation must be kept of the investigation and follow up.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #001 from inspection # 2019_755728_0010 issued on June 7, 2019, with a compliance due date of September 3, 2019.

The licensee was ordered to be compliant with s. 20. (1) of the LTCHA.

Specifically, the licensee must:
a) comply with the home's zero tolerance of abuse and neglect policy and related procedures for reporting incidents of alleged, suspected, or witnessed abuse or neglect.
b) ensure that all staff are aware of and follow the reporting process as outlined in their policy and have documentation of the completed education that is kept in the

home.
c) ensure that all staff are aware of roles/responsibilities of who to report to if management are absent and staff are unable to report to the charge nurse directly.

The home was in compliant with c) but not with a) and b).

The Responsive Health Management– Director of Operations (RHM-DOO) stated that they kept track of the home's PSWs that were educated in relation to the reporting process, however they did not keep track of whether all the agency staff were educated.

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

1) A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) stating Personal Support Worker (PSW) #120 provided rough and improper care to resident #005, on a specific day in September 2019.

The home's policy titled Abuse & Neglect – Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff, directed the Director of Care (DOC) and/or Executive Director to interview all parties and maintain a written record using the Abuse – Resident Incident Report (Appendix A) and directed the Director of Care (DOC), or in his/her absence, the Charge Nurse, to complete a Head to Toe Assessment of the resident and document the same.

A review of the home's internal investigation records and progress notes, in Point Click Care (PCC), showed there was no documented evidence that resident #005 was interviewed and there was no record of an Abuse – Resident Incident Report having been completed. DOC #108 said they were not there on the day of the incident and if resident #005 had been interviewed, the report would be included in the investigative package.

A review of the progress notes in PCC for the date of the incident showed an entry by former Nurse Manager #100 that a head to toe and pain assessment had been completed by Registered Practical Nurse (RPN) #112.

A review of the assessments and progress notes in PCC showed there was no

documented evidence that a head to toe or pain assessment had been completed for resident #005.

RPN #112 said they did not complete either assessment at the time of the incident. [137]

2) A CIS report was submitted to the MLTC on a specific date in September 2019, stating that two days earlier, resident #002 and resident #001 were found exhibiting sexual behaviours.

a) The home's policy titled, "Abuse & Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff," directed staff to immediately report an alleged/actual act of abuse, as outlined, to their immediate supervisor.

According to the home's investigation notes, Agency RPN #102, who witnessed the incident, was interviewed, however, there were no questions regarding why the incident was not reported. In addition, there was no interview with RN #109.

The former Nurse Manager stated that they only became aware of the incident after it occurred and that it was never reported to management. They spoke with Agency RPN #102 who stated they reported the incident immediately to RN #109. They did not follow up with RN #109 regarding late reporting as they believed that the DOC was going to follow up.

The DOC stated that they did not interview RN #109 or any other staff regarding the late reporting of this incident. They acknowledged that management in the home became aware of the incident two days after it occurred.

b) The home's policy titled, "Abuse & Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff," directed staff to ensure that the immediate needs of the resident(s) were attended to and to provide medical treatment as needed.

The former Nurse Manager confirmed that the sexually inappropriate behaviour was substantiated in relation to this CIS report. They referred resident #001 to the social worker for follow up. They also stated that a head to toe assessment was expected to be completed after an incident of sexual abuse and it should to be documented in

the electronic record, under assessments.

Review of the assessments showed that a head to toe assessment was not completed for resident #001. A progress note from two days after the incident, by the former Nurse Manager, stated "social work referral" and directed the social worker to review the BSO RPN's note regarding the incident. There were no progress notes by the social worker after the incident. The social worker referral binder was reviewed and there was no referral for resident #001 in regards to this incident.

The social worker stated they did not receive a referral for resident #001 regarding sexual abuse in regards to this incident.

The DOC acknowledged that there was no evidence of follow up by the social worker and no evidence the head to toe assessment was completed for resident #001. They acknowledged that both of these should have been completed after an incident of sexual abuse. [695]

3) A CIS report was submitted to the MLTC related to an incident in October 2019, where resident #003 was found exhibiting sexual behaviours towards resident #004.

a) The home's policy titled, "Abuse & Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff," directed staff to immediately notify the police of any alleged, suspected or witnessed incident of abuse or neglect of a resident that may constitute a criminal offence.

The home's investigation notes for this CIS report checked off "No" where it asked if police were notified of the incident.

The DOC acknowledged that the abuse was substantiated as resident #004 was not cognitive. They said the police were not contacted and should have been at the time of the incident.

The home failed to ensure that the abuse policy was followed by failing to notify the police when an incident of sexual abuse occurred.

b) The home's policy titled, "Abuse & Neglect - Staff to Resident, Family to Resident,

Resident to Resident, Resident and/or Family to Staff," directed staff to take measures such as heightened monitoring and behaviour support (BSO) services to ensure residents involved in abuse of other residents will be hindered from entering other resident rooms unattended.

After the incident of alleged sexual abuse in October 2019, the CIS report stated that a BSO referral was made and staff were to redirect the residents as per the plan of care.

Review of resident #003's plan of care showed that there was no update in regards to the residents new sexual behaviours, triggers, or interventions in place. There was no evidence that the interventions were being implemented. In addition, the Dementia Observation System (DOS), that was initiated for resident #003 and required the staff to monitor them every 30 minutes, was incomplete.

A progress note from three days after the incident stated that resident #003 was found in resident #004's room.

The DOC stated that after the incident occurred, staff were expected to provide heightened monitoring and redirect the residents away from one another. The trigger and interventions for resident #003's behaviour were also identified after the incident.

The DOC acknowledged that the DOS was incomplete after the incident, and there was no update to resident #003's plan of care in regards to their new sexual behaviour, triggers or interventions.

c) The home's policy titled, "Abuse & Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff," directed staff to interview both residents involved (if appropriate) to determine the cause of the behaviour, evaluating the events preceding the incident.

According to the CIS report, the incident of alleged sexual abuse in October 2019, between resident #003 and #004 was a one-time incident and neither of the residents involved had contact prior to the incident.

The DOC stated that the general practice of the home was to interview the residents and any witnesses of an alleged abuse incident.

The Investigation notes were reviewed for the CIS report and there were no interviews with the residents. Resident #006, who was in the room during the incident, was not interviewed. A written statement was taken from PSW #104, who stated they were called into the room by resident #006 when they saw resident #003 and #004 engaged in sexual activity.

Resident #006 informed Inspector #695 that they saw resident #004 and resident #003 in the same room a week before the CI as well. They also observed resident #003 attempting to enter resident #004's room two days after the incident. A progress note from three days after the incident, stated that resident #003 was found in resident #004's room.

The DOC acknowledged they did not attempt to interview the two residents involved in the incident because they were not cognitive and they did not interview resident #006 as they did not believe they were in the room at the time of the incident. [695]

The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with. Specifically they failed to: report an incident immediately to management, interview all the necessary individuals, conduct head to toe assessments, provide victim support, notify the police and provide behavioural monitoring as needed after an alleged or suspected abuse. [s. 20. (1)]

The severity of this issue was determined to be a level 2 as there was minimal risk of harm. The scope of the issue was a level 2, as there was a pattern identified. The home had a level 5 compliance history as they had ongoing non-compliance with this section of the LTCHA, that included:
- Compliance order (CO) issued June 7, 2019 (2019_755728_0010)
- Voluntary Plan of Correction (VPC) issued March 1, 2018 (2018_448155_0001);
- VPC issued February 23, 2017 (2016_262523_0039) (137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 25, 2020(A1)

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

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:

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

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 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

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

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 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 19th day of November, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by MARIA MCGILL (728) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

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