Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELISSA CHISHOLM (188)
Inspection No. / No de l'Inspection :	2012_099188_0023
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Jun 6, 7, 27, Jul 6, 2012
Licensee / Titulaire de permis :	LADY ISABELLE NURSING HOME LTD 102 CORKERY STREET, P.O. BOX 10, TROUT CREEK, ON, P0H-2L0
LTC Home / Foyer de SLD :	LADY ISABELLE NURSING HOME 102 CORKERY STREET, P.O. BOX 10, TROUT CREEK, ON, P0H-2L0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	DAVID K. A TRUDEL

To LADY ISABELLE NURSING HOME LTD, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (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 shall prepare, submit and implement a plan for achieving compliance with the requirement to protect all residents and specifically residents #0042 and #0062, from abuse, specifically sexual abuse, by anyone.

The plan is to be submitted by July 13, 2012 to the LTC Home's Inspector Melissa Chisholm, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 603 Sudbury, Ontario P3E 6A5. Fax: 705-564-3133

The plan must be fully implemented by July 20, 2012.

Grounds / Motifs :

1. Inspector reviewed the health care record including progress notes for resident #0061. Inspector noted a documented incident of sexual abuse towards another resident. Inspector noted that this incident of sexual abuse was not reported to the Ministry. Inspector noted that although it is documented that the residents were redirected following the incident that resident #0061 continued to enter other residents' rooms. Inspector noted a second incident of sexual abuse occurred between resident #0061 and a different female resident (#0062). This incident was reported to the Ministry via the critical incident system. Inspector noted the Director was notified outside of the immediate reporting time frame and was reported as a Critical Incident report and not a Mandatory Report.

Inspector reviewed the plan of care for resident #0061. Inspector noted that the plan of care includes a focus of inappropriate behaviour however the only intervention directs staff to document a summary of each episode and does not offer any description of the resident's inappropriate behaviours or any interventions related to responding to the inappropriate behaviours.

Inspector spoke with a staff member who identified resident #0061 wanders into other residents' rooms. The staff identified that a yellow band had been placed across resident #0062's door but identified it was not an effective intervention as it does not stop the resident from entering. It was identified to the inspector that the resident tends to always enter resident #0062's room and that might be because the room is directly across from the resident's own room. When asked about interventions to protect the other residents it was identified that the resident has a bed alarm so staff are alerted to when the resident leaves bed and starts to wander.

Inspector noted on June 6, 2012 while walking down the hallway at 13:55h towards resident #0061's room that a bed alarm could be heard alarming. Inspector noted that it was resident #0061's alarm and that the resident had already entered resident #0062's room. Resident #0062 was not in the room at this time, however three other residents where in their respective beds. One resident was yelling at resident #0061 to leave the room. Inspector noted the alarm continued to sound and staff responded at 14:00h, however resident #0061 had already left the room and was now wandering the hallway. It was identified to the inspector by one of resident #0062 roommate's that they were scared of resident #0061 and that the resident continues to enter their room. The staff who

responded to the sounding alarm told the inspector that the alarm could not be heard at the nursing desk were the staff had been documenting. It was identified that because the resident's room is not close to the nursing station staff do not hear the alarm unless they are in the hallway. The licensee failed to protect residents from abuse by anyone. [LTCHA 2007, S.O. 2007, c.8, s.19(1)] (188)
2. Inspector reviewed the health care record including progress notes for resident #0041. Inspector noted a documented incident of sexual abuse towards resident #0042. Inspector noted that this incident of sexual abuse was not reported to the Ministry. Inspector noted that although it is documented that the residents were redirected following the incident there was not any additional interventions put in place to protect resident #0042 from further sexual abuse. Inspector noted a second incident between the same residents occurred a few days later. This incident was reported to the Ministry via the critical incident system outside of the immediate reporting time frame.

Inspector reviewed the plan of care for resident #0041. Inspector noted that the plan of care does not include the resident's inappropriate sexual behaviour or any interventions to deal with this behaviour.

Inspector spoke with two PSWs who identified they were aware of the incidents which had occurred but could not articulate any interventions that had been implemented to further protect resident #0042 from sexual abuse. It was identified to the inspector that they think maybe the registered staff are keeping the residents apart. The inspector interviewed the Director of Care to determine what plan had been put in place to protect resident #0042 from further sexual abuse. It was identified that the Director of Care had spoken with resident #0041 about the resident's actions and seemed to understand. The Director of Care was unable to articulate any further interventions put in place to protect resident #0042.

Inspector observed during the inspection, despite two previous incidents of sexual abuse that resident #0041 was in the common area/tv lounge beside the nursing station. Inspector noted resident #0042 was sitting beside resident #0041. Inspector remained in the common room noting no staff intervened to redirect the residents. Inspector noted the two residents remained in the common room sitting beside each other for almost 20 minutes until an activation staff member entered the common room and removed resident #0041 from the common room to attend an activity in the dining room. The licensee failed to ensure that resident #0042 was protected from abuse by anyone. [LTCHA 2007, S.O. 2007, c.8, s.19(1)] (188)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 20, 2012

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with s.53(1). The compliance plan shall include how the licensee will develop a responsive behaviours program which meets all requirements under O.Reg 79/10 s.53. The plan shall include time frames for implementation and identify who will be responsible for oversight of implementation.

The plan is to be submitted in writing to Long Term Care Homes Inspector, Melissa Chisholm, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 603, Sudbury, ON, P3E 6A5 by July 20, 2012. The plan shall be fully implemented by October 1, 2012.

Grounds / Motifs :

1. Previous non-compliance related to s.53(1) was identified during the Resident Quality Inspection # 2011_057163_0025, a written notification and voluntary plan of correction was issued. (188)
2. Inspector spoke with the Director of Care related to responsive behaviour management for residents #0041 and #0061. Inspector noted that the responsive behaviours for these residents were not identified within their plans of care. Inspector noted that no assessments had occurred, no interventions implemented and no specialized resources contacted related to these residents with responsive behaviours. The Director of Care confirmed to the inspector that no responsive behaviour management program exists in the home. The licensee failed to ensure the following is developed to meet the needs of residents with responsive behaviours: (1) written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, (2) written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours, (3) monitoring and internal reporting protocols and (4) protocols for referral to specialized resources is fully developed and implemented. [O.Reg. 79/10, s.53(1)(2)(3)(4)] (188)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 01, 2012

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board

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

and the

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.

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

Ministère 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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

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

Issued on this 6th day of July, 2012

Signature of Inspector / Signature de l'inspecteur :

Name of inspector / Nom de l'inspecteur : MELISSA CHISHOLM

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of inspection/Genre d'inspection
Jun 6, 7, 27, Jul 6, 2012	2012_099188_0023	Critical Incident

Licensee/Titulaire de permis

LADY ISABELLE NURSING HOME LTD
102 CORKERY STREET, P.O. BOX 10, TROUT CREEK, ON, P0H-2L0

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

LADY ISABELLE NURSING HOME
102 CORKERY STREET, P.O. BOX 10, TROUT CREEK, ON, P0H-2L0

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

MELISSA CHISHOLM (188)

Inspection Summary/Résumé de l'Inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), registered nursing staff (RN/RPN), personal support workers (PSW), residents and families.

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed staff to resident interactions, reviewed health care records and various policies and procedures.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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

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

Specifically failed to comply with the following subsections:

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. Inspector reviewed the health care record including progress notes for resident #0041. Inspector noted a documented incident of sexual abuse towards resident #0042. Inspector noted that this incident of sexual abuse was not reported to the Ministry. Inspector noted that although it is documented that the residents were redirected following the incident there was not any additional interventions put in place to protect resident #0042 from further sexual abuse. Inspector noted a second incident between the same residents occurred a few days later. This incident was reported to the Ministry via the critical incident system outside of the immediate reporting time frame.

Inspector reviewed the plan of care for resident #0041. Inspector noted that the plan of care does not include the resident's inappropriate sexual behaviour or any interventions to deal with this behaviour.

Inspector spoke with two PSWs who identified they were aware of the incidents which had occurred but could not articulate any interventions that had been implemented to further protect resident #0042 from sexual abuse. It was identified to the inspector that they think maybe the registered staff are keeping the residents apart. The inspector interviewed the Director of Care to determine what plan had been put in place to protect resident #0042 from further sexual abuse. It was identified that the Director of Care had spoken with resident #0041 about the resident's actions and seemed to understand. The Director of Care was unable to articulate any further interventions put in place to protect resident #0042.

Inspector observed during the inspection, despite two previous incidents of sexual abuse that resident #0041 was in the common area/tv lounge beside the nursing station. Inspector noted resident #0042 was sitting beside resident #0041. Inspector remained in the common room noting no staff intervened to redirect the residents. Inspector noted the two residents remained in the common room sitting beside each other for almost 20 minutes until an activation staff member entered the common room and removed resident #0041 from the common room to attend an activity in the dining room. The licensee failed to ensure that resident #0042 was protected from abuse by anyone. [LTCHA 2007, S.O. 2007, c.8, s.19(1)]

2. Inspector reviewed the health care record including progress notes for resident #0061. Inspector noted a documented incident of sexual abuse towards another resident. Inspector noted that this incident of sexual abuse was not reported to the Ministry. Inspector noted that although it is documented that the residents were redirected following the incident that resident #0061 continued to enter other residents' rooms. Inspector noted a second incident of sexual abuse occurred between resident #0061 and a different female resident (#0062). This incident was reported to the Ministry via the critical incident system. Inspector noted the Director was notified outside of the immediate reporting time frame and was reported as a Critical Incident report and not a Mandatory Report.

Inspector reviewed the plan of care for resident #0061. inspector noted that the plan of care includes a focus of inappropriate behaviour however the only intervention directs staff to document a summary of each episode and does not offer any description of the resident's inappropriate behaviours or any interventions related to responding to the inappropriate behaviours.

Inspector spoke with a staff member who identified resident #0061 wanders into other residents' rooms. The staff identified that a yellow band had been placed across resident #0062's door but identified it was not an effective intervention as it does not stop the resident from entering. It was identified to the inspector that the resident tends to always enter resident #0062's room and that might be because the room is directly across from the resident's own room. When asked about interventions to protect the other residents it was identified that the resident has a bed alarm so staff are alerted to when the resident leaves bed and starts to wander.

Inspector noted on June 6, 2012 while walking down the hallway at 13:55h towards resident #0061's room that a bed alarm could be heard alarming. Inspector noted that it was resident #0061's alarm and that the resident had already entered resident #0062's room. Resident #0062 was not in the room at this time, however three other residents where in their respective beds. One resident was yelling at resident #0061 to leave the room. Inspector noted the alarm continued to sound and staff responded at 14:00h, however resident #0061 had already left the room and was now wandering the hallway. It was identified to the inspector by one of resident #0062 roommate's that they were scared of resident #0061 and that the resident continues to enter their room. The staff who responded to the sounding alarm told the inspector that the alarm could not be heard at the nursing desk were the staff had been documenting. It was identified that because the resident's room is not close to the nursing station staff do not hear the alarm unless they are in the hallway.

The licensee failed to protect residents from abuse by anyone. [LTCHA 2007, S.O. 2007, c.8, s.19(1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

s. 53. (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(a) integrated into the care that is provided to all residents;
(b) based on the assessed needs of residents with responsive behaviours; and
(c) co-ordinated and implemented on an interdisciplinary basis. O. Reg. 79/10, s. 53 (2).

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices;
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. Inspector spoke with the Director of Care related to responsive behaviour management for residents #0041 and #0061. Inspector noted that the responsive behaviours for these residents were not identified within their plans of care. Inspector noted that no assessments had occurred, no interventions implemented and no specialized resources contacted related to these residents with responsive behaviours. The Director of Care confirmed to the inspector that no responsive behaviour management program exists in the home. The licensee failed to ensure the following is developed to meet the needs of residents with responsive behaviours: (1) written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, (2) written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours, (3) monitoring and internal reporting protocols and (4) protocols for referral to specialized resources is fully developed and implemented. [O.Reg. 79/10, s.53(1)(2)(3)(4)]
2. Previous non-compliance related to s.53(1) was identified during the Resident Quality Inspection # 2011_057163_0025, a written notification and voluntary plan of correction was issued.

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

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, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. Inspector reviewed the health care record of resident #0061, noting an incident of sexual abuse towards another resident had occurred. This incident of sexual abuse was not reported to the Director. Inspector spoke with the Director of Care who confirmed this incident had not been reported to the Director. The licensee failed to ensure that the Director is immediately informed of abuse of a resident by anyone. [LTCHA 2007, S.O. 2007, c.8, s.24(1)(2)]
2. Inspector reviewed the health care record of resident #0041, noting an incident of sexual abuse towards another resident was documented as occurring. This incident of sexual abuse was not reported to the Director. Inspector spoke with the Director of Care who confirmed this incident had not been reported to the Director. The licensee failed to ensure that the Director is immediately informed of abuse of a resident by anyone. [LTCHA 2007, S.O. 2007, c.8, s.24(1)(2)]
3. Inspector reviewed a critical incident report. Inspector noted the reported resident to resident sexual abuse was reported outside the immediate reporting time frame. The licensee failed to ensure that the Director is immediately informed of abuse of a resident by anyone. [LTCHA 2007, S.O. 2007, c.8, s.24(1)(2)]
4. Inspector reviewed a critical incident report. Inspector noted the report identifies witnessed resident to resident sexual abuse. Inspector noted the Director was first notified via the critical incident system outside of the immediate reporting time frame. The licensee failed to ensure that the Director is immediately informed of abuse of a resident by anyone. [LTCHA 2007, S.O. 2007, c.8, s.24(1)(2)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following subsections:

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

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

Findings/Faits saillants :

1. Inspector spoke with the Director of Care related to two critical incident reports. It was identified that the substitute decision-makers of the residents were not notified of the results of the investigations immediately upon the completion. It was identified that the substitute decision-makers were not notified of the witnessed incidents of abuse. The licensee failed to ensure that the residents' substitute decision-makers are notified of the results on the investigation immediately upon the completion. [O.Reg. 79/10, s.97(2)]
2. Inspector reviewed the health care record of resident #0041. Inspector noted two incidents of sexual abuse towards another resident were documented as occurring. The inspector was unable to locate any documentation identifying the substitute decision-maker was notified of these incidents of sexual abuse. The Director of Care confirmed to the inspector that the substitute decision-maker was not notified of the witnessed sexual abuse. The licensee failed to ensure that the resident's substitute decision-maker is notified within 12 hours of the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of a resident. [O.Reg. 79/10, s.97(1)(b)]
3. Inspector reviewed a critical incident. Inspector noted the critical incident identifies witnessed resident to resident sexual abuse. Inspector noted that the critical incident report identifies the substitute decision-maker was not notified. Inspector spoke with the Director of Care who confirmed that the substitute decision-maker was not notified of the witnessed incident of sexual abuse. The licensee failed to ensure that the resident's substitute decision-maker are notified within 12 hours of the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of a resident. [O.Reg. 79/10, s.97(1)(b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring substitute decision-makers are notified as follows; (a) immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and (b) within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident and immediately upon the completion of the investigation, to be implemented voluntarily.

Issued on this 23rd day of July, 2012

Signature of Inspector(s)/Signature de l'Inspecteur ou des inspecteurs