Ministry of Health and Long-Term Care

Ottawa Service Area Office
Long-Term Care Inspections Branch
Long-Term Care Homes Division
347 Preston Street, 4th Floor, Suite 420
Ottawa ON K1S 3J4

Ministère de la Santé et des Soins de longue durée

Bureau régional de services d'Ottawa
Inspection de soins de longue durée
Division des foyers de soins de longue durée
347, rue Preston, 4iém étage, bureau 420
Ottawa ON K1S 3J4

Telephone/Téléphone: 613-569-5602
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Date: January 4, 2019

To: Administrator
The Four Seasons Lodge
President, Residents' Council
President, Family Council

Re: **Inspection #:** 2018_593573_0018
Report Date: December 20, 2018
Type of Inspection: Critical Incident

Enclosed is an *Inspection Report - Public Copy* for an inspection conducted under the *Long-Term Care Homes Act, 2007* (LTCHA) for the purpose of ensuring compliance with requirements under the LTCHA.

Individual envelopes addressed to the 'President, Residents' Council', and 'President, Family Council', must be distributed, unopened to the addressee.

This *Inspection Report – Public Copy* must be posted in the home, in a conspicuous and easily accessible location in accordance with the LTCHA, 2007, S.O. 2007, c.8, s.79 (1) and (2). A copy of the *Inspection Report-Public Copy* must be made available without charge upon request.

The report will also be on file with the Service Area Office, Long-Term Care Inspections Branch, and posted on the Long-Term Care Homes.net website

http://publicreporting.ltchomes.net/en-ca/default.aspx

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

Ottawa Service Area Office
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Public Copy/Copie 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
Dec 20, 2018	2018_593573_0018	009712-18, 011483-18, 016987-18	Critical Incident System

Licensee/Titulaire de permis

Deep River and District Hospital
117 Banting Drive DEEP RIVER ON K0J 1P0

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

The Four Seasons Lodge
117 Banting Drive DEEP RIVER ON K0J 1P0

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

ANANDRAJ NATARAJAN (573)

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): November 15, 16, 19, 20 and 21, 2018.

The Critical Incident System Log(s) #009712-18, 011483-18 and 016987-18 related to staff to resident alleged emotional and verbal abuse was inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Recreation Therapist (RT), Personal Support Workers (PSW), Food Service Workers (FSW), Housekeeping staff, and staffing clerk.

Inspector reviewed critical incident reports, documents related to the licensee's investigation into the identified alleged incidents of abuse, licensee's "Abuse and Neglect - Zero Tolerance and Mandatory Reporting" policy, resident health care record including care plans, assessments, progress notes and staff training records. In addition, inspector observed the provision of care and services to the resident and observed staff to resident interactions.

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)**
- **0 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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to protect resident #001, #002 and #004 from abuse by anyone.

In accordance with O.Reg. 79/10, section 2, emotional abuse means, any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

In accordance with O.Reg. 79/10, section 2, verbal abuse means, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

On an identified date in 2018, a Critical Incident Report (CIR) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to staff to resident alleged verbal and emotional abuse. The CIR indicated that the staff members reported concerns over PSW #101's conduct and interactions with the residents. Further, the CIR indicated that staff expressed concerns regarding the pattern of humiliating, threatening and demeaning comments made by PSW #101 to the residents.

On November 15, 2018, Inspector #573 reviewed the documents related to the licensee's investigation into the identified alleged incidents of abuse.
- On a specified date, FSW #102 reported allegation of PSW #101 to resident #001 emotional abuse that occurred during the breakfast meal service. Further, FSW #102 reported previous incident of an alleged PSW #101 to resident #004 verbal abuse.
- On a specified date, FSW #103 reported PSW #101's conduct and behaviour towards resident #004 during lunch meal service.
- On a specified date, the Administrator received letter from RT #104 reporting PSW #101 to resident #004 alleged emotional abuse that occurred a week ago.
- On a specified date, during the home's internal investigation, Housekeeping staff #105 reported previous incidents of PSW #101 to resident #002 and #004 alleged emotional and verbal abuse.

During an interview with Inspector #573, FSW #102 indicated that on a specified date, during meal services the FSW witnessed that PSW #101 was rude, while communicating with resident #001. The FSW indicated that PSW #101 comments made resident #001 worried and upset. FSW #102 stated that in the past during a meal service, the FSW observed PSW #101 was using profanity under their breath, referring to resident #004. The FSW confirmed with the inspector that they did not report the incident at that time to their supervisor.

During an interview with Inspector #573 on November 15, 2018, RT #104 indicated that on a specified date, during morning hours the RT witnessed that PSW #104 was rude to resident #004, forcing the resident to sit at the dining table. The RT stated that resident #004 was worried and upset with PSW #101's actions. The RT indicated that they felt PSW #101's actions were both emotional and verbally abusive towards the resident. RT #104 confirmed with the inspector that they did not report the incident at that time to their supervisor.

During an interview with Inspector #573 on November 15, 2018, Housekeeping staff #105 indicated that in the past, they had witnessed PSW #101 make comments to resident #002 that were in a demeaning tone and disrespectful towards the resident. Housekeeping staff #105 reported that PSW #101's comments and actions had caused increased agitation for resident #001. Housekeeping staff #105 confirmed with the inspector that they did not report any of the incident at that time to their supervisor.

FSW #101, RT #104 and Housekeeping staff #105 indicated awareness that they failed to follow the home's abuse prevention policy which requires that abuse of a resident is to be reported immediately to their supervisor and that it must also be reported immediately to the Ministry of Health and Long-Term Care.

On November 20, 2018, Inspector #573 spoke with the Administrator, who indicated that on a specified date, FSW #101 reported allegation of PSW #101 to residents' emotional and verbal abuse incidents. The Administrator indicated to the inspector that an investigation was initiated immediately and PSW #101 was placed on investigation leave. The Administrator stated that on a specified date, they received a letter from RT #104 reporting PSW #101 to resident #004 alleged emotional abuse that occurred a week ago. Further, during the home's internal investigation Housekeeping Staff #105 reported allegations of PSW #101 to residents' emotional and verbal abuse incidents that occurred in the past. The Administrator stated that the internal investigation confirmed that staff to resident emotional and verbal abuse occurred. The Administrator indicated to the inspector that following the incident, the executive leadership team meeting was held, mitigation strategies regarding staff education, policy review and incidents were evaluated.

During the interview on November 20, 2018, the Administrator indicated to Inspector #573 that on a specified date, the MOHLTCH Director, was notified through the CIR. The Administrator stated that there was no documents to support that MOHLTCH was notified

with the allegations immediately.

The Administrator stated to the inspector that they do not have any documents to support that the involved residents substitute decision maker (SDM) were notified upon becoming aware of alleged incidents of abuse. Further, no documents to support that resident's SDM were notified immediately of the results of the alleged abuse investigation upon the completion.

As demonstrated by this inspection report, the home failed to protect resident #001, #002 and #004 from abuse in that: staff members failed to immediately report all alleged, suspected or witnessed incidents of abuse and neglect of residents. As a result, the licensee failed to prevent the subsequent abuse of the residents. In addition, a report of the alleged abuse was not provided to the MOHLTCH Director immediately and notification was not provided to the resident's SDM(s), related to the alleged incidents of abuse nor the conclusions of the investigation results.

The licensee also failed to comply with:

1. LTCHA, s. 20 (1) the licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with. (refer to WN #2)

2. LTCHA, s. 24 (1) the licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone of a resident by the licensee or staff that resulted in harm or risk of harm to resident by not immediately reporting the suspicion and the information upon which it was based to the Director. (refer to WN #3)

3. O. Reg 79/10 s. 97 (1) (a) the licensee has failed to ensure that the resident's substitute decision maker, if any, and any other person specified by the resident are immediately notified upon becoming aware of alleged, suspected or witnessed incidents of abuse that resulted in physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well-being. (refer to WN #4)

4. O. Reg 79/10 s. 97 (2) the licensee has failed to 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. (refer to WN #4) (Log #011483-18/ 016987-18) [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Inspector #573 reviewed the licensee's policy titled Abuse and Neglect - Zero Tolerance and Mandatory Reporting, dated July 2017, Review Date May 15, 2018. The policy indicated that staff must immediately report all alleged, suspected or witnessed incidents of abuse and neglect of residents. On page three, bullet number one and two, under response to alleged abuse or neglect for the employees who witness or suspect alleged incident of resident abuse or neglect the policy indicated the following:

"1. Intervene, if safe to do so, or identify needed interventions to ensure resident/ employee safety and well being. Reassure resident and ensue that safety is maintained. Seek assistance from charge Nurse if needed.
2. Immediately report to the Manager of Nursing Services or Chief Nursing Officer."

Re: Log #011483-18

On an identified date in 2018, a Critical Incident Report (CIR) was submitted to the MOHLTC related to staff to resident alleged verbal and emotional abuse. The CIR indicated that staff members reported concerns over PSW #101's conduct and interactions with the residents. Further, the CIR indicated that staff expressed concerns regarding the pattern of humiliating, threatening and demeaning comments made by

PSW #101 to the residents.

During an interview with Inspector #573, FSW #102 indicated that on a specified date, during meal services the FSW witnessed that PSW #101 was rude, while communicating with resident #001. The FSW indicated that PSW #101 comments made resident #001 worried and upset. FSW #102 stated that in the past during a meal service, the FSW observed PSW #101 was using profanity under their breath, referring to resident #004. The FSW confirmed with the inspector that they did not report the incident at that time to their supervisor.

During an interview with Inspector #573 on November 15, 2018, RT #104 indicated that on a specified date and time, the RT witnessed that PSW #104 was rude to resident #004, forcing the resident to sit at the dining table. The RT stated that resident #004 was worried and upset with PSW #101's actions. The RT indicated that they felt PSW #101's actions were both emotional and verbally abusive towards the resident. RT #104 confirmed with the inspector that they did not report the incident at that time to their supervisor.

During an interview with Inspector #573 on November 15, 2018, Housekeeping staff #105 indicated that in the past, they had witnessed PSW #101 make comments to resident #002 that were in a demeaning tone and disrespectful towards the resident. Housekeeping staff #105 reported that PSW #101's comments and actions had caused increased agitation for resident #001. Housekeeping staff #105 confirmed with the inspector that they did not report any of the incident at that time to their supervisor.

Re: Log #016987-18

On a specified date and time, MOHLTCH info line - LTC homes after hours was contacted to report allegations of staff to resident #006 verbal abuse that occurred two days before. A CIR was submitted to MOHLTC, related to the incident. The CIR indicated that on a specified date, resident #006's SDM and family members reported concerns over PSW #106's conduct and interactions with resident #006.

During an interview with Inspector #573 on November 20, 2018, PSW #107 indicated on a specified date and time, the PSW had witnessed PSW #106's communications towards resident #006 were inappropriate and belittling nature. PSW #107 indicated that during the home's internal investigation on a specified date, they reported the incident to the

Director of Care. Further, PSW#107 confirmed with the inspector that they did not report the incident to their supervisor immediately.

During an interview with Inspector #573, FSW #101, RT #104, Housekeeping staff #105 and PSW #107 indicated awareness that they failed to follow the home's abuse prevention policy which requires that abuse of a resident is to be reported immediately to their supervisor and that it must also be reported immediately to the Ministry of Health and Long-Term Care.

During an interview with Inspector #573 on November 20, 2018, the Administrator stated to Inspector #573 that all staff members did not immediately report the alleged, suspected or witnessed incidents of abuse of residents as per the home's Abuse and Neglect - Zero Tolerance and Mandatory Reporting, policy. (Log #011483-18/ 016987-18) [s. 20. (1)]

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 ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

On an identified date in 2018, a CIR was submitted to the MOHLTC related to staff to resident alleged verbal and emotional abuse. The CIR indicated that staff members reported concerns over PSW #101's conduct and interactions with the residents. Further, the CIR indicated that staff expressed concerns regarding the pattern of humiliating, threatening and demeaning comments made by PSW #101 to the residents.

On November 20, 2018, Inspector #573 spoke with the Administrator, who indicated to Inspector #573 that a report of the alleged abuse incidents had not been reported immediately to the MOHLTCH Director until on a specified date, when the CIR was submitted.(Log #011483-18) [s. 24. (1)]

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:

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. The licensee has failed to ensure that the resident's SDM was notified immediately upon becoming aware of alleged, suspected or witnessed incidents of abuse that resulted in physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

On an identified date in 2018, a Critical Incident Report (CIR) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to staff to resident alleged verbal and emotional abuse. The CIR indicated that the staff members reported concerns over PSW #101's conduct and interactions with the residents. Further, the CIR indicated that staff expressed concerns regarding the pattern of humiliating, threatening and demeaning comments made by PSW #101 to the residents.

On November 15, 2018, Inspector #573 reviewed the documents related to the licensee's investigation into the identified alleged incidents of abuse.

- On a specified date, FSW #102 reported allegation of PSW #101 to resident #001 emotional abuse that occurred during the breakfast meal service. Further, FSW #102 reported previous incident of an alleged PSW #101 to resident #004 verbal abuse.
- On a specified date, FSW #103 reported PSW #101's conduct and behaviour towards resident #004 during lunch meal service.
- On a specified date, the Administrator received letter from RT #104 reporting PSW #101 to resident #004 alleged emotional abuse that occurred a week ago.
- On a specified date, during the home's internal investigation, Housekeeping staff #105 reported previous incidents of PSW #101 to resident #002 and #004 alleged emotional and verbal abuse.

On November 20, 2018, Inspector #573 spoke with the Administrator, who stated to the inspector that they do not have any documents to support that resident #001, #002 and #004's SDM(s) were notified upon becoming aware of alleged incidents of abuse. (Log #011483-18) [s. 97. (1) (a)]

2. The licensee failed to ensure that resident's Substitute Decision Maker (SDM) was immediately notified of the results of the alleged abuse investigation, upon the completion of the investigation.

Re: Log #011483-18

As cited in evidence above, on November 20, 2018, Inspector #573 spoke with the Administrator, who indicated to the inspector that an investigation was initiated immediately. The Administrator stated that the internal investigation confirmed that staff to resident emotional and verbal abuse occurred. The Administrator stated that on a specified date, the formal investigations was completed. Further, the Administrator indicated that the licensee failed to notify resident's SDM(s) of the outcome of the alleged abuse investigation.

Re: Log #016987-18

On a specified date and time, MOHLTCH info line - LTC homes after hours was contacted to report allegations of staff to resident #006 verbal abuse that occurred two days before. A CIR was submitted to MOHLTC, related to the incident. The CIR indicated that on a specified date, resident #006's SDM and family members reported concerns over PSW #106's conduct and interactions with resident #006.

On November 20, 2018, Inspector #573 spoke with the Administrator, who indicated to the inspector that on a specified date, the formal investigations was completed and the investigation results failed to verify that an abuse of resident #006 had occurred. Further, the Administrator stated that resident #006's SDM was contacted for the results of the investigations five days after the completion of the investigations. (Log #011483-18/ 016987-18) [s. 97. (2)]

Issued on this 2nd day of January, 2019

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

ANANDRAJ (ANDY) NATARAJAN

Original report signed by the inspector.

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ANANDRAJ NATARAJAN (573)
Inspection No. / No de l'inspection :	2018_593573_0018
Log No. / No de registre :	009712-18, 011483-18, 016987-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 20, 2018
Licensee / Titulaire de permis :	Deep River and District Hospital 117 Banting Drive, DEEP RIVER, ON, K0J-1P0
LTC Home / Foyer de SLD :	The Four Seasons Lodge 117 Banting Drive, DEEP RIVER, ON, K0J-1P0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Janna Hotson

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To Deep River and District Hospital, 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) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s.19 (1) of the act.

The licensee shall prepare, submit and implement a plan to ensure that all staff are educated on Zero Tolerance of Abuse and Neglect of residents. The licensee shall ensure that a documented record of the educational program is kept in the home that includes the date, subject heading, educational content and the staff name who has been educated.

At minimum, this education must include, but is not limited to:

- as defined by O. Reg 79/10, section 2 (1) (2) (3), definitions of abuse
- as outlined in LTCHA, section 24, mandatory reporting requirements
- as outlined in O. Reg 79/10, section 97 (1) (2) (3), person(s) who are to be notified when there is an alleged, suspected or witnessed incident of abuse or neglect of a resident.
- a review of the licensee's written policy related to "Abuse and Neglect - Zero Tolerance and Mandatory Reporting" .
- a review of the licensee's written policy and procedure related to "Whistle-blowing Protection".

Furthermore, the licensee shall ensure that there is a process for evaluating the learning acquired during the education session, and a process to identify the actions to be taken to address learning gaps.

Please submit the written plan for achieving compliance for 2018_593573_0018 to Anandraj (Andy) Natarajan, LTC Homes Inspector, MOHLTC, by email to OttawaSAO.MOH@ontario.ca by January 15, 2019. Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee failed to protect resident #001, #002 and #004 from abuse by anyone.

In accordance with O.Reg. 79/10, section 2, emotional abuse means, any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of

acknowledgement or infantilization that are performed by anyone other than a resident.

In accordance with O.Reg. 79/10, section 2, verbal abuse means, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

On an identified date in 2018, a Critical Incident Report (CIR) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to staff to resident alleged verbal and emotional abuse. The CIR indicated that the staff members reported concerns over PSW #101's conduct and interactions with the residents. Further, the CIR indicated that staff expressed concerns regarding the pattern of humiliating, threatening and demeaning comments made by PSW #101 to the residents.

On November 15, 2018, Inspector #573 reviewed the documents related to the licensee's investigation into the identified alleged incidents of abuse.

- On a specified date, FSW #102 reported allegation of PSW #101 to resident #001 emotional abuse that occurred during the breakfast meal service. Further, FSW #102 reported previous incident of an alleged PSW #101 to resident #004 verbal abuse.
- On a specified date, FSW #103 reported PSW #101's conduct and behaviour towards resident #004 during lunch meal service.
- On a specified date, the Administrator received letter from RT #104 reporting PSW #101 to resident #004 alleged emotional abuse that occurred a week ago.
- On a specified date, during the home's internal investigation, Housekeeping staff #105 reported previous incidents of PSW #101 to resident #002 and #004 alleged emotional and verbal abuse.

During an interview with Inspector #573, FSW #102 indicated that on a specified date, during meal services the FSW witnessed that PSW #101 was rude, while communicating with resident #001. The FSW indicated that PSW #101 comments made resident #001 worried and upset. FSW #102 stated that in the past during a meal service, the FSW observed PSW #101 was using profanity

under their breath, referring to resident #004. The FSW confirmed with the inspector that they did not report the incident at that time to their supervisor.

During an interview with Inspector #573 on November 15, 2018, RT #104 indicated that on a specified date, during morning hours the RT witnessed that PSW #104 was rude to resident #004, forcing the resident to sit at the dining table. The RT stated that resident #004 was worried and upset with PSW #101's actions. The RT indicated that they felt PSW #101's actions were both emotional and verbally abusive towards the resident. RT #104 confirmed with the inspector that they did not report the incident at that time to their supervisor.

During an interview with Inspector #573 on November 15, 2018, Housekeeping staff #105 indicated that in the past, they had witnessed PSW #101 make comments on resident #002 that were in a demeaning tone and disrespectful towards the resident. Housekeeping staff #105 reported that PSW #101's comments and actions had caused increased agitation for resident #001. Housekeeping staff #105 confirmed with the inspector that they did not report any of the incident at that time to their supervisor.

FSW #101, RT #104 and Housekeeping staff #105 indicated awareness that they failed to follow the home's abuse prevention policy which requires that abuse of a resident is to be reported immediately to their supervisor and that it must also be reported immediately to the Ministry of Health and Long-Term Care.

On November 20, 2018, Inspector #573 spoke with the Administrator, who indicated that on a specified date, FSW #101 reported allegation of PSW #101 to residents' emotional and verbal abuse incidents. The Administrator indicated to the inspector that an investigation was initiated immediately and PSW #101 was placed on investigation leave. The Administrator stated that on a specified date, they received a letter from RT #104 reporting PSW #101 to resident #004 alleged emotional abuse that occurred a week ago. Further, during the home's internal investigation Housekeeping Staff #105 reported allegations of PSW #101 to residents' emotional and verbal abuse incidents that occurred in the past. The Administrator stated that the internal investigation confirmed that staff to resident emotional and verbal abuse occurred. The Administrator indicated to the inspector that following the incident, the executive leadership team meeting

was held, mitigation strategies regarding staff education, policy review and incidents were evaluated.

During the interview on November 20, 2018, the Administrator indicated to Inspector #573 that on a specified date, the MOHLTCH Director, was notified through the CIR. The Administrator stated that there was no documents to support that MOHLTCH was notified with the allegations immediately.

The Administrator stated to the inspector that they do not have any documents to support that the involved residents substitute decision maker (SDM) were notified upon becoming aware of alleged incidents of abuse. Further, no documents to support that resident's SDM were notified immediately of the results of the alleged abuse investigation upon the completion.

As demonstrated by this inspection report, the home failed to protect resident #001, #002 and #004 from abuse in that: staff members failed to immediately report all alleged, suspected or witnessed incidents of abuse and neglect of residents. As a result, the licensee failed to prevent the subsequent abuse of the residents. In addition, a report of the alleged abuse was not provided to the MOHLTCH Director immediately and notification was not provided to the resident's SDM(s), related to the alleged incidents of abuse nor the conclusions of the investigation results.

The licensee also failed to comply with:

1. LTCHA, s. 20 (1) the licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with. (refer to WN #2)

2. LTCHA, s. 24 (1) the licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone of a resident by the licensee or staff that resulted in harm or risk of harm to resident by not immediately reporting the suspicion and the information upon which it was based to the Director. (refer to WN #3)

3. O. Reg 79/10 s. 97 (1) (a) the licensee has failed to ensure that the resident's substitute decision maker, if any, and any other person specified by the resident

are immediately notified upon becoming aware of alleged, suspected or witnessed incidents of abuse that resulted in physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well-being. (refer to WN #4)

4. O. Reg 79/10 s. 97 (2) the licensee has failed to 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. (refer to WN #4)

The severity of this issue was determined to be a level three as there was actual harm/ risk to the residents. The scope of the issue was a level two (Pattern) as it related to more than one resident reviewed. The home had a level two compliance history as they had previous non-compliance unrelated with this section of the Regulation.

A Compliance Order was issued based on the severity of actual harm/ risk to the residents.
(573)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 20, 2019

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
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

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 20th day of December, 2018

Signature of Inspector / Signature de l'inspecteur : Anandraj (Andy) Natarajan

Name of Inspector / Nom de l'inspecteur : Anandraj Natarajan

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