



SUBJECT: Zero Tolerance of Abuse and Neglect of Residents	POLICY #: HR-001-16
MANUAL: Administration and Nursing	PAGE: 1 of 6
SECTION:	REFERENCES: FLTCA, 2021
ORIGINAL ISSUE:	APPROV. AUTH:
PAST REVISIONS: Mar. 2022, Jan. 2024, Nov. 2024	RESPONSIBILITY: Administrator
CURRENT REVISION: March 4, 2025 May 2026	DISTRIBUTION: All Departments

PURPOSE: It is the requirement of the Fixing Long-Term Care Act, 2021, that there be a written policy in all Long-Term Care Homes regarding the Prevention of Abuse and Neglect for the purpose of promoting zero tolerance. This policy applies to all staff, contractors, students, volunteers, family members, visitors, board members, and individuals that are involved with the care of the resident and/or the safe operation of the home.

POLICY: All residents have the right to live in a home environment that treats them with dignity and respect, respect and is free from any form of abuse or neglect at all times, and in all circumstances. Valley Manor is committed to zero tolerance of abuse or neglect of its residents. Corrective action will be taken against anyone who abuses a resident or neglects a resident. This includes anyone who fails to immediately report alleged, suspected, or witnessed abuse once it becomes known that he/she has been withholding such information. Every resident has the right to freedom from abuse by anyone. Every resident has the right to freedom from neglect by the licensee and staff.

DEFINITION OF ABUSE AND NEGLECT

This policy uses the definition of “abuse” and “neglect” from the Fixing Long-Term Care Act, 2021, and its Regulations 246/22 - PART I 2. (1) and 7. These definitions are as follows:

“Emotional abuse” means,

- a) 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, or
- b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.

“Financial abuse” means any misappropriation or misuse of a resident’s money or property.

“Physical abuse” means,

- (a) the use of physical force by anyone other than a resident that causes physical injury or pain,
- (b) administering or withholding a drug for an inappropriate purpose, or
- (c) the use of physical force by a resident that causes physical injury to another resident.

“Sexual abuse” means,

- (a) any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or
- (b) 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.

“Verbal abuse” means,

- (a) 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, or
- (b) any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for their safety where the resident making the communication understands and appreciates its consequences.

“Neglect” means, the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

ACTIONS TO BE TAKEN TO PREVENT ABUSE

We are all responsible to prevent abuse and neglect by anyone within our home. To promote our ZERO TOLERANCE POLICY, we provide education to staff, residents, family members, board members, contractors, students, volunteers, and visitors.

Valley Manor shall ensure that screening measures are conducted in accordance with the Regulation before hiring a staff member, accepting a volunteer or permitting a person to be a member of the licensee’s board of directors, its board of management or committee of management or other governing structure. The screening measures shall include police record checks, unless the person being screened is under 18 years of age.

Where convicted of certain offences, etc. Every licensee of a long-term care home shall ensure that no staff member is hired and no volunteer accepted by the licensee if they have been convicted of an offence prescribed in the regulations; or found guilty of an act of professional misconduct prescribed in the regulations.

Raising awareness of the Zero Tolerance of Abuse and Neglect of Residents policy

among all staff and volunteers through our orientation program and ongoing annual education. This includes:

Residents Bill of Rights

Duty to report abuse and neglect

All managers demonstrate a commitment to our Zero Tolerance Policy and actively support staff, residents, and family who intervene and report an alleged or suspected incident of abuse and/or neglect while applying the Organization's Whistle Blower Policy.

Posting our Zero Tolerance policy in the home in locations within the home that are accessible to the public.

Reviewing our Zero Tolerance policy with Residents' Council and Family Council annually, and to staff, volunteers and Board Members at STEP AHEAD annual education.

Maintaining information regarding the number of complaints, investigations conducted, and actual cases of abuse on an ongoing basis.

Completing reviews of Critical Incidents of abuse to prevent recurrence and provide education as required regarding lessons learned.

Encouraging a Resident-Centered Care Approach and Creating Personalized Care Plans: Create care plans that are customized to meet each resident's unique needs, preferences, and abilities, ensuring they receive the right care while feeling valued and respected.

Respecting Autonomy: Encourage residents to make decisions about their own care whenever possible, helping them maintain a sense of control over their lives.

Observation and Interaction: Encourage meaningful interactions between staff and residents. Building strong, trusting relationships helps staff better understand the unique needs and concerns of each resident.

PROCEDURE:

1. The Licensee must investigate, respond and act.

As per subsection 27 (1) of the Fixing Long-term Care Act, 2021, (1) Every licensee of a long-term care home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:

(i) abuse of a resident by anyone,

(ii) neglect of a resident by the licensee or staff

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 Ministry of Long-Term Care:

- i. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
- ii. 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.
- iii. Unlawful conduct that resulted in harm or a risk of harm to a resident.
- iv. Misuse or misappropriation of a resident's money.
- v. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

2. When a mandatory reporting incident occurs, it must be reported immediately to the Administrator or Director of Care/Designate. Staff should begin documentation as soon as possible to include time, circumstances, witnesses, etc. The Guidelines for RNs to utilize during an investigation must be followed and the Investigation Templates must be completed and given to the Administrator, or Director of Care/Designate.

3. The Administrator or designate will be responsible for notifying the Ministry of Long-Term Care according to the timeframe requirements if during regular work hours (Monday to Friday) – see Appendix A (Abuse & Neglect).

If the incident occurs after regular business hours, including statutory holidays, the Nurse in Charge will be designated to call as per Appendix A. He/she will still report the incident to the Administrator or Director of Care/Designate who will follow up with the written report.

4. Licensees who report investigations under s. 27 (1) of Act 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:

- a. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
- b. 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.
- c. 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.

d. Analysis and follow-up action, including,

- i. the immediate actions that have been taken to prevent recurrence, and
- ii. the long-term actions planned to correct the situation and prevent recurrence.

5. 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.

6. 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 27 (1) of the Act, immediately upon the completion of the investigation.

7. Police notification - Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

8. The name and title of the person making the report to the Director (Ministry of Long-Term Care), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.

9. The Director of Care will report abuse of a resident by a nurse to the College of Nurses of Ontario.

EVALUATION

Every licensee of a long-term care home shall ensure,

(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;

(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.

(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation.

(d) that the changes and improvements under clause (b) are promptly implemented; and

(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared.

Valley Manor contact information: CEO 613-756-2643 ext. 224

MON – FRI 9:30 AM – 5:30 PM

Ministry of Long-Term Care Tel: 416-327-4327.

Toll-free: 1-800-268-1153

After hours: 1-888-999-6973