Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 8, 2015	2015_328571_0009	O-002472-15	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

BAY RIDGES
900 SANDY BEACH ROAD PICKERING ON L1W 1Z4

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

PATRICIA MATA (571)

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): September 21 and 22, 2015

Enter any additional information..

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Associate Director of Care, recreation staff, Registered Nurses, Registered Practical Nurses, Personal Support Workers and residents. In addition, clinical records, the home's Abuse policy, observed the locations of residents rooms and units.

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

During the course of this inspection, Non-Compliances were issued.
- **5 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	Legendé 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. For the purpose of the definition of "abuse" in subsection 2(1) of the Act, "sexual abuse" means (a) subject to subsection (3), 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. O. Reg. 79/10 s. 2(1).

A CI (Critical Incident) involving non-consensual touching of Resident #1 by Resident #2 was submitted. Resident #2 was observed hugging resident #1. The licensee reported the incident to the police, no charges were laid. Hourly checks on both residents were initiated. The plan of care for resident #2 was updated to direct staff to redirect resident #2 if found in resident #1's room and resident #2 was instructed not to touch resident #1 or go into his/her room. Resident #1's care plan was updated to instruct staff to encourage resident #1 to stay in the common areas during awake hours. The licensee reported the incident to the Director three days late and failed to investigate the incident.

Another CI was submitted on a later date. Resident #2 was observed embracing Resident #1. Resident #1 reported that the embrace was not welcomed and resident #1 felt uncomfortable. The licensee reported this incident immediately to the Director and to the police. Resident #2 was not charged by the Police. The licensee moved resident #1 to another home area. The licensee failed to investigate this incident.

A review of the clinical record further revealed that non-consensual touching of a sexual nature was suspected or actually occurred while resident #1 was living on the same resident home area as resident #2 on three more dates:
-resident #2 was observed in resident #1's room attempting to embrace him/her
-resident #1 claims that a person entered his/her room through the night, and was told to remove clothing and pulled his/her hair-this incident was not investigated to determine if the incident actually occurred or the identity of the person
-resident #2 was observed hugging and kissing resident #1; resident #1 did not like to be touched by resident #2 nor enter resident #1's room as it is frightening and resident #1 just wants to find a safe place to live.

In an interview with the Executive Director and the Director of Care, they indicated investigation notes did not exist for any of the noted incidents.

At the time of the first incident, resident #1 lived across the hall from resident #2. In order to prevent resident #2 from sexually abusing resident #1 after the first incident, the licensee moved resident #1 to another room on the same home area. After resident #1 was again sexually abused by resident #2, resident #1 was moved a second time to a

non-resident room , on another home area. Resident #1 remained in the non-resident room for an undetermined amount of days while a permanent room on the same home area was being cleaned and prepared. Resident #1 was move a fourth time to another home area at the request of resident #1's power of attorney. After resident #1 moved off his/her original home area, the hourly checks were stopped for both residents, the interventions to prevent sexual abuse of resident #1 by resident #2 were removed from resident #2's care plan.

Interviews with the following staff indicated that resident #2 continues to seek out resident #1 after resident #1 moved to his/her present home area:
-recreation staff # 100 indicated that at medium to large group functions, resident #2 will start by talking to resident #1, then resident #2 will sit beside resident #1 with his/her hand on resident #1's leg-they are not always separated as resident #2 can become verbally aggressive and staff want to avoid confrontation-staff #100 has also seen resident #2 look for resident #1
-RN #102 indicated that they had seen resident #2 on resident #1's present home area since resident #1 has moved there
-Psw #105 indicated that they saw resident #2 hug resident #1 approximately one month ago-staff #105 states they separated the residents and reported the incident to Rpn #115-Rpn #115 does not recall staff #105 reporting this incident, Psw #105 did not report this incident to the Director
-the Director of Care and Associate Director of Care indicated that sometimes resident #2 sits in a common area near where resident #1 now lives-the Executive Director indicated that resident #1 also sits in the same common area- therefore, resident #1 and resident #2 could both be in the same area at the same time which would put resident #1 at risk for sexual abuse by resident #2

In interviews the following staff from resident #1's present home area stated that they were not told about the potential risk of sexual abuse of resident #1 by resident #2. Nor is it specified in resident #1 or 2's current plan of care:
-Psws #104, 106, 107, 108 were not informed
-Psw #111 heard about it through the "grape vine"
-RN #112 heard it from resident #1's POA

Psws #109, 110 and 113 who work on the home area where resident #1 originally lived indicated that since the initial sexual assault on resident #1 by resident #2, resident #1 barricaded his/her bedroom door with chairs and a walker and would not open the door until a staff member had identified themselves.

Psws #104, #106, #107, and #108 indicated in interviews that since resident #1 moved to his/her present home area, he/she continues to barricade the bedroom door with chairs and a walker and will not open the door until staff identify themselves.

In conclusion, evidence gathered during this inspection shows the licensee failed to :
-immediately report the incident of sexual abuse on three dates to the Director. WN #4 (s.24)
-immediately investigate all allegations of sexual abuse. WN #3 (s.23)
-report incidents of documented sexual abuse on two specified dates and the alleged sexual abuse on a specified date to the Director. WN #4 (s.24)
-take actions to protect resident #1 from potential sexual abuse after resident #1 moved to a specified home area. WN #5 (s.55)
-ensure staff comply with their Abuse policy "LP-B-20". WN #2 (s.20)

During this critical incident inspection of resident to resident sexual abuse, actual harm and or risk of harm was demonstrated as resident #1 who is a vulnerable resident was subjected to sexual abuse by resident #2 on several occasions. These incidents occurred over a time period over several months and resident #1 continues to be at risk despite four room changes. Direct care staff and management have not complied with several sections of the LTCHA, 2007 and O. Reg 79/10 and in doing so have not protected resident #1 from actual and potential sexual abuse by resident #2. [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 their written policy that promotes zero tolerance of abuse of residents is complied with.

A review of the licensee's Policy LP-B-20-ON entitled Resident Non-Abuse defines sexual abuse. The definition includes that any non-consensual touching , behaviour or remarks of a sexual nature is abuse and can include unwanted touching or molestation that is sexual in nature; sexual assault and sexual harassment.

To summarize Policy LP-B-20 directs the following:
-any staff member or person , who becomes aware of and/or has reasonable grounds to suspect abuse of a Resident must immediately report that suspicion and the information on which it is based to the Executive Director (ED) or the Home or, if unavailable, to the most senior Supervisor on shift at that time.
-any person must also make a report to the Director
-an immediate an thorough investigation of the reported alleged, suspected or witnessed abuse or neglect will be initiated by the Homes ED or designate
-all direct care staff will be advised at the beginning of every shift, of each Resident whose behaviours require heightened monitoring because those behaviours pose a potential risk to the Resident and others in the home
-each home ensure 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

A review of the clinical records indicate that non-consensual touching or alleged sexual abuse occurred towards Resident #1 on five specified dates.
The incidents occurring on two specified dates were not reported to the Director as per the licensee's Abuse policy despite being documented by registered staff.

The ED and Director of Care (DOC) indicated in interviews that they were unaware of the incidents occurring two specified dates. They were unable to provide investigation notes or analysis for the any of the incidents on five specified dates.

In addition staff were not reporting incidents to the ED or managers. The Director of Care (DOC) and Associate Director of Care(ADOC) indicated they were not aware of the incident occurring on two specified dates. Nor were they aware that resident #2 continues to seek resident #1 out. The ED indicated she was not aware that resident #2 continues to seek out resident #1.

In interviews the following staff that work on the unit that resident #1 currently resides indicated that they were not told about the potential risk of sexual abuse of resident #1 by resident #2; nor is it specified in resident #1's plan of care:
-Psws #104, 106, 107, 108 were not told
-Psw #111 heard about it through the "grape vine"
-RN #112 heard it from resident #1's POA

To summarize, the licensee failed to ensure that staff complied with their Abuse policy, specifically staff failed to: report all allegations of sexual abuse to the Director; report all allegations of alleged sexual abuse to the Executive Director or supervisor; investigate all allegations of sexual abuse; analyze every incident of sexual abuse; and inform all direct care staff of risk of sexual abuse of resident #1 by resident #2. [s. 20. (1)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of sexual abuse of Resident #1 that the licensee knows of, or that is reported is immediately investigated.

A review of the clinical records indicates the following incidents on separate dates:
-Resident #2 was observed hugging Resident #1 and after being separated by Staff , Resident #1 indicated Resident #2's advances were unwelcome.
-Resident #2 was seen in Resident #1's room attempting to embrace him/her.
-Resident #1 reported to staff that a person had entered his/her room through the night ,told them to take off his/her clothes and pulled his/her hair.
-Resident #2 was observed hugging and kissing Resident #1.
-Resident #2 and Resident #1 were observed in an embrace. When questioned, Resident #1 indicated that he/she did not like Resident #2's embrace or like him/her entering resident #1's room as it scared resident #1 and he/she wants to live in a safe place.

The ED or DOC were unable to provide evidence that the allegations of sexual abuse were reported by registered staff to the ED, and Director on three specified dates. In addition, the ED was unable to provide evidence of investigations being completed for all incidents. [s. 23. (1) (a)]

WN #4: 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 report was immediately made to the Director when staff had reasonable grounds to suspect sexual abuse of Resident #1 by Resident #2.

Resident #1 has a power of attorney in charge of care and is incapable of consenting to sexual advances. Resident #2 is capable of consent.

A CI was submitted involving sexual abuse of Resident #1 by Resident #2. Resident #2 was observed hugging resident #1. The sexual abuse was not reported immediately to the Director as required by the LTCHA 2007, but rather three days later.

A review of the clinical record further revealed three more dates that non-consensual touching of a sexual nature also occurred while resident #1 was living on the same resident home area as resident #2:
-resident #2 was observed in resident #1's room attempting embrace him/her
-resident #1 claims that a person entered his/her room through the night, and was told to remove clothing and pulled resident #1's hair
-resident #2 was observed hugging and kissing resident #1; resident #1 did not like resident #2 touching him/her or going into his/her room as it was scary and resident #1 just wanted to find a safe place to live.

None of these incidents of sexual abuse were reported to the Director. [s. 24. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that procedures and interventions were developed and implemented to assist Resident #1 who was at risk for sexual advances by Resident #2.

At the time of the first incident, resident #1 lived across the hall from resident #2. In order to prevent resident #2 from sexually abusing resident #1 after the incident, the licensee moved resident #1 to another room on the same home unit. After resident #1 was again sexually abused by resident #2, resident #1 was moved a second time to a non-resident room , on another unit. Resident #1 remained in the non-resident room for an undetermined amount of days while a permanent room on the same unit was being cleaned and prepared. From that home area, resident #1 was move a fourth time to the home area where he/she know lives at the request of resident #1's power of attorney. After resident #1 moved off the first home area, the hourly checks were stopped for both residents, the interventions to prevent sexual abuse of resident #1 by resident #2 were removed from resident #2's care plan.

Interviews with the following staff indicated that resident #1 continues to be at risk of sexual abuse from resident #2 despite resident #1 being moved to their present home area and that resident #2 continues to seek out resident #1:
-recreation staff #100 indicated that at medium to large group functions, resident #2 will start by talking to resident #1, then resident #2 will sit beside resident #1 with his/her hand on his/her leg-they are not always separated as resident #2 can become verbally aggressive and staff want to avoid confrontation-staff #100 has also seen resident #2 look for resident #1
-RN #102 indicated that they have seen resident #2 on resident #1's present home unit since the move
-Psw #104 indicated that they saw resident #2 on a approximately two months ago after resident #1 had moved to the unit
-Psw #105 indicated that he/she saw resident #2 hug resident #1 approximately one month ago-staff #105 states the incident was reported to the nurse but no documentation can be found to support this
-the Director of Care and Associate Director of Care indicated that sometimes resident #2 sits in a common area
-the Executive Director indicated that resident #1 also sits in the same area and that office staff monitor resident #1; however, the front reception desk was observed vacant

on four occasions.

A review of resident #1's current plan of care directs staff to encourage resident #1 to stay in the common areas on the home area during waking hours as resident #1 will stay in his/her room or the same common area as resident #2. This intervention is to prevent anxiety or sadness due to unwanted embraces from an unnamed co-resident.

A review of resident #2's current plan of care does not have any mention of the potential of sexual abuse towards resident #1. [s. 55. (a)]

2. The licensee failed to ensure that all direct care staff are advised at the beginning of every shift to ensure that resident #1 is safe from potential sexual abuse by resident #2.

In interviews the following staff that work on the unit that resident #1 currently resides indicated that they were not told about the potential risk of sexual abuse of resident #1 by resident #2. Nor is it specified in resident #1's plan of care:
-Psws #104, 106, 107, 108 were not informed
-Psw #111 heard about it through the "grape vine"
-RN #112 heard it from resident #1's POA [s. 55. (b)]

Issued on this 15th day of October, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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) :	PATRICIA MATA (571)
Inspection No. / No de l'inspection :	2015_328571_0009
Log No. / Registre no:	O-002472-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 8, 2015
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	BAY RIDGES 900 SANDY BEACH ROAD, PICKERING, ON, L1W-1Z4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Andrea DeLuca

To REVERA LONG TERM CARE INC., 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 shall to prepare, implement and submit a corrective action plan to ensure that the following measures are in place so that residents are protected from abuse by anyone.

-ensuring all allegations of abuse involving residents are to be reported immediately to the Director.
-re-education and ensuring compliance of all staff related to the licensee's Policy on Abuse "LP-B-20". Specifically focusing on what constitutes sexual abuse and the definition of sexual abuse.
-ensuring that all allegations of abuse are immediately investigated and that actions are taken to ensure resident safety.
-ensuring that procedures and interventions are developed and implemented to assist residents who are at risk of harm or who are harmed as a result of a resident's behaviours and to minimize the risk of altercations and potentially harmful interactions between and among residents.
-ensuring all direct care staff are advised at the beginning of every shift of each resident whose behaviours , including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others.

The licensee will provide a written plan by October 26, 2015. This plan must be submitted in writing to the MOHLTC, Attention: Patti Mata, Fax (613) 569-9670.

While this plan is being prepared, the licensee shall immediately devise a plan to manage the behaviours of resident #2 and ensure that resident #1 and any other female residents are protected from sexual abuse by resident #2.

Grounds / Motifs :

1. For the purpose of the definition of "abuse" in subsection 2(1) of the Act, "sexual abuse" means (a) subject to subsection (3), 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. O. Reg. 79/10 s. 2(1).

A CI (Critical Incident) was submitted involving non-consensual touching of resident #1 by resident #2. Resident #2 was observed hugging resident #1 in his/her room. The licensee reported the incident to the police, no charges were laid. Hourly checks on both residents were initiated. The plan of care for resident #2 was updated to direct staff to redirect resident #2 if found in resident #1's room and resident #2 was instructed not to touch resident #1 or go into his/her room. Resident #1's care plan was updated to instruct staff to encourage resident #1 to stay in the common areas during awake hours. The licensee reported the incident to the Director three days late and failed to investigate the incident.

Another CI was submitted on a later date. Resident #2 was observed embracing Resident #1. Resident #1 reported that the embrace was not welcomed and he/she felt uncomfortable. The licensee reported this incident immediately to the Director and to the police. Resident #2 was not charged by the Police. The licensee moved resident #1 to another home area. The licensee failed to investigate this incident.

In addition, a review of the clinical record further revealed that non-consensual touching of a sexual nature was suspected or actually occurred while resident #1 was living on the same resident home area as resident #2 on three other dates:
-resident #2 was observed in resident #1's room attempting to embrace him/her
-resident #1 claims that someone entered his/her room through the night and instructed the removal of resident #1's clothing and pulled the resident's hair-this incident was not investigated to determine if the incident actually occurred or the identity of the person
-resident #2 was observed hugging and kissing resident #1; resident #1 indicated he/she did not like to be touched or visited by resident #2 as this

scares resident #1 and he/she just wants to find a safe place to live.

In an interview with the Executive Director and the Director of Care, they indicated investigation notes did not exist for any of the noted incidents.

At the time of the first incident, resident #1 lived across the hall from resident #2. In order to prevent resident #2 from sexually abusing resident #1 after this incident, the licensee moved resident #1 to a different room on the same home area. After resident #1 was again sexually abused by resident #2, resident #1 was moved a second time to a non-resident room, on a different home area. Resident #1 remained in the non-resident room for an undetermined amount of days while a permanent room on the same home area was being cleaned and prepared. From there, resident #1 was moved a fourth time to a different room on another home area, at the request of resident #1's power of attorney. After resident #1 moved off of the first home area, the hourly checks were stopped for both residents, the interventions to prevent sexual abuse of resident #1 by resident #2 were removed from resident #2's care plan.

Interviews with the following staff indicated that resident #2 continues to seek out resident #1 after the move to resident #1's present home area:
-recreation staff # 100 indicated that at medium to large group functions, resident #2 will start by talking to resident #1, then resident #2 will sit beside resident #1 with his/her hand on resident #1's leg-they are not always separated as resident #2 can become verbally aggressive and staff want to avoid confrontation-staff #100 has also seen resident #2 look for resident #1
-RN #102 indicated that they have seen resident #2 on resident #1's unit since the move
-Psw #105 indicated that they saw resident #2 hug resident #1 approximately one month ago
-staff #105 states they separated the residents and reported the incident to Rpn #115 -Rpn #115 does not recall staff #105 reporting this incident, Psw #105 did not report this incident to the Director
-the Director of Care and Associate Director of Care indicated that sometimes resident #2 sits in a common area near where resident #1 now lives-the Executive Director indicated that resident #1 also sits in the same common area-therefore, resident #1 and resident #2 could both be in same area at the same time which would put resident #1 at risk for sexual abuse by resident #2

In interviews the following staff from the unit where resident #1 currently lives

stated that they were not told about the potential risk of sexual abuse of resident #1 by resident #2. Nor is it specified in resident #1 or 2's current plan of care:
-Psws #104, 106, 107, 108 were not informed
-Psw #111 heard about it through the "grape vine"
-RN #112 heard it from resident #1's POA

Psws #109, 110 and 113 who work on the unit where resident #1 originally lived indicated that since the initial sexual assault on resident #1 by resident #2, resident #1 barricaded their bedroom door with chairs and walker and would not open the door until a staff member had identified themselves.

Psws #104, #106, #107, and #108 indicated in interviews that since resident #1 moved to his/her present unit, resident #1 continues to barricade the bedroom door with chairs and walker and will not open the door until staff identify themselves.

In conclusion, evidence gathered during this inspection shows the licensee failed to :
-immediately report the incident of sexual abuse on a specified date to the Director. WN #4 (s.24)
-immediately investigate all allegations of sexual abuse. WN #3 (s.23)
-report incidents of documented sexual abuse on two specified dates and the alleged sexual abuse on a specified date to the Director. WN #4 (s.24)
-take actions to protect resident #1 from potential sexual abuse after resident #1 moved to a specified resident home area. WN #5 (s.55)
-ensure staff comply with their Abuse policy "LP-B-20". WN #2 (s.20)

During this critical incident inspection of resident to resident sexual abuse, actual harm and or risk of harm was demonstrated as resident #1 who is vulnerable was subjected to sexual abuse by resident #2 on several occasions. These incidents occurred over a time period over several months and resident #1 continues to be at risk despite four room changes. Direct care staff and management have not complied with several sections of the LTCHA, 2007 and O. Reg 79/10 and in doing so have not protected resident #1 from actual and potential sexual abuse by resident #2.

(571)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2015

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 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
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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 8th day of October, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Patricia Mata

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