Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 8, 2021	2020_778563_0036	023280-20	Complaint

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue Woodstock ON N4S 3V9

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

Caressant Care Woodstock Nursing Home
81 Fyfe Avenue Woodstock ON N4S 8Y2

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

MELANIE NORTHEY (563), AMIE GIBBS-WARD (630)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December, 2, 3, 4 7, 8, 9 and 10, 2020

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, Resident Care Coordinators, Registered Social Worker, London Health Sciences Centre (LHSC) Ethicist, Registered Nursing Staff, Behavioural Supports Ontario Personal Support Worker (PSW), PSWs, and residents.

The inspector(s) also made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed.

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.
- **6 WN(s)**
- **1 VPC(s)**
- **5 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for a resident that set out their planned care and provided clear directions to staff regarding their behaviours.

A Personal Support Worker (PSW) reported to the Registered Practical Nurse (RPN) that two residents were exhibiting sexual behaviours. The note indicated that the RPN directed the PSW staff to intervene when the residents were in a public place and provide privacy. There were additional documented incidents of sexual activities between one resident and other residents over a number of months.

The plan of care for the resident included no direction for staff regarding the resident's specific sexual behaviours until after the first incident, when the focus related to a problematic manner was created. This focus specified the resident was sexually expressive to multiple other residents in a specific way. The interventions included that staff were to remove the resident when the behaviour was disruptive/unacceptable, however there was no direction regarding which behaviours were to be considered disruptive/unacceptable. When asked about the interventions for the resident’s interactions with other residents, the staff and management said they thought the resident was consenting in the moment to these activities with other residents as they were not resisting them and liked the company of these other residents. Interviews and documentation indicated that staff would intervene when the sexual activities were occurring in a public place and would provide the residents privacy. The resident's capacity to provide consent to these activities with other residents as well as directions for staff regarding their role in determining consent was not addressed in the resident’s written plan of care. The written plan of care also did not provide direction for staff regarding interventions to ensure the resident’s safety related to their activities or behaviours in private locations with other residents. The lack of clear direction in the plan of care placed the resident at risk for harm related to resident to resident sexual abuse.

Sources: Care plan and other clinical records for the resident; interview with the Resident Care Coordinator (RCC) and other staff. [s. 6. (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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to protect a resident from sexual abuse.

Section 2 (1) of the Ontario Regulation 79/10 defines sexual abuse as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

A resident had long-standing difficulties communicating and making decisions due to dementia and a language barrier. It was identified in an assessment and the care plan that the resident was rarely to never understanding what was being said to them. The resident had multiple specific responsive behaviours. Staff reported the resident was known to engage in sexual activities with other residents in the home and that they were not sure how much the resident was able to understand these activities. Staff and management said they thought the resident was "consenting in the moment" to the sexual activities as they were not resisting them and liked the company of these other residents.

Clinical records included progress notes which described five separate incidents of sexual touching involving the resident and other residents in the home.

The staff and leadership team in the home did not demonstrate through interviews and documentation that they had an understanding of the resident's cognitive capacity to provide consent to the touching of a sexual nature for any of these incidents. The home did not have a clear process for assessing and documenting the assessment of the

resident‘s cognitive ability to consent. The staff and leadership in the home also did not clearly demonstrate that the resident consented to this touching of a sexual nature or that there was a clear understanding of what had occurred between the two residents prior to the staff discovering the residents engaged in the activities of a sexual nature. It was unclear as to whether the incidents documented in the progress notes were reported to the leadership team and there was no documented record of an investigation. The effects of the incidents on the resident’s well-being were unknown as this was not fully assessed or documented by the staff in the home.

The resident’s cognitive deficit, sexually expressive behaviours, other responsive behaviours and communication difficulties placed them at risk for sexual exploitation by other residents. After the initial documented incident, the home failed to clearly demonstrate that they had protected the resident from the subsequent sexual touching.

Sources: Progress notes and other clinical records for three residents, interviews with the Resident Care Coordinator (RCC) and other staff. (630)

2. The licensee has failed to protect another resident from sexual abuse.

A Critical Incident Report was submitted to the Ministry of Long-Term Care (MLTC) related to ongoing sexual responsive behaviours between two specific residents. There was also a MLTC anonymous complaint reporting non-consensual sexual touching and behaviours directed at the resident by another resident.

Clinical records included progress notes which described multiple separate incidents of sexual touching involving two specific residents in the home.

A care plan intervention was added to identify that a consensual relationship had been initiated for both residents. This was the same day the CIS Report was submitted related to the MLTC for alleged resident to resident sexual abuse. In interviews with the staff, they expressed their confusion with the term “consensual relationship” as there were times when the resident did not consent to sexual touching and behaviour expressed by the other resident. Staff reported there were times when the resident was more confused. The requirements for consent include that consent must be free, informed and voluntary and consent may be withdrawn during the touching, behaviour or remarks. The resident’s ability to provide consent (or inability to provide consent) about other activities should not be determinative of the resident’s ability to provide consent in relation to sexual touching or behaviour or remarks. The resident may have consented to going to the other

resident's room, but there was no documented evidence that the resident was informed of what was going to happen in the other resident's room. At these times, staff would provide privacy. The resident was at risk of potential sexual abuse and sexual exploitation by the other resident. A resident cannot give blanket consent or pre-consent to ongoing sexual activity.

The staff and leadership team in the home did not demonstrate through interviews and documentation that they had an understanding of the resident’s cognitive capacity to provide consent to the touching of a sexual nature for any of the multiple incidents over multiple months. The home did not have a clear process for assessing and documenting the assessment of the resident‘s cognitive ability to consent. The staff and leadership in the home also did not clearly demonstrate that the resident consented to this touching of a sexual nature or that there was a clear understanding of what had occurred between the two residents prior to the staff discovering the residents engaged in the activities of a sexual nature. It was unclear as to whether the incidents documented in the progress notes were reported to the leadership team and there was no documented record of an investigation. Multiple incidents were not documented as part of both residents clinical records and family was not documented as notified. The effects of the incidents on the resident’s well-being were unknown at times as this was not fully supervised, assessed or documented by the staff in the home. Other times, the resident was documented as crying, stating no and repeatedly removing the other resident's hand from their body. Staff reported the resident looked scared and cried at times in the other resident's company.

Between the initial encounter between the two specific residents and when the resident was transferred to another home care area, the Follow Up Question Report for the resident detailed 19 documented entries by PSWs related to signs of sad, pained, worried facial expressions. The Follow Up Question Report detailed 62 documented entries by PSWs related to signs of socially inappropriate/disruptive behaviour for the other resident.

The resident’s dementia, short and long term memory problems, their severely impaired cognitive skills for daily decision making, the resident’s varied mental function over the course of the day, and unclear speech placed them at risk for sexual exploitation by other residents. The resident was assessed and the assessment identified that the resident’s cognitive status and ability to express and understand information had deteriorated. After the initially documented incident, the home failed to clearly demonstrate that they had protected the resident from the subsequent sexual touching involving the other resident.

Sources: Progress notes, Follow Up Question Report and other clinical records for two residents; interviews with the residents, and interviews with the Ethicist, physician, leadership staff and other nursing staff in the home. [s. 19. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 in place in the home to promote zero tolerance of abuse and neglect of residents, was complied with for residents.

Clinical records described multiple incidents where two residents were found involved in activities of a sexual nature. Staff who witnessed the incidents did not immediately report this to the management of the home as an alleged resident to resident sexual abuse in accordance with the home's policy.

The staff and leadership team in the home did not demonstrate through interviews and documentation that they had an understanding whether or not the residents had the capacity to provide consent to these incidents of touching and behaviour of a sexual nature. The home did not have a clear process for assessing and documenting the assessment of the residents cognitive ability to consent. The staff and leadership in the home also did not clearly demonstrate that the residents consented to this touching and behaviour of a sexual nature.

The Director of Care (DOC) said they thought all of these incidents would have been investigated or assessed by someone in the home as sexual expressions or behaviours but were not brought forward by staff as allegations of resident to resident sexual abuse. The Executive Director (ED) said they thought the concern was more about the location of one of the incidents, as it had taken place in a public area with other residents present, versus a concern that this needed to be investigated as an incident of resident to resident sexual abuse.

There was no documented evidence to demonstrate that the home's policy had been complied with for each of these incidents in the following areas: immediate investigation; interviews with the residents to determine the cause of the behaviours; evaluation of the events preceding the incident; completion of an "Internal Incident Report Form" and notification of the family. The staff and leadership team's failure to comply with the home's policy placed the resident at risk of harm related to sexual exploitation or abuse by other residents in the home.

Sources: Progress notes and other clinical records for two residents; the home's "Abuse and Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff Policy effective August 2018; interviews with the DOC and other staff. [s. 20. (1)].

2. The licensee has failed to ensure that the written policy in place in the home to promote zero tolerance of abuse and neglect of residents, was complied with for another resident.

Clinical records for two specific residents described multiple incidents of touching, behaviour or remarks of a sexual nature which occurred over several months. According to leadership in the home, staff who witnessed the incidents did not immediately report these to the management of the home as alleged resident to resident sexual abuse in accordance with the home's policy.

The staff and leadership team in the home did not demonstrate through interviews and documentation that they had an understanding whether or not the resident had the capacity to provide consent to the touching and behaviour of a sexual nature that occurred over four months. The home did not have a clear process for assessing and documenting the assessment of the resident's cognitive ability to consent. The staff and leadership team in the home did not demonstrate through interviews and documentation that there was a clear understanding of the events leading up to or what had occurred

between the two residents prior to the staff discovering the residents engaged in an activity of a sexual nature. At times when the resident did not consent to the other resident's request for sexual activities, the other resident continued to persist (touching, asking, gesturing) which then upset the resident. The leadership indicated that the resident had "consented in the moment" and this was known because the resident did not show distress or would say "yes" when the staff asked or found the resident with the other resident. However, there was unclear evidence that the resident's consent in the moment had been fully observed by staff when the two residents were left alone unsupervised. The leadership in the home said the incidents documented in the progress notes were reported to the leadership team as an incident of sexual expressions and were investigated, however there was no documented record of that investigation or the results of the investigation.

The Director of Care (DOC) said they thought all of these incidents would have been investigated or assessed by someone in the home as sexual expressions or behaviours but were not brought forward by staff as allegations of resident to resident sexual abuse. There was no documented evidence to demonstrate that the home's policy had been complied with for each of these incidents in the following areas: immediate investigation; interviews with the residents to determine the cause of the behaviours; evaluation of the events preceding the incident; completion of an "Internal Incident Report Form" and notification of the family. The staff and leadership team's failure to comply with the home's policy placed the resident at risk of harm related to non-consensual touching, behaviour or remarks of a sexual nature.

Sources: Progress notes and other clinical records for both residents; the home's Abuse and Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff Policy effective August 2018; interviews with the residents, the DOC and other staff. [s. 20. (1)] (563)

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 person who had reasonable grounds to suspect sexual abuse of a resident by anyone, immediately reported the suspicion and the information upon which it was based to the Director.

Clinical records for multiple residents described incidents of touching of a sexual nature between these residents which occurred over the course of several months. Staff who witnessed these incidents did not immediately report this to the management of the home as alleged resident to resident sexual abuse in accordance with the home's policy. These were not reported to the Ministry of Long-Term Care (MLTC) by staff or management as suspected sexual abuse.

Staff and leadership in the home said their understanding of resident to resident abuse was unwanted or non-consensual sexual touching. Staff and the leadership in the home expressed that they thought that residents with significant cognitive impairment could consent to sexual touching in the moment and thought there was a point where a resident with dementia would no longer be able to consent, but were unclear when that would be or how that would be determined. The leadership in the home said they would expect all alleged incidents of sexual abuse to be reported to the MLTC, however thought this did not apply to residents with dementia who were consenting in the moment to sexual activities with other residents.

The staff and leadership team in the home did not demonstrate through interviews and documentation that they had an understanding whether or not the residents had the capacity to provide consent to these incidents of touching and behaviour of a sexual nature. The home did not have a clear process for assessing and documenting the assessment of the residents' cognitive ability to consent. The staff and leadership in the home also did not clearly demonstrate that the residents consented to the touching of a sexual nature or that the residents had not been sexually exploited by other residents.

There were no Critical Incident System (CIS) reports submitted to the Ministry of Long-Term Care (MLTC) in 2020 related to suspected sexual abuse for the residents involved. There was however one CIS report submitted to the MLTC in 2020 related to suspected sexual abuse of one of the residents which stemmed from a family complaint. The staff and leadership team's failure to immediately report these incidents placed the residents at risk of harm related to sexual exploitation or abuse by other residents in the home.

Sources: Progress notes and other clinical records for four residents; the home's "Abuse and Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff Policy effective August 2018; review of the home's 2020 submitted CIS reports for two residents; interviews with the Executive Director (ED) and other staff. [s. 24. (1)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 there were procedures and interventions developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident’s behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between two specific residents.

Section 1 of the Ontario Regulation 79/10 defines responsive behaviours as behaviours that often indicate an unmet need in a person, whether cognitive, physical, emotional, social, environmental or other, or a response to circumstances within the social or physical environment that may be frustrating, frightening or confusing to a person.

A Critical Incident Report was submitted to the Ministry of Long-Term Care (MLTC) related to ongoing sexual responsive behaviours between two specific residents. There was also a MLTC anonymous complaint reporting non-consensual sexual touching and behaviours directed at one resident by another resident.

Clinical records included progress notes that described multiple incidents involving two specific residents over the course of several months.These potentially harmful interactions increased the risk for falls and injury for the resident. There were also multiple incidents where the other resident’s behaviours escalated to physical and verbal aggression towards staff and another resident.

The Follow Up Question Report detailed 18 documented entries by Personal Support Workers (PSWs) related to signs of verbally abusive behaviour (others were threatened, screamed at, cursed at) for the other resident. During the same time period, the report detailed 10 documented entries of physically abusive behaviour that was not easily altered on two occasions.

The care plan for the other resident had no documented focus statements, goals or interventions related to the resident's verbally and physically aggressive behaviours towards staff and other residents. There were no documented interventions developed to assist residents and staff when the resident was sexually inappropriate. There were no documented interventions to minimize the risk of altercations and potentially harmful interactions when the resident would transfer the other resident unassisted. The

resident's care plan did not indicate the risk of falls and injury related to self-transfers. The care plan had no documented interventions to direct staff to ensure a specific strategy was placed on the resident's door to ensure privacy and safety.

Interviews with nursing staff verified that the other resident was verbally and physically aggressive when staff intervened between the two specific residents, and between the resident and another resident. Behavioural Supports Ontario (BSO) staff verified the care plan should have identified interventions when the resident was distressed and refused the other resident's companionship. The care plan identified the resident was high risk for falls with no documented interventions developed to minimize the risk of potentially harmful interactions during transfers done by the other resident. There were no interventions as part of the resident's care plan developed to assist staff who were at risk of harm and to minimize the risk of altercations and potentially harmful interactions between the other resident and staff, as well as between two residents.

Sources: Progress notes, Follow Up Question Report and other clinical records for three residents; interviews with the physician, leadership staff and other nursing staff in the home. [s. 55. (a)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among two residents by identifying factors that could potentially trigger such altercations; and identifying and implementing interventions.

Documentation review of a different resident's progress notes referenced an incident between two residents. The PSW reported to the RPN that the other resident was asking the resident to go with them. Staff intervened immediately. This was the same resident involved with two other residents mentioned as part of this report.

There was no other documentation as part of the resident's clinical record and the incident was not documented as part of the other resident's clinical record. The BSO staff stated there were sexually responsive behaviours directed towards other residents but could not elaborate. The incident involving this different resident occurred days after another incident involving another resident where they were found by staff engaged in touching of a sexual nature. The triggers for such altercations and the identifying factors were absent from documentation as part of the clinical record for both residents.

The Director of Care and the Executive Director acknowledged there was inconsistent documentation of incidents of sexually inappropriate behaviours.

Sources: clinical records for two residents; and interviews with leadership staff and other nursing staff in the home. [s. 54.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and identifying and implementing interventions, to be implemented voluntarily.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Issued on this 12th day of January, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELANIE NORTHEY (563), AMIE GIBBS-WARD (630)
Inspection No. / No de l'inspection :	2020_778563_0036
Log No. / No de registre :	023280-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 8, 2021
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, Woodstock, ON, N4S-3V9
LTC Home / Foyer de SLD :	Caressant Care Woodstock Nursing Home 81 Fyfe Avenue, Woodstock, ON, N4S-8Y2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Natalie Aikens

To Caressant-Care Nursing and Retirement Homes Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee must be compliant with s. 6 (1) of the LTCHA.
Specifically, the licensee must:
a) Review and revise the written plan of care for the resident to ensure it includes all aspects of their planned care and provides clear direction for staff regarding their sexual behaviours and the associated risks.
b) This review and revision must include at a minimum:
- direction for staff regarding the resident's capacity to provide consent to sexual activities with other residents;
- direction for staff regarding their role in determining the resident's consent to sexual activities;
- directions for staff regarding interventions to maintain the resident's safety related to their sexual behaviours when in public or private locations with other residents.
c) Ensure the Executive Director (ED), Director of Care (DOC), Assistant DOC, Resident Care Coordinators (RCCs) and all staff who provide direct care to the resident are trained on this revised plan of care for sexual behaviours. The home must keep a written record of the training that was provided and who attended.

Grounds / Motifs :

1. The licensee has failed to ensure that there was a written plan of care for a resident that set out their planned care and provided clear directions to staff regarding their behaviours.

A Personal Support Worker (PSW) reported to the Registered Practical Nurse

(RPN) that two residents were exhibiting sexual behaviours. The note indicated that the RPN directed the PSW staff to intervene when the residents were in a public place and provide privacy. There were additional documented incidents of sexual activities between one resident and other residents over a number of months.

The plan of care for the resident included no direction for staff regarding the resident's specific sexual behaviours until after the first incident, when the focus related to a problematic manner was created. This focus specified the resident was sexually expressive to multiple other residents in a specific way. The interventions included that staff were to remove the resident when the behaviour was disruptive/unacceptable, however there was no direction regarding which behaviours were to be considered disruptive/unacceptable. When asked about the interventions for the resident's interactions with other residents, the staff and management said they thought the resident was consenting in the moment to these activities with other residents as they were not resisting them and liked the company of these other residents. Interviews and documentation indicated that staff would intervene when the sexual activities were occurring in a public place and would provide the residents privacy. The resident's capacity to provide consent to these activities with other residents as well as directions for staff regarding their role in determining consent was not addressed in the resident's written plan of care. The written plan of care also did not provide direction for staff regarding interventions to ensure the resident's safety related to their activities or behaviours in private locations with other residents. The lack of clear direction in the plan of care placed the resident at risk for harm related to resident to resident sexual abuse.

Sources: Care plan and other clinical records for the resident; interview with the Resident Care Coordinator (RCC) and other staff. [s. 6. (1)]

An order was made by taking the following factors into account:
Severity: There was actual risk to a resident's safety related to resident to resident sexual abuse.
Scope: The scope of this non-compliance was isolated; one of three resident care plans lacked clear direction related to sexual activities and behaviours.
Compliance History: One Compliance Order (CO) complied, one voluntary plan of correction (VPC) and one Written Notification (WN) were issued to the home

related to the same section of the legislation in the past 36 months.
(630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 26, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCHA.
Specifically, the licensee must:
a) Ensure the two residents are protected from sexual abuse. "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."
b) Ensure the home has a clear process for assessing and documenting the assessment of a resident's cognitive ability to consent to the touching of a sexual nature that is implemented.
c) Ensure the registered staff in the home assess and document the assessment of the two residents' cognitive capacity to provide consent to the touching of a sexual nature.
d) Ensure the management and registered nursing staff are provided education and trained on the process for assessing and documenting the assessment of a resident's cognitive ability to consent to the touching of a sexual nature. The home must keep a written record of the training that was provided and who attended.

Grounds / Motifs :

1. The licensee has failed to protect a resident from sexual abuse.

Section 2 (1) of the Ontario Regulation 79/10 defines sexual abuse as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

A resident had long-standing difficulties communicating and making decisions

due to dementia and a language barrier. It was identified in an assessment and the care plan that the resident was rarely to never understanding what was being said to them. The resident had multiple specific responsive behaviours. Staff reported the resident was known to engage in sexual activities with other residents in the home and that they were not sure how much the resident was able to understand these activities. Staff and management said they thought the resident was "consenting in the moment" to the sexual activities as they were not resisting them and liked the company of these other residents.

Clinical records included progress notes which described five separate incidents of sexual touching involving the resident and other residents in the home.

The staff and leadership team in the home did not demonstrate through interviews and documentation that they had an understanding of the resident's cognitive capacity to provide consent to the touching of a sexual nature for any of these incidents. The home did not have a clear process for assessing and documenting the assessment of the resident's cognitive ability to consent. The staff and leadership in the home also did not clearly demonstrate that the resident consented to this touching of a sexual nature or that there was a clear understanding of what had occurred between the two residents prior to the staff discovering the residents engaged in the activities of a sexual nature. It was unclear as to whether the incidents documented in the progress notes were reported to the leadership team and there was no documented record of an investigation. The effects of the incidents on the resident's well-being were unknown as this was not fully assessed or documented by the staff in the home.

The resident's cognitive deficit, sexually expressive behaviours, other responsive behaviours and communication difficulties placed them at risk for sexual exploitation by other residents. After the initial documented incident, the home failed to clearly demonstrate that they had protected the resident from the subsequent sexual touching.

Sources: Progress notes and other clinical records for three residents, interviews with the Resident Care Coordinator (RCC) and other staff. (630)

2. The licensee has failed to protect another resident from sexual abuse.

A Critical Incident Report was submitted to the Ministry of Long-Term Care (MLTC) related to ongoing sexual responsive behaviours between two specific residents. There was also a MLTC anonymous complaint reporting non-consensual sexual touching and behaviours directed at the resident by another resident.

Clinical records included progress notes which described multiple separate incidents of sexual touching involving two specific residents in the home.

A care plan intervention was added to identify that a consensual relationship had been initiated for both residents. This was the same day the CIS Report was submitted related to the MLTC for alleged resident to resident sexual abuse. In interviews with the staff, they expressed their confusion with the term "consensual relationship" as there were times when the resident did not consent to sexual touching and behaviour expressed by the other resident. Staff reported there were times when the resident was more confused. The requirements for consent include that consent must be free, informed and voluntary and consent may be withdrawn during the touching, behaviour or remarks. The resident's ability to provide consent (or inability to provide consent) about other activities should not be determinative of the resident's ability to provide consent in relation to sexual touching or behaviour or remarks. The resident may have consented to going to the other resident's room, but there was no documented evidence that the resident was informed of what was going to happen in the other resident's room. At these times, staff would provide privacy. The resident was at risk of potential sexual abuse and sexual exploitation by the other resident. A resident cannot give blanket consent or pre-consent to ongoing sexual activity.

The staff and leadership team in the home did not demonstrate through interviews and documentation that they had an understanding of the resident's cognitive capacity to provide consent to the touching of a sexual nature for any of the multiple incidents over multiple months. The home did not have a clear process for assessing and documenting the assessment of the resident's cognitive ability to consent. The staff and leadership in the home also did not clearly demonstrate that the resident consented to this touching of a sexual nature or that there was a clear understanding of what had occurred between the two residents prior to the staff discovering the residents engaged in the activities of a sexual nature. It was unclear as to whether the incidents

documented in the progress notes were reported to the leadership team and there was no documented record of an investigation. Multiple incidents were not documented as part of both residents clinical records and family was not documented as notified. The effects of the incidents on the resident's well-being were unknown at times as this was not fully supervised, assessed or documented by the staff in the home. Other times, the resident was documented as crying, stating no and repeatedly removing the other resident's hand from their body. Staff reported the resident looked scared and cried at times in the other resident's company.

Between the initial encounter between the two specific residents and when the resident was transferred to another home care area, the Follow Up Question Report for the resident detailed 19 documented entries by PSWs related to signs of sad, pained, worried facial expressions. The Follow Up Question Report detailed 62 documented entries by PSWs related to signs of socially inappropriate/disruptive behaviour for the other resident.

The resident's dementia, short and long term memory problems, their severely impaired cognitive skills for daily decision making, the resident's varied mental function over the course of the day, and unclear speech placed them at risk for sexual exploitation by other residents. The resident was assessed and the assessment identified that the resident's cognitive status and ability to express and understand information had deteriorated. After the initially documented incident, the home failed to clearly demonstrate that they had protected the resident from the subsequent sexual touching involving the other resident.

Sources: Progress notes, Follow Up Question Report and other clinical records for two residents; interviews with the residents, and interviews with the Ethicist, physician, leadership staff and other nursing staff in the home. [s. 19. (1)]

An order was made by taking the following factors into account:
Severity: There was actual risk to a resident and actual harm and risk to a resident related to resident to resident sexual abuse.
Scope: The scope of this non-compliance was a pattern; two of three residents were not protected from two residents.
Compliance History: There was no non-compliance issued to the home related to s. 19 of the legislation in the past 36 months.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

(563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 26, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 20 (1) of the LTCHA.
Specifically, the licensee must:
a) Ensure the prevention of abuse and neglect policy is complied with related to every potential/alleged incident of sexual abuse.
b) Ensure each incident of alleged sexual abuse is immediately investigated, there are interviews with the residents to determine the cause of the sexual behaviours; evaluation of the events preceding the incident; appropriate action is taken in response to every such incident, completion of internal incident reporting and notification of the family.
c) Ensure the education and training provided to all staff includes re-education regarding sexual abuse and the prevention of sexual abuse. This education must address consensual versus non-consensual touching, behaviour or remarks of a sexual nature directed towards a resident by anyone including who can and cannot consent to these sexual activities. The home must keep a written record of the training that was provided and who attended.

Grounds / Motifs :

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

Clinical records described multiple incidents where two residents were found involved in activities of a sexual nature. Staff who witnessed the incidents did not immediately report this to the management of the home as an alleged resident to resident sexual abuse in accordance with the home's policy.

The staff and leadership team in the home did not demonstrate through interviews and documentation that they had an understanding whether or not the residents had the capacity to provide consent to these incidents of touching and behaviour of a sexual nature. The home did not have a clear process for assessing and documenting the assessment of the residents cognitive ability to consent. The staff and leadership in the home also did not clearly demonstrate that the residents consented to this touching and behaviour of a sexual nature.

The Director of Care (DOC) said they thought all of these incidents would have been investigated or assessed by someone in the home as sexual expressions or behaviours but were not brought forward by staff as allegations of resident to resident sexual abuse. The Executive Director (ED) said they thought the concern was more about the location of one of the incidents, as it had taken place in a public area with other residents present, versus a concern that this needed to be investigated as an incident of resident to resident sexual abuse.

There was no documented evidence to demonstrate that the home's policy had been complied with for each of these incidents in the following areas: immediate investigation; interviews with the residents to determine the cause of the behaviours; evaluation of the events preceding the incident; completion of an "Internal Incident Report Form" and notification of the family. The staff and leadership team's failure to comply with the home's policy placed the resident at risk of harm related to sexual exploitation or abuse by other residents in the home.

Sources: Progress notes and other clinical records for two residents; the home's "Abuse and Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff Policy effective August 2018; interviews with the DOC and other staff. [s. 20. (1)].
(630)

2. The licensee has failed to ensure that the written policy in place in the home to promote zero tolerance of abuse and neglect of residents, was complied with for another resident.

Clinical records for two specific residents described multiple incidents of

touching, behaviour or remarks of a sexual nature which occurred over several months. According to leadership in the home, staff who witnessed the incidents did not immediately report these to the management of the home as alleged resident to resident sexual abuse in accordance with the home's policy.

The staff and leadership team in the home did not demonstrate through interviews and documentation that they had an understanding whether or not the resident had the capacity to provide consent to the touching and behaviour of a sexual nature that occurred over four months. The home did not have a clear process for assessing and documenting the assessment of the resident's cognitive ability to consent. The staff and leadership team in the home did not demonstrate through interviews and documentation that there was a clear understanding of the events leading up to or what had occurred between the two residents prior to the staff discovering the residents engaged in an activity of a sexual nature. At times when the resident did not consent to the other resident's request for sexual activities, the other resident continued to persist (touching, asking, gesturing) which then upset the resident. The leadership indicated that the resident had "consented in the moment" and this was known because the resident did not show distress or would say "yes" when the staff asked or found the resident with the other resident. However, there was unclear evidence that the resident's consent in the moment had been fully observed by staff when the two residents were left alone unsupervised. The leadership in the home said the incidents documented in the progress notes were reported to the leadership team as an incident of sexual expressions and were investigated, however there was no documented record of that investigation or the results of the investigation.

The Director of Care (DOC) said they thought all of these incidents would have been investigated or assessed by someone in the home as sexual expressions or behaviours but were not brought forward by staff as allegations of resident to resident sexual abuse. There was no documented evidence to demonstrate that the home's policy had been complied with for each of these incidents in the following areas: immediate investigation; interviews with the residents to determine the cause of the behaviours; evaluation of the events preceding the incident; completion of an "Internal Incident Report Form" and notification of the family. The staff and leadership team's failure to comply with the home's policy placed the resident at risk of harm related to non-consensual touching,

behaviour or remarks of a sexual nature.

Sources: Progress notes and other clinical records for both residents; the home's Abuse and Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff Policy effective August 2018; interviews with the residents, the DOC and other staff. [s. 20. (1)] (563)

An order was made by taking the following factors into account:
Severity: There was actual risk of harm to two residents. The home did not comply with the abuse policy and ensure each incident of suspected resident to resident abuse was reported to management and investigated.
Scope: The scope of this non-compliance was a pattern, two of three residents were affected.
Compliance History: One Voluntary Plan of Correction (VPC) was issued to the home related to the same section of the legislation in the past 36 months. (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 26, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee must be compliant with s. 24 (1) of the LTCHA.
Specifically, the licensee must:
a) Ensure that any person who had reasonable grounds to suspect sexual abuse of a resident by anyone, immediately reports the suspicion and the information upon which it was based to the Director.
b) Ensure the education and training provided to all staff includes re-education regarding mandatory reporting requirements and each staff members role responsibilities related to notification of sexual abuse. The home must keep a written record of the training that was provided and who attended.

Grounds / Motifs :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect sexual abuse of a resident by anyone, immediately reported the suspicion and the information upon which it was based to the Director.

Clinical records for multiple residents described incidents of touching of a sexual nature between these residents which occurred over the course of several months. Staff who witnessed these incidents did not immediately report this to the management of the home as alleged resident to resident sexual abuse in accordance with the home's policy. These were not reported to the Ministry of

Long-Term Care (MLTC) by staff or management as suspected sexual abuse.

Staff and leadership in the home said their understanding of resident to resident abuse was unwanted or non-consensual sexual touching. Staff and the leadership in the home expressed that they thought that residents with significant cognitive impairment could consent to sexual touching in the moment and thought there was a point where a resident with dementia would no longer be able to consent, but were unclear when that would be or how that would be determined. The leadership in the home said they would expect all alleged incidents of sexual abuse to be reported to the MLTC, however thought this did not apply to residents with dementia who were consenting in the moment to sexual activities with other residents.

The staff and leadership team in the home did not demonstrate through interviews and documentation that they had an understanding whether or not the residents had the capacity to provide consent to these incidents of touching and behaviour of a sexual nature. The home did not have a clear process for assessing and documenting the assessment of the residents' cognitive ability to consent. The staff and leadership in the home also did not clearly demonstrate that the residents consented to the touching of a sexual nature or that the residents had not been sexually exploited by other residents.

There were no Critical Incident System (CIS) reports submitted to the Ministry of Long-Term Care (MLTC) in 2020 related to suspected sexual abuse for the residents involved. There was however one CIS report submitted to the MLTC in 2020 related to suspected sexual abuse of one of the residents which stemmed from a family complaint. The staff and leadership team's failure to immediately report these incidents placed the residents at risk of harm related to sexual exploitation or abuse by other residents in the home.

Sources: Progress notes and other clinical records for four residents; the home's "Abuse and Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff Policy effective August 2018; review of the home's 2020 submitted CIS reports for two residents; interviews with the Executive Director (ED) and other staff. [s. 24. (1)]

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to two residents. The home did not report each incident of suspected resident to resident abuse to the Director.
Scope: The scope of this non-compliance was a pattern, two of three residents were affected.
Compliance History: One Voluntary Plan of Correction (VPC) was issued to the home related to the same section of the legislation in the past 36 months. (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 26, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 55. 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.

Order / Ordre :

The licensee must be compliant with s. 55 (a) of the Ontario Regulation 79/10. Specifically, the licensee must ensure the home's procedures and interventions are consistently implemented to minimize the risk of altercations and potentially harmful interactions between the resident and any other resident or staff in the home. This includes, but is not limited to, ensuring the resident's plan of care has documented interventions to address verbal and physical aggressive behaviours and interventions when the resident is sexually inappropriate.

Grounds / Motifs :

1. The licensee failed to ensure that there were procedures and interventions developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between two specific residents.

Section 1 of the Ontario Regulation 79/10 defines responsive behaviours as behaviours that often indicate an unmet need in a person, whether cognitive, physical, emotional, social, environmental or other, or a response to circumstances within the social or physical environment that may be frustrating, frightening or confusing to a person.

A Critical Incident Report was submitted to the Ministry of Long-Term Care (MLTC) related to ongoing sexual responsive behaviours between two specific residents. There was also a MLTC anonymous complaint reporting non-consensual sexual touching and behaviours directed at one resident by another resident.

Clinical records included progress notes that described multiple incidents involving two specific residents over the course of several months.These potentially harmful interactions increased the risk for falls and injury for the resident. There were also multiple incidents where the other resident's behaviours escalated to physical and verbal aggression towards staff and another resident.

The Follow Up Question Report detailed 18 documented entries by Personal Support Workers (PSWs) related to signs of verbally abusive behaviour (others were threatened, screamed at, cursed at) for the other resident. During the same time period, the report detailed 10 documented entries of physically abusive behaviour that was not easily altered on two occasions.

The care plan for the other resident had no documented focus statements, goals or interventions related to the resident's verbally and physically aggressive behaviours towards staff and other residents. There were no documented interventions developed to assist residents and staff when the resident was sexually inappropriate. There were no documented interventions to minimize the risk of altercations and potentially harmful interactions when the resident would transfer the other resident unassisted. The resident's care plan did not indicate the risk of falls and injury related to self-transfers. The care plan had no documented interventions to direct staff to ensure a specific strategy was placed on the resident's door to ensure privacy and safety.

Interviews with nursing staff verified that the other resident was verbally and physically aggressive when staff intervened between the two specific residents, and between the resident and another resident. Behavioural Supports Ontario (BSO) staff verified the care plan should have identified interventions when the resident was distressed and refused the other resident's companionship. The care plan identified the resident was high risk for falls with no documented

interventions developed to minimize the risk of potentially harmful interactions during transfers done by the other resident. There were no interventions as part of the resident's care plan developed to assist staff who were at risk of harm and to minimize the risk of altercations and potentially harmful interactions between the other resident and staff, as well as between two residents.

Sources: Progress notes, Follow Up Question Report and other clinical records for three residents; interviews with the physician, leadership staff and other nursing staff in the home.[s. 55. (a)]

An order was made by taking the following factors into account:
Severity: There was actual risk of harm to two residents and nursing staff. There was no documentation of interventions when the resident was physically and verbally aggressive to staff, and there were no interventions to address unsafe transfers and use of safety measures.
Scope: The scope of this non-compliance was isolated.
Compliance History: There was no non-compliance issued to the home related to s. 55 of the legislation in the past 36 months. (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 26, 2021

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 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 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 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 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 8th day of January, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Melanie Northey

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