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

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

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

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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
Feb 13, 2017	2017_380593_0003	002311-17	Complaint

Licensee/Titulaire de permis

CARVETH NURSING HOME LIMITED
375 JAMES STREET GANANOQUE ON K7G 2Z1

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

CARVETH CARE CENTRE
375 JAMES STREET GANANOQUE ON K7G 2Z1

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

GILLIAN CHAMBERLIN (593)

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): January 30 - 31, February 1, 2017.

This inspection was completed related to a complaint alleging multiple incidents of resident to resident sexual abuse.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nursing Staff, Personal Support Workers (PSW) and residents.

The inspector observed the provision of care and services to residents, staff to resident interactions, resident to resident interactions, residents' environment, reviewed resident health care records, staff training records and licensee policies.

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)**
- **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. The licensee has failed to protect residents from sexual abuse by resident #001.

Under O.Reg. 79/10, sexual abuse is defined 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 complaint was submitted to the Director of the Ministry of Health and Long-Term Care (MOHLTC) January 25, 2016, related to the sexual abuse of residents in the home by resident #001. The complainant reported that there have been multiple incidents that have occurred which have not been reported to the Director. The complainant specifically mentioned an incident of alleged sexual abuse toward resident #002 that occurred recently. At the time of the complaint, this incident had not been reported to the Director.

A Critical Incident (CI) was submitted to the Director related to an incident of alleged resident to resident sexual abuse. It was reported that resident #001 was found seated next to resident #002, engaging in sexual touching without consent.

A review of resident 002's current care plan found that the resident has cognitive loss, with a cognitive performance scale indicating very severe impairment for decision making.

A review of resident #001's progress notes found an entry related to the incident as reported in the CI documented by the RN on duty, RN #100:

PSW reported witnessing resident #001 "sexually fondling resident #002". This resident is non-verbal and unable to defend themselves. DOC called and made aware.

A review of resident #001's progress notes found further incidents of sexual abuse by resident #001 toward residents in the home:

* Before lunch, resident #001 was removed from resident #003's room, doing sexually inappropriate touching.

A review of resident 003's care plan at the time of the incident, found that the resident has cognitive loss related to dementia with a cognitive performance scale indicating severe impairment for decision making.

The following progress note was documented by the charge RN:

* Previous incident entry noted and unusual occurrence report initiated and provided for

DOC for proper reporting of sexual assault incident. Will note to day RN for reporting to both POA's of incident and proper follow up related to nursing home policy.

The following progress note was documented by the charge RN:

* DOC reported conflicting reports of above mentioned incident. DOC confirmed she will contact the RN to retrieve actual incident happenings and follow up accordingly.

* Resident #001 touched a resident sexually inappropriately twice, then another resident and resident #001 were embraced in heavy kissing. RN aware. DOC called.

* Grabbed resident #005 in the crotch area, as they were bent over speaking to resident #001. Resident #001 was taken to their room. Resident #005 was found in resident #001's room twice after the incident, once with the door closed.

A review of resident 005's current care plan found that the resident has cognitive loss related to dementia with a cognitive performance scale indicating a moderate impairment for decision making.

The following progress note was documented by the charge RN:

* Mobile Response Team (MRT) was called at 1930 hours and above incidents of today were reported. Written incident forms have been gathered this evening, POA's of residents will be informed of the physical / sexual abuse incidents and DOC will be informed in am.

* DOC was notified of behavioural incidents from last two days.

A review of resident #002's progress notes found a further incident of sexual abuse by resident #001 documented by the charge RN, toward resident #002 in the home:

* Resident #001 found touching residents sexually inappropriately while in activity room. Resident #001 removed from the situation and appropriate steps being taken.

Further review of resident #001's progress notes found a pattern of sexual verbal behaviours towards staff and residents in the home over the past 12 months documented on most days, including the following sample:

* Resident #001 states “you are a bitch, going to slap you around". At lunch, resident #001 was upset as they were told resident #003 was not theirs, they were already married. Resident #001 stated “mind your own business”.

* At supper resident #001 was noted to be lifting hips in an upward motion, when asked what they were doing, stated “my crotch is hot for them”.

* Yelling and calling staff sexually derogative names.

* Yelling, cursing, calling staff and residents sexually derogative names.

* Continues to call the staff sexually derogative names as they will not take the resident to the bank.

* Verbal threats uttered to staff including calling staff sexually derogative names.

* PRN given for verbal sexual outburst at another resident.

During an interview with Inspector #593, January 31, 2017, PSW #103 reported that she has not witnessed any sexual abuse toward residents in the home however she is aware of these behaviours. For example, this morning in the dining room, resident #001 asked a resident to lift up their shirt and resident #001 also tried to grab at another resident when they were walking past, resident #001 they could not reach them. PSW #103 reported that they recently started to complete 15 minute checks on resident #001 and they were to be kept away from other residents however resident #001 was able to ambulate on their own and they often find them ambulating in the hallways of the home. PSW #103 indicated that the resident has always had sexual verbal behaviours since admission to the home.

During an interview with Inspector #593, January 31, 2017, PSW #104 reported that she was the staff member that found resident #001 sexually abusing resident #002. PSW #104 reported that she found them together in the activity room, resident #002 was on the left of resident #001, resident #002`s shirt was up and resident #001`s hand was fondling resident #002 in a sexually inappropriate way. PSW #104 indicated that there were no other staff in this area at the time and that she felt sorry for resident #002 as the resident was not cognitive and unable to defend themself. After she separated the two residents, PSW #104 reported the incident to the charge RN, RN #100. PSW #104 added that this behaviour has been going on for awhile as it was hard to keep resident

#001 away from residents as they ambulated on their own. PSW #104 further indicated that resident #001 has sexually inappropriate behaviours on a daily basis, mostly verbal directed at both staff and residents regularly calling staff sexually derogatory names. PSW #104 reported that there have been other incidents of sexual abuse toward residents, resident #001 was found in resident #003's room many times and caught fondling resident #003 in a sexually inappropriate way. PSW #104 added that there was another resident and resident #001 would also touch this resident inappropriately however she could not remember this resident's name. PSW #104 indicated that resident #001 has had sexual behaviours since admission to the home.

During an interview with Inspector #593, January 31, 2017, RPN #105 reported that since admission, she has known of resident #001 sexually abusing a resident on three occasions, however their verbal sexual behaviours were present most days. RPN #105 added that two of these incidents were toward resident #002, who was unable to consent. RPN #105 indicated that resident #001 has had sexual behaviours toward staff since admission, mostly verbal and to manage this, a PRN (medication as needed) was given to the resident before their behaviours started to escalate. RPN #105 indicated that there were no interventions in place to keep resident #001 away from other residents, however since the most recent incident, they were completing 15 minute checks on resident #001 which the PSW's were responsible for.

During an interview with Inspector #593, February 1, 2017, PSW #101 reported that since the day resident #001 was admitted to the home, they have had inappropriate sexual behaviours and this has escalated over the years from verbal to physical behaviours with the behaviours worsening over the past two years. Although, she has not witnessed any sexual abuse by resident #001 toward a resident, PSW #101 was aware that it has happened multiple times in the past. PSW #101 reported that interventions to manage these behaviours included a 15 minute check which was started recently however this was not always practical, as they could be busy with another resident and unable to check every 15 minutes as required. Resident #001 was also to be kept away from other residents however they were in a wheelchair and able to ambulate themself around the home.

During an interview with Inspector #593, February 1, 2017, RPN #102 reported that resident #001 has sexual behaviours which were mostly verbal however she was aware of them sexually abusing other residents in the home. RPN #102 indicated that these behaviours were not new for resident #001, they have been present since admission to the home. RPN #102 reported that current interventions included 15 minute checks of

resident #001 and they were also to be kept away from other residents however these interventions have not always been in place and resident #001 was able to ambulate themself out of their room and down the hallway of the home.

During an interview with Inspector #593, February 6, 2017, RN #100 reported that she was the RN on duty during the incident referred to in the CI. RN #100 reported that she was aware of sexual verbal behaviours by resident #001 toward staff in the home however they were not aware of any previous incidents related to sexual abuse toward residents in the home.

During an interview with Inspector #593, February 1, 2017, the DOC reported that she was made aware of the incident of resident to resident sexual abuse referred to in the CI. The DOC reported that they were not aware of the additional incidents of sexual abuse by resident #001 toward residents in the home dating back 10 months, until the most recent incident when a chart review of resident #001 was undertaken. The DOC reported that after the most recent incident, 15 minute checks were put into place to monitor resident #001 and a DOS was started to see if there were any patterns to their behaviour. Regarding resident #003, the DOC knew that resident #001 had an attraction to this resident and that they had to be diverted away from them on multiple occasions.

A review of resident #001's health care record found the following documentation related to an admission on a Form 1 to Brockville General Hospital:

Document 1:

Resident #001 was seen from 2130 - 2230 hours on a specific day and from 0000 – 0100 hours on another day. Resident #001 had a significant change in their presentation of illness over the past approximately one month. They are frequently punching and verbally aggressive towards nursing staff. They normally are not aggressive or agitated with people. Sometimes they can be sexually inappropriate with their comments and occasionally loud, but that is about it.

Document 2:

The patient was sent on a Form 1 by their physician due to concerns of escalating aggression over the past one month. For the past several years, they have been a well-liked member of the Carveth Centre with no major behavioural issues of note, however in the last month they have had escalating periods of both verbal and physical agitation

directed towards staff.

Document 3:

Resident #001 was put on a Form 1 due to increasing aggression over the past few days by their physician. Resident #001 has been displaying aggressive behaviour over the past 1.5 months. They have been more physically aggressive than their baseline. They have also been making inappropriate sexual comments to the staff.

A review of resident #001's care plans in place 2016, found the following entry:

Focus- sexually inappropriate verbalizations and touching.

Goals- reduced incidents of inappropriate sexual behaviour.

Interventions- explain to resident #001 that their comments or grabbing at others are inappropriate. Explain to resident #001 that you are leaving due to their behaviour and return later to continue with care. Report all incidents to registered staff.

A review of resident #001's health care record found the following hand written entries, dated the day after the incident referred to in the CI, to the residents current care plan:

* Staff to monitor whereabouts Q15 minutes
* Staff to utilize MRT strategies
* Staff to keep resident away from residents

A review of resident #001's current care plan, found the following entry:

Focus- problematic manner in which resident #001 acts characterized by Inappropriate sexual behaviour (Verbal or Physical) related to: resident #001 makes inappropriate remarks and touches staff inappropriately.

Goals- reduced incidents of inappropriate sexual behavior.

Interventions - avoid type of conversation that could encourage or initiate inappropriate behavior. Set limits for acceptable behavior: make shake hand but no other physical touching of staff or worker will leave room and return once actions are appropriate.

A review of resident #001's health care record found a memo dated the day after the incident referred to in the CI, from Behavioural Support Services Southeastern Ontario, with the following interventions:

* If resident #001 is asking about inappropriate topics such as having "babies" or making verbal insults, redirect the conversation to another topic of interest.
* If resident is sexually inappropriate with staff and/or co-residents, redirect them away from the area. If that is not possible, redirect staff and/or co-residents away. Ensure resident is in a safe place, explain that behaviour is not appropriate and staff will return when they stop. Consider having a registered staff approach them about their behaviours. This authority may trigger the residents compliance and understanding with a firm approach. Encourage all LTCH staff to report all behaviours during each shift to LTCH registered staff.
* When the above non-pharmacological interventions are not successful, please consider a PRN to help reduce behaviours if available and as indicated.

As per documented progress notes and staff interviews, resident #001 has a history of sexually verbal behaviours since admission directed at both staff and residents. Furthermore, over the past 10 months, multiple incidents have been documented related to sexual abuse by resident #001 to several residents in the home. The resident's plan of care did not include any interventions to manage sexual behaviours directed at residents until the day after the fifth documented incident of sexual abuse. Resident #001 was assessed recently related to behaviours, however documents did not indicate nor interventions address the sexual abuse toward residents in the home. The sexual abuse toward residents in the home was well known, however interventions were not implemented and multiple incidents of sexual abuse did occur over the past 10 months. As such, the licensee has failed to protect residents from sexual abuse by resident #001.

The decision to issue this compliance order was based on the severity which was actual harm, and the scope, which was a pattern due to multiple incidents of sexual abuse by resident #001 toward residents in the home.

The licensee also failed to comply with:

1. LTCHA, s. 20 (2) The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents shall contain an explanation of the duty under section 24 to make mandatory reports. (refer to WN #2)

2. LTCHA, s. 24 (1) The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to residents #002, #003 and #005 by not immediately reporting the suspicion and the information upon which it was based to the Director. (refer to WN #3)

3. LTCHA, s. 23 (1) (a) The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that is reported to the licensee, is immediately investigated. (refer to WN #4)

4. O. Reg. 79/10, s. 54. (b) The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions. (refer to WN #5)

5. O. Reg. 79/10, s. 98. The licensee has failed to ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. (refer to WN #6) [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. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents shall contain an explanation of the duty under section 24 to make mandatory reports.

A review of the licensee's policy "Abuse / Neglect" (not dated), found that when an employee or client has asked their manager to deal with a situation involving abuse and/or neglect, the manager should, only upon the direction of the Administrator/designate notify the Director of the Ministry of Health and Long-Term Care (MOHLTC) upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident. For purposes of this policy "Manager and Management" includes all department managers, Registered Nurses, Assistant Director of Care, Director of Care and Administrator.

During an interview with Inspector #593, January 31, 2017, RPN #105 reported that if she were to become aware of any alleged, suspected or witnessed abuse or neglect of a resident, she would report this information to the charge RN. When asked about

reporting such incidents to the MOHLTC, RPN #102 reported that she would not report such incidents to the MOHLTC, this was the responsibility of the DOC.

During an interview with Inspector #593, February 1, 2017, RPN #102 reported that if she were to become aware of any alleged, suspected or witnessed abuse or neglect of a resident, she would report this information to the charge RN. When asked about reporting such incidents to the MOHLTC, RPN #102 reported that this was the responsibility of the DOC as she does not have those privileges.

During an interview with Inspector #593, January 31, 2017, RPN #105 reported that if she were to become aware of any alleged, suspected or witnessed abuse or neglect of a resident, she would report this information to the charge RN. When asked about reporting such incidents to the MOHLTC, RPN #102 reported that she would not report such incidents to the MOHLTC, this would be the responsibility of the DOC.

During an interview with Inspector #593, February 6, 2017, RN #100 reported that the licensee's policy regarding mandatory reporting was that, she would report suspicions of abuse or neglect of residents to the DOC and await further instruction from the DOC. RN #100 indicated that they were aware that certain incidents were to be immediately reported to the MOHLTC, however their understanding based on the licensee's policy was that the DOC was responsible for this.

During an interview with Inspector #593, February 1, 2017, the DOC reported that the rationale behind the wording of the policy "only upon the direction of the Administrator/designate will managers notify the Director of the MOHLTC" was to ensure that management were informed of any alleged, suspected or witnessed incidents of abuse or neglect before being reported to the Director of the MOHLTC. The DOC indicated that the charge nurse was aware of mandatory reporting requirements and they were able to directly report to the MOHLTC.

The licensee's policy "Abuse / Neglect" (not dated), does not provide a clear explanation to front-line staff and management on their individual obligation for reporting to the Director, under s. 24 (1) of the LTCHA, with the policy stating that "Managers" are only to report under direction from the Administrator/designate. It is also evident through staff interviews, that front-line staff do not understand their obligations for reporting to the Director. [s. 20. (2)]

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 abuse that the licensee knows of, or that is reported to the licensee, is immediately investigated.

A Critical Incident (CI) was submitted to the Director related to an incident of alleged resident to resident sexual abuse. It was reported that resident #001 was found seated next to resident #002, engaging in sexual touching without consent.

A review of resident #001's progress notes found an entry related to the incident as reported in the CI documented by the RN on duty, RN #100:

PSW reported witnessing resident #001 "sexually fondling resident #002". This resident is non-verbal and unable to defend themselves. DOC called and made aware.

A review of resident #001's progress notes found further incidents of sexual abuse by resident #001 toward residents in the home:

* Before lunch, resident #001 was removed from resident #003's room, engaging in

sexually inappropriate touching.

The following progress note was documented by the charge RN:

* Previous incident entry noted and unusual occurrence report initiated and provided for DOC for proper reporting of sexual assault incident. Will note to day RN for reporting to both POA's of incident and proper follow up related to nursing home policy.

The following progress note was documented by the charge RN:

* DOC reported conflicting reports of above mentioned incident. DOC confirmed she will contact the RN to retrieve actual incident happenings and follow up accordingly.

* Resident #001 touched a resident sexually inappropriately twice, then another resident and resident #001 were embraced in heavy kissing. RN aware. DOC called.

* Grabbed resident #005 in the crotch area, as they were bent over speaking to resident #001. Resident #001 was taken to their room. Resident #005 was found in resident #001's room twice after the incident, once with the door closed.

The following progress note was documented by the charge RN:

* Mobile Response Team (MRT) was called at 1930 hours and above incidents of today were reported. Written incident forms have been gathered this evening, POA's of residents will be informed of the physical / sexual abuse incidents and DOC will be informed in am.

* DOC was notified of behavioural incidents from last two days.

A review of resident #002's progress notes found a further incident of sexual abuse by resident #001 documented by the charge RN, toward resident #002 in the home:

* Resident #001 found touching residents sexually inappropriately while in activity room. Resident #001 removed from the situation and appropriate steps being taken.

Five additional incidents of sexual abuse by resident #001 over the past 10 months, were found documented in the progress notes. As documented, the charge RN and / or DOC were aware of each incident.

During an interview with Inspector #593, February 1, 2017, the DOC reported that she was made aware of the incident of resident to resident sexual abuse reported in the CI however they were not aware of the additional incidents of sexual abuse by resident #001 toward female residents in the home dating back 10 months, until the incident referred to in the CI when a chart review of resident #001 was undertaken. The DOC further indicated that they had not investigated any of the previous incidents and the investigation completed for the incident referred to in the CI, was not documented.

A review of the licensee's policy "Abuse / Neglect" (not dated), found that Carveth Care Centre shall take all claims of abuse and/or neglect seriously, and will investigate thoroughly, Carveth Care Centre management will follow the investigation process outlined, conduct the investigation immediately after learning of the complaint and document all information appropriately. For purposes of this policy "Manager and Management" includes all department managers, Registered Nurses, Assistant Director of Care, Director of Care and Administrator. [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 suspicions of abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident is immediately reported to the Director.

Under O.Reg. 79/10, sexual abuse is defined 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 Critical Incident (CI) was submitted to the Director related to an incident of alleged resident to resident sexual abuse. It was reported that resident #001 was found seated next to resident #002, engaging in sexual touching without consent.

The CI was submitted, however the incident actually occurred more than five days earlier than when the incident was first reported to the Director.

A review of resident #001's progress notes found an entry related to the incident reported in the CI, documented by the RN on duty, RN #100:

PSW reported witnessing resident #001 "fondling resident #002 sexually inappropriately". This resident is non-verbal and unable to defend themself. DOC called and made aware.

During an interview with Inspector #593, February 6, 2017, RN #100 reported that she was the RN on duty during the incident reported in the CI, and they reported the incident to the DOC shortly after the incident occurred. RN #100 reported that the licensee's policy regarding mandatory reporting was that, she will report certain incidents to the DOC and await further instruction from the DOC. RN #100 indicated that the DOC did not provide any instruction regarding reporting to the MOHLTC, when this incident was reported to them and confirmed that they did not report this incident to the MOHLTC. The RN indicated that they were aware that certain incidents were to be immediately reported to the MOHLTC, however their understanding based on the licensee's policy was that the DOC was responsible for this.

A review of resident #001's progress notes found further incidents of sexual abuse by resident #001 toward residents in the home:

* Before lunch, resident #001 was removed from resident #003's room, engaging in sexually inappropriate touching.

The following progress note was documented by the charge RN:

* Previous incident entry noted and unusual occurrence report initiated and provided for DOC for proper reporting of sexual assault incident. Will note to day RN for reporting to both POA's of incident and proper follow up related to nursing home policy.

The following progress note was documented by the charge RN:

* DOC reported conflicting reports of above mentioned incident. DOC confirmed she will contact the RN to retrieve actual incident happenings and follow up accordingly.

* Resident #001 touched a resident sexually inappropriately twice, then another resident and resident #001 were embraced in heavy kissing. RN aware. DOC called.

* Grabbed resident #005 in the crotch area, as they were bent over speaking to resident #001. Resident #001 was taken to their room. Resident #005 was found in resident #001's room twice after the incident, once with the door closed.

The following progress note was documented by the charge RN:

* Mobile Response Team (MRT) was called at 1930 hours and above incidents of today were reported. Written incident forms have been gathered this evening, POA's of residents will be informed of the physical / sexual abuse incidents and DOC will be informed in am.

* DOC was notified of behavioural incidents from last two days.

A review of resident #002's progress notes found a further incident of sexual abuse by resident #001 documented by the charge RN, toward resident #002 in the home:

* Resident #001 found touching residents sexually inappropriately while in activity room. Resident #001 removed from the situation and appropriate steps being taken.

Five additional incidents of sexual abuse by resident #001 over the past 10 months were found documented in the progress notes. None of these incidents were reported to the Director of the MOHLTC. As documented, the charge RN and / or DOC were aware of each incident. Furthermore, the incident reported in the CI was not reported to the Director until five days after the incident occurred.

During an interview with Inspector #593, February 1, 2017, the DOC reported that she was made aware of the incident of resident to resident sexual abuse as reported in the CI. The DOC reported that a CI was submitted to the MOHLTC within the 10 days and was unaware of the requirement of immediate reporting of such incidents. The DOC reported that they were not aware of the additional incidents of sexual abuse by resident #001 toward female residents in the home dating back 10 months, until the most recent incident, when a chart review of resident #001 was undertaken. The DOC further indicated that the charge nurses were aware of reporting requirements and they could report directly to the MOHLTC. [s. 24. (1)]

WN #5: 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 has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

A Critical Incident (CI) was submitted to the Director related to an incident of alleged resident to resident sexual abuse. It was reported that resident #001 was found seated next to resident #002, engaging in sexual touching without consent.

A review of resident #001's progress notes found an entry related to the incident as reported in the CI documented by the RN on duty, RN #100:

PSW reported witnessing resident #001 "sexually fondling resident #002". This resident is non-verbal and unable to defend themselves. DOC called and made aware.

A review of resident #001's progress notes found further incidents of sexual abuse by resident #001 toward residents in the home:

* Before lunch, resident #001 was removed from resident #003's room, doing sexually inappropriate touching.

The following progress note was documented by the charge RN:

* Previous incident entry noted and unusual occurrence report initiated and provided for DOC for proper reporting of sexual assault incident. Will note to day RN for reporting to both POA's of incident and proper follow up related to nursing home policy.

The following progress note was documented by the charge RN:

* DOC reported conflicting reports of above mentioned incident. DOC confirmed she will contact the RN to retrieve actual incident happenings and follow up accordingly.

* Resident #001 touched a resident sexually inappropriately twice, then another resident and resident #001 were embraced in heavy kissing. RN aware. DOC called.

* Grabbed resident #005 in the crotch area, as they were bent over speaking to resident #001. Resident #001 was taken to their room. Resident #005 was found in resident #001's room twice after the incident, once with the door closed.

The following progress note was documented by the charge RN:

* Mobile Response Team (MRT) was called at 1930 hours and above incidents of today were reported. Written incident forms have been gathered this evening, POA's of residents will be informed of the physical / sexual abuse incidents and DOC will be informed in am.

* DOC was notified of behavioural incidents from last two days.

A review of resident #002's progress notes found a further incident of sexual abuse by resident #001 documented by the charge RN, toward resident #002 in the home:

* Resident #001 found touching residents sexually inappropriately while in activity room. Resident #001 removed from the situation and appropriate steps being taken.

Further review of resident #001's progress notes over the past 12 months, found a pattern of sexually verbal behaviours towards staff and residents in the home documented on most days.

During an interview with Inspector #593, January 31, 2017, PSW #103 reported that she has not witnessed any sexual abuse toward residents in the home however she was aware of these behaviours, for example this morning in the dining room, resident #001 asked a resident to lift up their shirt and they also tried to grab at another resident when they were walking past, however could not reach them. PSW #103 reported that they were now to complete 15 minute checks on this resident and they were to be kept away from other residents however they were able to ambulate on their own and they often find the resident ambulating in the hallways of the home. PSW #103 indicated that the resident has always had sexually verbal behaviours since admission to the home.

During an interview with Inspector #593, January 31, 2017, PSW #104 reported that she was the staff member that found resident #001 sexually abusing resident #002. PSW #104 reported that she found them together in the activity room, resident #002 was on the left of resident #001, resident #002`s shirt was up and resident #001`s hand was fondling resident #002. PSW #104 reported that there were no other staff in this area at the time and that she felt sorry for resident #002 as they were not cognitive and was unable to defend themself. After she separated the two residents, PSW #104 reported the incident to the charge RN, RN #100. PSW #104 indicated that this behaviour has been going on for awhile as it was hard to keep them away from residents as the resident ambulates on their own. They have sexually inappropriate behaviours on a daily basis, mostly verbal and directed at both staff and residents, regularly calling staff sexually derogatory names. PSW #104 reported that there have been other residents, they were found in resident #003's room many times and caught touching resident #003 in a sexually inappropriate way. She added that there was another resident and resident #001 would touch them inappropriately however she cannot remember the resident's name. PSW #104 added that the resident has had sexual behaviours since admission to the home.

During an interview with Inspector #593, January 31, 2017, RPN #105 reported that since admission, she has known of resident #001 sexually abusing a resident on three

occasions, however their verbal sexual behaviours are present most days. RPN #105 added that two of these incidents were toward resident #002, who was unable to consent. RPN #105 indicated that resident #001 has had sexual behaviours toward staff since admission, mostly verbal and to manage this, a PRN was given to the resident before their behaviours started to escalate. RPN #105 indicated that there were no interventions in place to keep resident #001 away from other residents, however since the most recent incident, they were completing 15 minute checks on resident #001, which the PSW's were responsible for.

During an interview with Inspector #593, February 1, 2017, PSW #101 reported that since the day resident #001 was admitted to the home, they have had inappropriate sexual behaviours and this has escalated over the years from verbal to physical behaviours with the behaviours worsening over the past two years. Although, she has not witnessed any sexual abuse by resident #001 toward a resident, PSW #101 was aware that it has happened multiple times in the past. PSW #101 reported that interventions to manage these behaviours included a 15 minute check which was started recently however this was not always practical, as they could be busy with another resident and unable to check every 15 minutes as required. The resident was also to be kept away from other residents however they were in a wheelchair and able to ambulate themself around the home.

During an interview with Inspector #593, February 1, 2017, RPN #102 reported that resident #001 has sexual behaviours which are mostly verbal however she was aware of the resident sexually abusing other residents in the home. RPN #102 indicated that these behaviours were not new for resident #001, they have been present since admission to the home. RPN #102 reported that current interventions included 15 minute checks of resident #001 and they were also to be kept away from other residents however these interventions have not always been in place and resident #001 was able to ambulate themself out of their room and down the hallway of the home.

During an interview with Inspector #593, February 6, 2017, RN #100 reported that she was the RN on duty during the incident occurring January 22, 2017. RN #100 reported that she was aware of sexually verbal behaviours by resident #001 toward staff in the home however was not aware of any previous incidents related to sexual abuse toward residents in the home.

During an interview with Inspector #593, February 1, 2017, the DOC reported that she was made aware of the incident of resident to resident sexual abuse as documented in

the CI. The DOC reported that they were not aware of the additional incidents of sexual abuse by resident #001 toward residents in the home dating back 10 months until the most recent incident when a chart review of resident #001 was undertaken. The DOC reported that after the most recent incident, 15 minute checks were put into place to monitor resident #001 and a DOS was started to see if there were any patterns to their behaviour. Regarding resident #003, the DOC knew that resident #001 had an attraction to this resident and that they had to be diverted away from resident #003 on multiple occasions.

A review of resident #001's health care record found the following documentation related to an admission on a Form 1 to Brockville General Hospital:

Document 1:

Resident #001 was seen from 2130 - 2230 hours on a specific day and from 0000 – 0100 hours on another day. Resident #001 had a significant change in their presentation of illness over the past approximately one month. They are frequently punching and verbally aggressive towards nursing staff. They normally are not aggressive or agitated with people. Sometimes they can be sexually inappropriate with their comments and occasionally loud, but that is about it.

Document 2:

The patient was sent on a Form 1 by their physician due to concerns of escalating aggression over the past one month. For the past several years, they have been a well-liked member of the Carveth Centre with no major behavioural issues of note, however in the last month they have had escalating periods of both verbal and physical agitation directed towards staff.

Document 3:

Resident #001 was put on a Form 1 due to increasing aggression over the past few days by their physician. Resident #001 has been displaying aggressive behaviour over the past 1.5 months. They have been more physically aggressive than their baseline. They have also been making inappropriate sexual comments to the staff.

A review of resident #001's care plans in place 2016, found the following entry:

Focus- sexually inappropriate verbalizations and touching.

Goals- reduced incidents of inappropriate sexual behaviour.

Interventions- explain to resident #001 that their comments or grabbing at others are inappropriate. Explain to resident #001 that you are leaving due to their behaviour and return later to continue with care. Report all incidents to registered staff.

A review of resident #001's health care record found the following hand written entries, dated the day after the incident referred to in the CI, to the residents current care plan:

* Staff to monitor whereabouts Q15 minutes
* Staff to utilize MRT strategies
* Staff to keep resident away from residents

A review of resident #001's current care plan, found the following entry:

Focus- problematic manner in which resident #001 acts characterized by Inappropriate sexual behaviour (Verbal or Physical) related to: resident #001 makes inappropriate remarks and touches staff inappropriately.

Goals- reduced incidents of inappropriate sexual behavior.

Interventions - avoid type of conversation that could encourage or initiate inappropriate behavior. Set limits for acceptable behavior: make shake hand but no other physical touching of staff or worker will leave room and return once actions are appropriate.

A review of resident #001's health care record found a memo dated the day after the incident referred to in the CI, from Behavioural Support Services Southeastern Ontario, with the following interventions:

* If resident #001 is asking about inappropriate topics such as having "babies" or making verbal insults, redirect the conversation to another topic of interest.
* If resident is sexually inappropriate with staff and/or co-residents, redirect them away from the area. If that is not possible, redirect staff and/or co-residents away. Ensure resident is in a safe place, explain that behaviour is not appropriate and staff will return when they stop. Consider having a registered staff approach them about their behaviours. This authority may trigger their compliance and understanding with a firm

approach. Encourage all LTCH staff to report all behaviours during each shift to LTCH registered staff.
* When the above non-pharmacological interventions are not successful, please consider a PRN to help reduce behaviours if available and as indicated.

As per documented progress notes and staff interviews, resident #001 has a history of sexually verbal behaviours since admission directed at both staff and residents. Furthermore, over the past 10 months, multiple incidents have been documented related to sexual abuse by resident #001 to several residents in the home. The resident's plan of care did not include any interventions to manage sexual behaviours directed at residents until the day after the fifth documented incident of sexual abuse over the past 10 months. Resident #001 was assessed recently related to behaviours, however documents did not indicate nor interventions address the sexual abuse toward residents in the home. The sexual abuse toward residents in the home was well known, however interventions were not implemented and multiple incidents of sexual abuse did occur over the past 10 months. The licensee has failed to identify and implement interventions to minimize the risk of altercations and potential harmful interactions between resident #001 and residents in the home. [s. 54. (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force were immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

A Critical Incident (CI) was submitted to the Director related to an incident of alleged resident to resident sexual abuse. It was reported that resident #001 was found seated next to resident #002, engaging in sexual touching without consent.

Five additional incidents of sexual abuse by resident #001 over the past 10 months were found documented in the progress notes. The appropriate police force were not notified for any of these incidents. As documented in the progress notes, the charge RN and / or DOC were aware of each incident.

The Ottawa Service Area Office contacted the DOC of the home related to the complaint received. At the time, the DOC reported that the police had not been notified but then indicated that they would call the police that same afternoon.

During an interview with Inspector #593, February 1, 2017, the DOC reported that she was made aware of the incident of resident to resident sexual abuse however they were not aware of the additional incidents of sexual abuse by resident #001 toward residents in the home dating back 10 months the most recent incident when a chart review of resident #001 was undertaken. The DOC further indicated that they had not investigated any of the incidents occurring over the past 10 months including notification of the police. Furthermore, the police were contacted regarding the most recent incident, however they were not contacted until three days after the incident occurred. The DOC further indicated that the police were placing criminal charges on resident #001 the following day. [s. 98.]

Issued on this 14th day of February, 2017

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GILLIAN CHAMBERLIN (593)
Inspection No. / No de l'inspection :	2017_380593_0003
Log No. / Registre no:	002311-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 13, 2017
Licensee / Titulaire de permis :	CARVETH NURSING HOME LIMITED 375 JAMES STREET, GANANOQUE, ON, K7G-2Z1
LTC Home / Foyer de SLD :	CARVETH CARE CENTRE 375 JAMES STREET, GANANOQUE, ON, K7G-2Z1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Brett Gibson

To CARVETH NURSING HOME LIMITED, 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 is required to prepare, submit and implement a plan for achieving compliance under s.19 (1) of the LTCHA. This plan is to include:

1. A re-assessment of resident #001's plan of care to include the following:

a. Identification of the sexual behavioral triggers for resident #001, if possible, how these triggers are minimized and the response taken by each staff discipline when triggers are present.
b. Interventions to minimize inappropriate sexual behaviours displayed by resident #001 including psychological, pharmaceutical, behavioural and physical interventions.
c. Responsibilities of each staff discipline in preventing further occurrence of sexual abuse from resident #001 towards another resident.
d. Review and revise the plan of care when resident #001's care needs change or care set out in the plan of care has not been effective.

2. Strategies to ensure that all staff members within the home are aware of the mandatory reporting requirements as per the LTCHA, 2007. Including a process ensuring that all abuse or alleged abuse of a resident is reported immediately to the Director.

3. Strategies to ensure that all reported allegations of resident abuse are immediately investigated and that residents in the home are protected during the investigation.

4. Strategies to ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident

that the licensee suspects may constitute a criminal offence.

5. A comprehensive review of the licensee's zero tolerance of abuse and neglect policy called "Abuse / Neglect" and revise the procedures reflected in the policy to make mandatory reports including that all staff members have a duty to report under s.24, irrespective of the Licensee's duty and that staff members must report any incident or suspected incident of resident abuse or neglect to the Director, and that the duty to report to the Director is immediate.

6. A training and education program to all front-line staff on the long-term care home's revised policy to promote zero tolerance of abuse and neglect of residents, and the duty under section 24 to make mandatory reports. A schedule of this training program is to be included.

This plan may be submitted in writing at 347 Preston St, Suite 420, Ottawa, Ontario, K1S 3J4. Alternatively, the plan may be faxed to the inspector's attention at (613) 569-9670 or emailed to OttawaSAO.MOH@ontario.ca. This plan must be received by February 24, 2017, and fully implemented by April 14, 2017.

Grounds / Motifs :

1. The licensee has failed to protect residents from sexual abuse by resident #001.

Under O.Reg. 79/10, sexual abuse is defined 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 complaint was submitted to the Director of the Ministry of Health and Long-Term Care (MOHLTC) January 25, 2016, related to the sexual abuse of residents in the home by resident #001. The complainant reported that there have been multiple incidents that have occurred which have not been reported to the Director. The complainant specifically mentioned an incident of alleged sexual abuse toward resident #002 that occurred recently. At the time of the complaint, this incident had not been reported to the Director.

A Critical Incident (CI) was submitted to the Director related to an incident of alleged resident to resident sexual abuse. It was reported that resident #001 was found seated next to resident #002, engaging in sexual touching without

consent.

A review of resident 002's current care plan found that the resident has cognitive loss, with a cognitive performance scale indicating very severe impairment for decision making.

A review of resident #001's progress notes found an entry related to the incident as reported in the CI documented by the RN on duty, RN #100:

PSW reported witnessing resident #001 "sexually fondling resident #002". This resident is non-verbal and unable to defend themselves. DOC called and made aware.

A review of resident #001's progress notes found further incidents of sexual abuse by resident #001 toward residents in the home:

* Before lunch, resident #001 was removed from resident #003's room, doing sexually inappropriate touching.

A review of resident 003's care plan at the time of the incident, found that the resident has cognitive loss related to dementia with a cognitive performance scale indicating severe impairment for decision making.

The following progress note was documented by the charge RN:

* Previous incident entry noted and unusual occurrence report initiated and provided for DOC for proper reporting of sexual assault incident. Will note to day RN for reporting to both POA's of incident and proper follow up related to nursing home policy.

The following progress note was documented by the charge RN:

* DOC reported conflicting reports of above mentioned incident. DOC confirmed she will contact the RN to retrieve actual incident happenings and follow up accordingly.

* Resident #001 touched a resident sexually inappropriately twice, then another resident and resident #001 were embraced in heavy kissing. RN aware. DOC called.

* Grabbed resident #005 in the crotch area, as they were bent over speaking to resident #001. Resident #001 was taken to their room. Resident #005 was found in resident #001's room twice after the incident, once with the door closed.

A review of resident 005's current care plan found that the resident has cognitive loss related to dementia with a cognitive performance scale indicating a moderate impairment for decision making.

The following progress note was documented by the charge RN:

* Mobile Response Team (MRT) was called at 1930 hours and above incidents of today were reported. Written incident forms have been gathered this evening, POA's of residents will be informed of the physical / sexual abuse incidents and DOC will be informed in am.

* DOC was notified of behavioural incidents from last two days.

A review of resident #002's progress notes found a further incident of sexual abuse by resident #001 documented by the charge RN, toward resident #002 in the home:

* Resident #001 found touching residents sexually inappropriately while in activity room. Resident #001 removed from the situation and appropriate steps being taken.

Further review of resident #001's progress notes found a pattern of sexual verbal behaviours towards staff and residents in the home over the past 12 months documented on most days, including the following sample:

* Resident #001 states "you are a bitch, going to slap you around". At lunch, resident #001 was upset as they were told resident #003 was not theirs, they were already married. Resident #001 stated "mind your own business".

* At supper resident #001 was noted to be lifting hips in an upward motion, when asked what they were doing, stated "my crotch is hot for them".

* Yelling and calling staff sexually derogative names.

* Yelling, cursing, calling staff and residents sexually derogative names.

* Continues to call the staff sexually derogative names as they will not take the resident to the bank.

* Verbal threats uttered to staff including calling staff sexually derogative names.

* PRN given for verbal sexual outburst at another resident.

During an interview with Inspector #593, January 31, 2017, PSW #103 reported that she has not witnessed any sexual abuse toward residents in the home however she is aware of these behaviours. For example, this morning in the dining room, resident #001 asked a resident to lift up their shirt and resident #001 also tried to grab at another resident when they were walking past, resident #001 they could not reach them. PSW #103 reported that they recently started to complete 15 minute checks on resident #001 and they were to be kept away from other residents however resident #001 was able to ambulate on their own and they often find them ambulating in the hallways of the home. PSW #103 indicated that the resident has always had sexual verbal behaviours since admission to the home.

During an interview with Inspector #593, January 31, 2017, PSW #104 reported that she was the staff member that found resident #001 sexually abusing resident #002. PSW #104 reported that she found them together in the activity room, resident #002 was on the left of resident #001, resident #002`s shirt was up and resident #001`s hand was fondling resident #002 in a sexually inappropriate way. PSW #104 indicated that there were no other staff in this area at the time and that she felt sorry for resident #002 as the resident was not cognitive and unable to defend themself. After she separated the two residents, PSW #104 reported the incident to the charge RN, RN #100. PSW #104 added that this behaviour has been going on for awhile as it was hard to keep resident #001 away from residents as they ambulated on their own. PSW #104 further indicated that resident #001 has sexually inappropriate behaviours on a daily basis, mostly verbal directed at both staff and residents regularly calling staff sexually derogatory names. PSW #104 reported that there have been other incidents of sexual abuse toward residents, resident #001 was found in resident #003's room many times and caught fondling resident #003 in a sexually inappropriate way. PSW #104 added that there was another resident and resident #001 would also touch this resident inappropriately however she could

not remember this resident's name. PSW #104 indicated that resident #001 has had sexual behaviours since admission to the home.

During an interview with Inspector #593, January 31, 2017, RPN #105 reported that since admission, she has known of resident #001 sexually abusing a resident on three occasions, however their verbal sexual behaviours were present most days. RPN #105 added that two of these incidents were toward resident #002, who was unable to consent. RPN #105 indicated that resident #001 has had sexual behaviours toward staff since admission, mostly verbal and to manage this, a PRN (medication as needed) was given to the resident before their behaviours started to escalate. RPN #105 indicated that there were no interventions in place to keep resident #001 away from other residents, however since the most recent incident, they were completing 15 minute checks on resident #001 which the PSW's were responsible for.

During an interview with Inspector #593, February 1, 2017, PSW #101 reported that since the day resident #001 was admitted to the home, they have had inappropriate sexual behaviours and this has escalated over the years from verbal to physical behaviours with the behaviours worsening over the past two years. Although, she has not witnessed any sexual abuse by resident #001 toward a resident, PSW #101 was aware that it has happened multiple times in the past. PSW #101 reported that interventions to manage these behaviours included a 15 minute check which was started recently however this was not always practical, as they could be busy with another resident and unable to check every 15 minutes as required. Resident #001 was also to be kept away from other residents however they were in a wheelchair and able to ambulate themself around the home.

During an interview with Inspector #593, February 1, 2017, RPN #102 reported that resident #001 has sexual behaviours which were mostly verbal however she was aware of them sexually abusing other residents in the home. RPN #102 indicated that these behaviours were not new for resident #001, they have been present since admission to the home. RPN #102 reported that current interventions included 15 minute checks of resident #001 and they were also to be kept away from other residents however these interventions have not always been in place and resident #001 was able to ambulate themself out of their room and down the hallway of the home.

During an interview with Inspector #593, February 6, 2017, RN #100 reported

that she was the RN on duty during the incident referred to in the CI. RN #100 reported that she was aware of sexual verbal behaviours by resident #001 toward staff in the home however they were not aware of any previous incidents related to sexual abuse toward residents in the home.

During an interview with Inspector #593, February 1, 2017, the DOC reported that she was made aware of the incident of resident to resident sexual abuse referred to in the CI. The DOC reported that they were not aware of the additional incidents of sexual abuse by resident #001 toward residents in the home dating back 10 months, until the most recent incident when a chart review of resident #001 was undertaken. The DOC reported that after the most recent incident, 15 minute checks were put into place to monitor resident #001 and a DOS was started to see if there were any patterns to their behaviour. Regarding resident #003, the DOC knew that resident #001 had an attraction to this resident and that they had to be diverted away from them on multiple occasions.

A review of resident #001's health care record found the following documentation related to an admission on a Form 1 to Brockville General Hospital:

Document 1:

Resident #001 was seen from 2130 - 2230 hours on a specific day and from 0000 – 0100 hours on another day. Resident #001 had a significant change in their presentation of illness over the past approximately one month. They are frequently punching and verbally aggressive towards nursing staff. They normally are not aggressive or agitated with people. Sometimes they can be sexually inappropriate with their comments and occasionally loud, but that is about it.

Document 2:

The patient was sent on a Form 1 by their physician due to concerns of escalating aggression over the past one month. For the past several years, they have been a well-liked member of the Carveth Centre with no major behavioural issues of note, however in the last month they have had escalating periods of both verbal and physical agitation directed towards staff.

Document 3:

Resident #001 was put on a Form 1 due to increasing aggression over the past few days by their physician. Resident #001 has been displaying aggressive behaviour over the past 1.5 months. They have been more physically aggressive than their baseline. They have also been making inappropriate sexual comments to the staff.

A review of resident #001's care plans in place 2016, found the following entry:

Focus- sexually inappropriate verbalizations and touching.

Goals- reduced incidents of inappropriate sexual behaviour.

Interventions- explain to resident #001 that their comments or grabbing at others are inappropriate. Explain to resident #001 that you are leaving due to their behaviour and return later to continue with care. Report all incidents to registered staff.

A review of resident #001's health care record found the following hand written entries, dated the day after the incident referred to in the CI, to the residents current care plan:

* Staff to monitor whereabouts Q15 minutes
* Staff to utilize MRT strategies
* Staff to keep resident away from residents

A review of resident #001's current care plan, found the following entry:

Focus- problematic manner in which resident #001 acts characterized by Inappropriate sexual behaviour (Verbal or Physical) related to: resident #001 makes inappropriate remarks and touches staff inappropriately.

Goals- reduced incidents of inappropriate sexual behavior.

Interventions - avoid type of conversation that could encourage or initiate inappropriate behavior. Set limits for acceptable behavior: make shake hand but no other physical touching of staff or worker will leave room and return once actions are appropriate.

A review of resident #001's health care record found a memo dated the day after the incident referred to in the CI, from Behavioural Support Services Southeastern Ontario, with the following interventions:

* If resident #001 is asking about inappropriate topics such as having "babies" or making verbal insults, redirect the conversation to another topic of interest.
* If resident is sexually inappropriate with staff and/or co-residents, redirect them away from the area. If that is not possible, redirect staff and/or co-residents away. Ensure resident is in a safe place, explain that behaviour is not appropriate and staff will return when they stop. Consider having a registered staff approach them about their behaviours. This authority may trigger the residents compliance and understanding with a firm approach. Encourage all LTCH staff to report all behaviours during each shift to LTCH registered staff.
* When the above non-pharmacological interventions are not successful, please consider a PRN to help reduce behaviours if available and as indicated.

As per documented progress notes and staff interviews, resident #001 has a history of sexually verbal behaviours since admission directed at both staff and residents. Furthermore, over the past 10 months, multiple incidents have been documented related to sexual abuse by resident #001 to several residents in the home. The resident's plan of care did not include any interventions to manage sexual behaviours directed at residents until the day after the fifth documented incident of sexual abuse. Resident #001 was assessed recently related to behaviours, however documents did not indicate nor interventions address the sexual abuse toward residents in the home. The sexual abuse toward residents in the home was well known, however interventions were not implemented and multiple incidents of sexual abuse did occur over the past 10 months. As such, the licensee has failed to protect residents from sexual abuse by resident #001.

The decision to issue this compliance order was based on the severity which was actual harm, and the scope, which was a pattern due to multiple incidents of sexual abuse by resident #001 toward residents in the home.

The licensee also failed to comply with:

1. LTCHA, s. 20 (2) The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents shall contain an explanation of the duty under section 24 to make mandatory reports. (refer to WN #2)

2. LTCHA, s. 24 (1) The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to residents #002, #003 and #005 by not immediately reporting the suspicion and the information upon which it was based to the Director. (refer to WN #3)

3. LTCHA, s. 23 (1) (a) The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that is reported to the licensee, is immediately investigated. (refer to WN #4)

4. O. Reg. 79/10, s. 54. (b) The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions. (refer to WN #5)

5. O. Reg. 79/10, s. 98. The licensee has failed to ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. (refer to WN #6)

This plan must be received by February 24, 2017, and fully implemented by April 14, 2017. (593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 14, 2017

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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing 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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 13th day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Gillian Chamberlin

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