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 sions 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
Sep 19, 2016	2016_270531_0025	017496-16, 019983-16	Critical Incident System

Licensee/Titulaire de permis

CENTENNIAL PLACE MILLBROOK INC.
307 Aylmer Street PETERBOROUGH ON K9L 7M4

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

CENTENNIAL PLACE LONG-TERM CARE HOME
2 Centennial Lane North MILLBROOK ON M5J 2G2

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

SUSAN DONNAN (531)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 14, 15, 18, 19 and 20 2016.

The following logs were completed with this inspection:
Log #019983-16 regarding resident to resident alleged abuse
Log #017496-16 regarding staff to resident alleged abuse

During the course of the inspection, the inspector(s) spoke with residents, residents' substitute decision maker, personal support workers, registered practical nurses, registered nurses, life enrichment staff, the RAI coordinator and quality improvement manager, the Director of Care and the Administrator.

During the course of the inspection the inspector toured the home, observed resident care and services, reviewed resident health care and services, and reviewed appropriated policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 resident #003, 004, 005 and 006 from abuse by resident #002.

In reference to Log #019983-16

On a specified date an inspection began for a critical incident report,an allegation of resident to resident sexual abuse. The critical incident was as follows:
Staff located resident #002 seated beside resident #003’s bed, touching resident #003 in a sexual manner. The incident report also indicated that resident #002 had demonstrated increased inappropriate sexual behaviours such as attempting to kiss and touch other residents.

Under O. Reg. 79/10 s. 2 (1) (a), 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".

Upon entering the home inspector #531 requested the home’s investigation into the incident that occurred on a specified date. Inspector was provided with a copy of resident #002’s progress notes which reflected multiple incidents of sexual behaviour by resident #002 towards five co-residents on the home area over a specified period. The incidents were documented in resident #002’s progress notes.

Resident #002's care plan was reviewed and indicated the following:
Problematic way in which resident acts characterized by inappropriate sexual behaviour (verbal and physical) resident makes inappropriate remarks and touches other residents and or staff inappropriately,
-resident has been identified as a high risk for responsive sexually inappropriate behaviours.
-monitor resident's sexually inappropriate behaviour.
-protect other residents if unable to protect themselves.
-resident is on 15 minute checks

On a specified date: a Critical incident was submitted to the Ministry of Health which indicated that resident #002 found kissing resident #004 in resident #004's room. Resident #002 noted in the past to be in resident #004’s room whispering in resident #004’s ears. Resident #004 was extremely agitated and angry after this interaction. Resident #002 denied behaviour.

On a specified date it was documented that resident #002 was found coming out of

resident #003's room pulling up his/her pants.

On a specified date it was documented that resident #002 was found with resident #003 on resident #002's bed.
Resident #002 was kissing resident #003 on the lips both residents had their arms around each other. RN supervisor spoke to resident #002 who denied doing anything with resident #003.

On a specified date it was documented that resident #002 was observed wheeling past resident #003 in the dining room stating "come on with me, want to come to my bed" resident #003 did not acknowledge resident #002. When being re directed resident #002 stated to resident #003 " never mind her lets go."

On a specified date it was documented PTA (Physiotherapy assistant) #115 witnessed resident #002 with resident #003 in the doorway to resident #002's room. Appeared as though resident #003 was attempting to leave the room and resident #002 was attempting to assist resident #003 towards his/her side of the room. PTA #115 explained to resident #002 that this was not acceptable and that both Substitute Decision Makers were uncomfortable with this behaviour.
The RN Supervisor also spoke with resident #002 and asked that resident #002 discontinue this behaviour with resident #003.

On a specified date it was noted that resident #002 was noted approaching resident #003 in the dining room stating " Why don't you have your housecoat on today, you had it yesterday and yesterday you had nothing on underneath your house coat." Resident #002 was observed after lunch approaching resident #003 stating "come see me later" The charge nurse intervened advised resident #002 that this type of behaviour is not acceptable.

On a identified date it was documented that Resident #002 acknowledged ongoing behaviour with other residents by stating " You know what I've been doing here? I know it's wrong."

On a specified date it was documented that resident #002 was found luring resident #003 into his/her room. Found resident #002 sitting with resident #003 on resident #002's bed rubbing resident #003's back. Staff intervened before anything further could happen.

On a specified date it was documented that resident #002 was noted in the dining room

staring and making inappropriate gestures such as licking his/her lips at resident #003.

On a specified date it was documented resident #002 was removed from activities for rubbing resident #006's arms and saying inappropriate comments to resident #006.

On two specified dates it was documented that resident #002 was witnessed asking resident #005 to come over later to his/her room for sex.

On a specified date it was documented that resident #002 was found by the windows in the dining room whispering to resident #005 and touched resident #005's thigh. Resident #002 was told that it was inappropriate to touch other residents.

On a identified date it was documented that resident #002 was found in resident #007's room with a hand on resident #007's thigh. Staff intervened before anything further took place.

On a specified date it was documented that resident #002 leaned toward resident #008 in the dining room telling resident #008 "I love you, how about you come by my room after lunch." Resident #008 looked uncomfortable and looked to writer for assistance.

On an identified date it was documented that resident #002 was found with resident #003. Resident #003's pants were down and resident #002 was doing up his/her pants when staff entered the room and intervened. Resident #002 was advised that this was unacceptable behaviour that would not be tolerated and the police would be called. Resident #003 was removed from the room and taken to the nurses station.

On an identified date it was documented that resident #002 was found lingering and approaching wheelchair bound co-residents sitting in the dining hall area. Resident #002 approached resident #005 and placed a hand on resident #005's thigh. Staff intervened before anything further could happen.

On a specified date it was documented that resident #002 was found with resident #003 in resident #002's room. Resident #002 was behaving inappropriately towards resident #003. The LEA #104 intervened, removing resident #003 from the room and advised resident #002 that he/she had been told by staff on multiple occasions that this behaviour was unappropriate.

On an identified date it was documented that resident #002 was found whispering in

resident #003's ear and when staff intervened resident #002 slapped resident #003 on the buttocks and moved on.

On a specified date it was documented that a critical incident report (CI) was submitted stating that resident #002 was found in resident #003's room beside the bed touching resident #003 in a sexual manner. Staff intervened before anything further could happen.

Inspector #531 was not able to obtain any information from the home to provide evidence that the home established consent in any of the above incidents.

On July 20, 2016 PSW #106 and #108 were interviewed related to the documented incidents of resident #002 making inappropriate comments and "touching residents' thighs". PSW #108 indicated that she witnessed resident #002 making inappropriate sexual comments and sexual gestures to resident #003, 004 and 005 in the dining room and had been informed that this behaviour was inappropriate. PSW #106 indicated that she has found resident #002 lingering around resident #003, 004, and 005 making inappropriate comments, gestures and placing a hand on resident #005 and #006. They both indicate that resident #002 has been identified as a high risk for sexually inappropriate behaviours and that the behaviour has escalated despite interventions in place.

On July 20, 2016 Inspector #531 interviewed LEA #104 (Life Enrichment Aide) who witnessed an incident on an identified date. LEA #104 indicated that resident #002 was behaving inappropriately towards resident #003. LEA #104 indicated that she intervened, removing resident #003 from the room. LEA #104 indicated that she advised resident #002 that he/she had been told by staff on multiple occasions that this behaviour was unappropriate.

RN supervisor #100 was interviewed on July 19, 2016 regarding an incident that occurred on a specified date. RN #100 could not provide information to determine if consent was received from resident #003 therefore consent was deemed as "undetermined" for this incident. RN #100 could not recall if she advised the Director of Care or Administrator of the incident.

Inspector #531 interviewed PSW #107 on July 18, 2016 who witnessed the incident on a particular date. PSW #107 indicates she and a co- worker (PSW #112) went to assist resident #002 with evening care to find the resident was missing. She indicated that they found resident #002 in the next room occupied by resident #003,touching the resident in

a sexual manner. She indicated that resident #002 had been identified as a high risk for sexually inappropriate behaviour . PSW #107 indicated that resident #003 requires assistance of one staff with personal care and a great deal of supervision an cuing to complete a task.

The documented incident on an identified date can be determined as non-consensual as resident #004 was observed extremely agitated and angry after the interaction with resident #002.

The documented incident on a specified date can be determined as non-consensual as RN supervisor spoke to resident #002 and was firm in her explanation that this type of behaviour was unacceptable.

The documented incident on a particular date can be determined as non-consensual as resident #003 did not acknowledge resident #002.

The documented incident on a specified date can be determined as non-consensual as resident #003 appeared to be attempting to leave the room and resident #002 was attempting to assist resident #003 towards his/her side of the room.

The documented incident on a specified date can be determined as non-consensual as resident #002 was removed from activities for rubbing resident #006's arms and saying inappropriate comments to resident #006.

The documented incident on another identified date can be determined as non-consensual as resident #002 was told that resident #006 was not capable of responding or making decisions.

The documented incident on a specified date can be defined as non-consensual as resident #008 looked uncomfortable and looked to writer for assistance.

The documented incident on particular date can be determined as non-consensual as resident #002 was advised that this was unacceptable behaviour and the police would be called.

The licensee has failed to comply with:

1. LTCHA 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. 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 (refer to WN #003)

2. 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 an alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. (Refer to WN #004)

3. LTCHA 2007, c. 8, s. 20 (1).Every licensee of a long-term care home shall ensure that there written policy to promote zero tolerance of abuse and neglect of residents, is complied with (Refer to WN #002) [s. 19. (1)]

The severity of harm was determined to be harm or potential for harm and the scope was identified as "pattern" as 3 or more residents were allegedly sexually abused by resident #002.

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written Abuse Policy HR-F-40, HR-F-50, HR-F-10 and HR-F-11D were complied with:

HR-F-10 Abuse and Neglect-Zero Tolerance
Reads:
All employees are expected to be vigilant and immediately report suspected cases of resident abuse or neglect to their supervisor and complete a Resident Incident Report (GA-E-30: resident incident report))
The RN supervisor should immediately advise the Administrator (HR-F-50 External reporting) and GA-A-44: (Mandatory reporting)

Procedure:
. report the incident to supervisor (or DOC, depending on time/day of the week)
. supervisor manager document the circumstances on an incident report, obtain written signed statements from witnesses or concerned parties.

HR-F-11D Abuse and Neglect Reporting :algorithm
Section One: Titled Staff Witnesses/suspects Resident Abuse:
.report incident to supervisor immediately
.complete resident incident report
Section Two: Staff mandatory reporting to MOHLTC
.contact the Director (MOHLTC) via phone to report abuse/neglect
.record tracking number on the incident report
Section Three: Supervisors responsibilities
.assess resident's physical and emotional response
.immediately advise the administrator /delegate of incident
.incident reported to family/SDM/police
.begins incident investigation
.original incident report given to the Administrator, DOC and supervisor of reporting staff members.

On July 19 and 20, 2016 during interviews with RPN #102 and RPN #105 and review of the abuse reporting procedures the RPNs indicate that any suspected, witnessed or alleged abuse reported to them by a staff member or visitor they are responsible to ensure that the residents are safe, assess for injuries and notify the RN supervisor in charge who then immediately investigates and notifies the Director of Care and the Administrator.

During and interview with RN supervisor #100 who was involved in an incident on an identified date , she indicated that she is responsible to notify the substitute decision makers the Director of Care and the Administrator depending if the incident occurs after

hours or on the weekend. She does not recall if she completed a risk management report, notified the Director of Care or the Administrator of the specified incident.

RN Supervisor #116 who was involved in an incident on a particular date and advised resident #002 that the police would be notified was not available for an interview as the staff member is on a leave of absence from duty.

The licensee failed to ensure that the homes abuse and Neglect Policy was followed as evident in:
-The Administrator and Director of Care were not notified of each incident of suspected, alleged, or witnessed abuse by the RN Supervisor.
-The Director was not immediately notified of two incidents that involved resident #002
-the police were not immediately notified of the two incidents that involved resident #002

Subsequently during an interview with the Director of Care she was asked to provide copies of the completed Risk management assessments for each incident involving resident #002 and indicated that only the last incident was documented. She confirmed that two specified incidents should have been documented as per policy in risk management and were not.
The Director of Care and Administrator both confirmed that they were not aware of two specified incidents that involved resident #002 therefore the Director and police were not immediately notified as per policy. [s. 20. (1)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect sexual abuse has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

Over a specified period of time there were two documented incidents where resident #002 allegedly sexually abused residents #003, #004 and #005 (Refer to WN #001)

Subsequently the Administrator and the Director of Care were interviewed and indicated that they were not made aware of the two identified incidents therefore the Director was not immediately notified. [s. 24. (1)]

WN #4: 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 was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offense.

Over a specified period there were two identified incidents documented where resident #002 allegedly sexually abused residents #003, #004 and #005 (Refer to WN #001).

Subsequently during an interview with the Administrator and the Director of Care they indicated that they were not aware of the two identified incidents therefore the police were not immediately notified. [s. 98.]

Issued on this 22nd day of September, 2016

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 sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN DONNAN (531)
Inspection No. / No de l'inspection :	2016_270531_0025
Log No. / Registre no:	017496-16, 019983-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 19, 2016
Licensee / Titulaire de permis :	CENTENNIAL PLACE MILLBROOK INC. 307 Aylmer Street, PETERBOROUGH, ON, K9L-7M4
LTC Home / Foyer de SLD :	CENTENNIAL PLACE LONG-TERM CARE HOME 2 Centennial Lane North, MILLBROOK, ON, M5J-2G2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Debbie Maddison

To CENTENNIAL PLACE MILLBROOK INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

1. Immediately upon receiving this Compliance Order, all residents exhibiting responsive behavior of a sexual nature are re-assessed and the plans of care are reviewed and revised until effective interventions are identified and in place.
2. All staff, including members of the management team, are re-educated on the licensee's abuse policies HR-F-10, HR-F-50 including abuse reporting algorithm HR-F-11D ensuring that the following topics are covered:
a. Definition and identification of resident sexual abuse, under the LTCH Act, 2007, s. 2(1) and policy HR-F-10A definitions of abuse and GA-A55A definitions of resident to resident.
B. Reporting requirements under the LTCH Act, 2007 and O. Reg 79/10,and
c. Investigation procedures and implementation of resident protection measures in response to suspected, alleged or witnessed incidents of sexual abuse of a resident, as per Abuse and neglect-Zero Tolerance policy HR-F-10, HR-F-40"abuse and neglect -investigations policy"
3. A monitoring system is implemented whereby daily audits are conducted by members of the management team for the purpose of assessing compliance with all requirements set in O. Reg. 79/10 s. 99.

Grounds / Motifs :

1. 1. The licensee has failed to protect resident #003, 004, 005 and 006 from abuse by resident #002.

In reference to Log #019983-16

On a specified date an inspection began for a critical incident report,an

allegation of resident to resident sexual abuse. The critical incident was as follows:
Staff located resident #002 seated beside resident #003's bed, touching resident #003 in a sexual manner. The incident report also indicated that resident #002 had demonstrated increased inappropriate sexual behaviours such as attempting to kiss and touch other residents.

Under O. Reg. 79/10 s. 2 (1) (a), 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".

Upon entering the home inspector #531 requested the home's investigation into the incident that occurred on a specified date. Inspector was provided with a copy of resident #002's progress notes which reflected multiple incidents of sexual behaviour by resident #002 towards five co-residents on the home area over a specified period. The incidents were documented in resident #002's progress notes.

Resident #002's care plan was reviewed and indicated the following:
Problematic way in which resident acts characterized by inappropriate sexual behaviour (verbal and physical) -resident makes inappropriate remarks and touches other residents and or staff inappropriately,
-resident has been identified as a high risk for responsive sexually inappropriate behaviours.
-monitor resident's sexually inappropriate behaviour.
-protect other residents if unable to protect themselves.
-resident is on 15 minute checks

On a specified date: a Critical incident was submitted to the Ministry of Health which indicated that resident #002 found kissing resident #004 in resident #004's room. Resident #002 noted in the past to be in resident #004's room whispering in resident #004's ears. Resident #004 was extremely agitated and angry after this interaction. Resident #002 denied behaviour.

On a specified date it was documented that resident #002 was found coming out of resident #003's room pulling up his/her pants.

On a specified date it was documented that resident #002 was found with resident #003 on resident #002's bed.
Resident #002 was kissing resident #003 on the lips both residents had their arms around each other. RN supervisor spoke to resident #002 who denied doing anything with resident #003.

On a specified date it was documented that resident #002 was observed wheeling past resident #003 in the dining room stating "come on with me, want to come to my bed" resident #003 did not acknowledge resident #002. When being re directed resident #002 stated to resident #003 " never mind her lets go."

On a specified date it was documented PTA (Physiotherapy assistant) #115 witnessed resident #002 with resident #003 in the doorway to resident #002's room. Appeared as though resident #003 was attempting to leave the room and resident #002 was attempting to assist resident #003 towards his/her side of the room. PTA #115 explained to resident #002 that this was not acceptable and that both Substitute Decision Makers were uncomfortable with this behaviour. The RN Supervisor also spoke with resident #002 and asked that resident #002 discontinue this behaviour with resident #003.

On a specified date it was noted that resident #002 was noted approaching resident #003 in the dining room stating " Why don't you have your housecoat on today, you had it yesterday and yesterday you had nothing on underneath your house coat." Resident #002 was observed after lunch approaching resident #003 stating "come see me later"
The charge nurse intervened advised resident #002 that this type of behaviour is not acceptable.

On a identified date it was documented that Resident #002 acknowledged ongoing behaviour with other residents by stating " You know what I've been doing here? I know it's wrong."

On a specified date it was documented that resident #002 was found luring resident #003 into his/her room. Found resident #002 sitting with resident #003 on resident #002's bed rubbing resident #003's back. Staff intervened before anything further could happen.

On a specified date it was documented that resident #002 was noted in the

dining room staring and making inappropriate gestures such as licking his/her lips at resident #003.

On a specified date it was documented resident #002 was removed from activities for rubbing resident #006's arms and saying inappropriate comments to resident #006.

On two specified dates it was documented that resident #002 was witnessed asking resident #005 to come over later to his/her room for sex.

On a specified date it was documented that resident #002 was found by the windows in the dining room whispering to resident #005 and touched resident #005's thigh. Resident #002 was told that it was inappropriate to touch other residents.

On a identified date it was documented that resident #002 was found in resident #007's room with a hand on resident #007's thigh. Staff intervened before anything further took place.

On a specified date it was documented that resident #002 leaned toward resident #008 in the dining room telling resident #008 "I love you, how about you come by my room after lunch." Resident #008 looked uncomfortable and looked to writer for assistance.

On an identified date it was documented that resident #002 was found with resident #003. Resident #003's pants were down and resident #002 was doing up his/her pants when staff entered the room and intervened. Resident #002 was advised that this was unacceptable behaviour that would not be tolerated and the police would be called. Resident #003 was removed from the room and taken to the nurses station.

On an identified date it was documented that resident #002 was found lingering and approaching wheelchair bound co-residents sitting in the dining hall area. Resident #002 approached resident #005 and placed a hand on resident #005's thigh. Staff intervened before anything further could happen.

On a specified date it was documented that resident #002 was found with resident #003 in resident #002's room. Resident #002 was behaving inappropriately towards resident #003. The LEA #104 intervened, removing

resident #003 from the room and advised resident #002 that he/she had been told by staff on multiple occasions that this behaviour was unappropriate.

On an identified date it was documented that resident #002 was found whispering in resident #003's ear and when staff intervened resident #002 slapped resident #003 on the buttocks and moved on.

On a specified date it was documented that a critical incident report (CI) was submitted stating that resident #002 was found in resident #003's room beside the bed touching resident #003 in a sexual manner. Staff intervened before anything further could happen.

Inspector #531 was not able to obtain any information from the home to provide evidence that the home established consent in any of the above incidents.

On July 20, 2016 PSW #106 and #108 were interviewed related to the documented incidents of resident #002 making inappropriate comments and "touching residents' thighs". PSW #108 indicated that she witnessed resident #002 making inappropriate sexual comments and sexual gestures to resident #003, 004 and 005 in the dining room and had been informed that this behaviour was inappropriate. PSW #106 indicated that she has found resident #002 lingering around resident #003, 004, and 005 making inappropriate comments, gestures and placing a hand on resident #005 and #006.
They both indicate that resident #002 has been identified as a high risk for sexually inappropriate behaviours and that the behaviour has escalated despite interventions in place.

On July 20, 2016 Inspector #531 interviewed LEA #104 (Life Enrichment Aide) who witnessed an incident on an identified date. LEA #104 indicated that resident #002 was behaving inappropriately towards resident #003. LEA #104 indicated that she intervened, removing resident #003 from the room. LEA #104 indicated that she advised resident #002 that he/she had been told by staff on multiple occasions that this behaviour was unappropriate.

RN supervisor #100 was interviewed on July 19, 2016 regarding an incident that occurred on a specified date. RN #100 could not provide information to determine if consent was received from resident #003 therefore consent was deemed as "undetermined" for this incident. RN #100 could not recall if she advised the Director of Care or Administrator of the incident.

Inspector #531 interviewed PSW #107 on July 18, 2016 who witnessed the incident on a particular date. PSW #107 indicates she and a co- worker (PSW #112) went to assist resident #002 with evening care to find the resident was missing. She indicated that they found resident #002 in the next room occupied by resident #003,touching the resident in a sexual manner. She indicated that resident #002 had been identified as a high risk for sexually inappropriate behaviour . PSW #107 indicated that resident #003 requires assistance of one staff with personal care and a great deal of supervision an cuing to complete a task.

The documented incident on an identified date can be determined as non-consensual as resident #004 was observed extremely agitated and angry after the interaction with resident #002.

The documented incident on a specified date can be determined as non-consensual as RN supervisor spoke to resident #002 and was firm in her explanation that this type of behaviour was unacceptable.

The documented incident on a particular date can be determined as non-consensual as resident #003 did not acknowledge resident #002.

The documented incident on a specified date can be determined as non-consensual as resident #003 appeared to be attempting to leave the room and resident #002 was attempting to assist resident #003 towards his/her side of the room.

The documented incident on a specified date can be determined as non-consensual as resident #002 was removed from activities for rubbing resident #006's arms and saying inappropriate comments to resident #006.

The documented incident on another identified date can be determined as non-consensual as resident #002 was told that resident #006 was not capable of responding or making decisions.

The documented incident on a specified date can be defined as non-consensual as resident #008 looked uncomfortable and looked to writer for assistance.

The documented incident on particular date can be determined as non-consensual as resident #002 was advised that this was unacceptable behaviour and the police would be called.

The licensee has failed to comply with:

1. LTCHA 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. 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 (refer to WN #003)

2. 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 an alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. (Refer to WN #004)

3. LTCHA 2007, c. 8, s. 20 (1).Every licensee of a long-term care home shall ensure that there written policy to promote zero tolerance of abuse and neglect of residents, is complied with (Refer to WN #002) [s. 19. (1)]

The severity of harm was determined to be harm or potential for harm and the scope was identified as "pattern" as 3 or more residents were allegedly sexually abused by resident #002. (531)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

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 sions 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 sions 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 19th day of September, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Susan Donnan

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