Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 20, 2014	2014_328571_0022	O-003132-14	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE COBOURG
130 NEW DENSMORE ROAD COBOURG ON K9A 5W2

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

PATRICIA BELL (571)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 21,22 and September 2, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses, Registered Practical Nurses, Personal Support Workers, private care givers, and family.

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.
- **4 WN(s)**
- **0 VPC(s)**
- **4 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. 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".

This non-compliance is supported by the following findings:

Family member (F10) of Resident #4, submitted a written complaint to the home on a specified date as they had witnessed inappropriate sexual touching of Resident #1 by Resident #2 on a specified date. The home subsequently submitted a Critical Incident report to the director.

During an interview with F10, they indicated that on the specified date, Resident #2 walked slowly toward Resident #1 who was sitting beside the nursing station in a wheelchair. Resident #2 proceeded to look around and then put a hand underneath the clothing of Resident #1. F10 called out to Resident #2 to stop. The resident stopped and immediately walked towards F10 with an angry look in their eyes. F10 walked away from the resident and then returned to the nursing station to watch over Resident #1 until the Charge Nurse or a Personal Support Worker returned. F10 stated that they believed Resident #1 was upset as the resident began to rock back and forth in the wheelchair faster than usual and gripped the arms of the chair tightly. In addition, F10 disclosed that their family member, Resident #4, had been sexually assaulted by Resident #2 in the past.

A review of the Clinical Record indicated:

Resident #1 has a specified diagnosis and spends time in a wheelchair.

Resident #4 has a specified diagnosis, is wheelchair bound and has a history of sexual abuse by Resident #2.

In a telephone interview on a specified date, the DOC indicated that Resident #1 and #4 were incapable of giving consent.

Resident # 2 has a specified diagnosis, and is ambulatory. Resident#2 has a history of sexually inappropriate behaviour and was referred to PASE for the following incidents:
-the resident was suspected of removing Resident #4's clothing while he/she was lying in bed on a specified date although it was unwitnessed, Resident #4 was found undressed with face flushed, Resident #2 stated he/she had "patted" Resident #4
-Resident #2 was seen by a psychiatrist on a specified date after an incident occurring on a specified date, when the Resident #2 was seen having a hand under another

resident's clothing
-a review by a Social Worker from the PASE dated on a specified date,after the incident, indicated that Resident #2 is "aware of the social nuances of engaging in "Sexual Touching/Actions" and is a risk for further actions.

A review of the Clinical Record for Resident #2 indicated the following sexual/inappropriate/suspicious behaviour directed towards Resident #1:

-on a specified date, Resident #2 was found standing over Resident #1 in their wheelchair. Resident #1's seat belt was undone. Resident #2 was put on every 15 minutes checks.
-on a specified date, Resident #2 was discovered by Staff #10 touching Resident #1 in the lounge. It was also documented that Resident #2 had moved Resident #1's legs onto his/her lap. Doctor informed by fax. On the fax cover sheet Staff #20 indicated that Resident #2 had been exhibiting sexual disinhibition in form of touching residents of the opposite sex who are unable to object/defend themselves" and that the behaviour appears to occur at a certain time of day.
-on a specified date, Resident #2 was observed reaching for Resident #1 and was stopped by Staff #12. Every 15 minute checks continue and a new order for medication was received.
-on a specified date, Resident #2 was observed "hovering" around nursing station while Resident #1 was behind the nursing station with the gate closed.
-on a specified date- Resident #2 was discovered by the family of Resident #4 to put a hand under the clothing of Resident #1 after first looking around as if to ensure he/she would not be seen. Resident stopped when F10 called out to stop. Close monitoring continued "as per normal".

A review of the Clinical Record for Resident #2 indicated the following sexual/inappropriate/suspicious behaviour directed towards Resident #4:

-on a specified date, the resident was observed leaning over Resident #4. Resident #4 was moved closer to the nursing station. Doctor informed by fax and every 15 minute checks started and medication increased.
-on a specified date, Resident #2 found "fondling" Resident #4. Resident #2 refused to be redirected. Every 15 minute checks continue. (Please note: a late entry on a specified date, clarifies that the "fondling" was Resident #2 with a hand in the lap of Resident #4. Every 15 minute checks were implemented. Doctor was called and informed)

A review of the Clinical Record for Resident #2 indicated the following sexual/inappropriate behaviour directed towards unidentified residents:

-on a specified date, Resident was observed touching the leg of a co-resident (not identified). Staff instructed to monitor. Doctor was informed and medication was decreased
-on a specified date, Resident #2 was observed feeling the leg of another resident (unidentified) who was sitting in a wheelchair with their lower leg exposed. Resident #2 discontinued the behaviour when they saw Staff #11 watching. Every 15 minute checks re-initiated. The doctor discontinued medication, when informed of the resident's behaviours toward co-resident(s)

As evidenced by documented progress notes, plans of care, and staff interview; Resident #2 was known to display sexually inappropriate behaviour towards Residents of the opposite sex in the home including prior documented non-consensual touching of Residents of the opposite sex. The plan of care for this resident was not reassessed and different interventions were not implemented when the sexual behaviour continued except for some medication adjustments. The staff continued to separate the residents involved, implement or continue every 15 minute checks of Resident #2 after 10 sexually inappropriate incidents with no reassessment of the effectiveness of these interventions alone. It wasn't until after the 11th sexually inappropriate incident that the home updated Resident #2's Plan of Care and included 1:1 staffing to monitor Resident #2 at all times on evening shift, a referral to Psychiatric Assessment Services for the Elderly (PASE), and an order for long acting medication. Therefore, the home failed to protect Residents, in particular Resident #1, and Resident #4 from sexual abuse. [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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1.The licensee has failed to ensure that a person who has reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or a risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director.

A review of Resident Abuse Policy # Oper-02-02-04 includes the following:
Procedure-Responding/Reporting - Suspected or Witnessed Abuse
All Persons in the Home
1. If the abuse was witnessed, separate the resident from the alleged perpetrator (if safe to do so)
2. Stay at the scene to provide comfort and reassurance to the resident as needed.
3. Immediately report (verbally) any suspected or witnessed abuse:
-to the Administrator, Director of Care, or their designate (eg. supervisor)
-the Administrator, Director of Care, or their designate must report the incident, as required by provincial legislation and jurisdictional requirements, including but not limited to: ...MOHLTC Director through the Critical Incident Reporting System/after hours pager
4. Do not disturb any evidence

A review of the progress notes for Resident #2 indicate that on a specified date, Staff #10 had witnessed Resident #2 touching Resident # 1.

No report of this incident can be found in the Critical Incident System.

2. A review of the Clinical Records indicate that the Staff #17 was the Registered Nurse in charge of the home on the evening on a specified date. Staff #17 became aware that Resident #2 had put a hand under the clothing of Resident #1. Staff #17 completed an incident report yet failed to report this incident immediately to the Director. The incident was reported late on a specified date.[s. 24. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1.The licensee has failed to ensure that behavioural triggers have been identified for Resident #2 who was demonstrating responsive behaviours, specifically, sexually inappropriate touching:

Resident # 2 has a specified diagnosis and a history of sexually inappropriate behaviours.

Review of the Plan of Care indicated:
-Focus-Responsive Behaviours Symptoms: Resident #2 wanders the secure unit very frequently and can be resistive to personal care and bathing. Resident #2 has a history of being sexually inappropriate toward resident's of the opposite sex on the unit. This is due to cognitive impairment. The resident is easily redirected.
-Interventions-q 15min checks
-When Resident #2 is seen displaying sexually inappropriate behaviours, staff are to intervene and inform the resident that their behaviour is not acceptable. Report any inappropriate behaviours to registered staff immediately and initiate q 15 min checks

No triggers were identified in Resident #2's Plan of Care.[s. 53. (4) (a)]

2. The licensee has failed to ensure that for Resident #2 who was demonstrating sexually inappropriate behaviour, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

A review of the Clinical Record for Resident #2 indicated the following:

-on a specified date, Resident #2 was observed touching the leg of a co-resident. Staff instructed to monitor. Doctor was informed and medication decreased
-on a specified date, Resident #2 was observed leaning over Resident #4. Resident #4 was moved closer to the nursing station. Doctor informed by fax and every 15 minute checks started-medication increased.
-on a specified date, Resident #2 was observed feeling the leg of another resident who was sitting in a wheelchair with their lower leg exposed. Resident #2 discontinued the behaviour when he/she saw Staff #11 watching. Every 15 minute checks re-initiated. The doctor discontinued a medication, when informed of the resident's behaviours toward co-resident(s).
-on a specified date, Resident #2 was found standing over Resident #1 in their wheelchair. Resident #1's seat belt was undone. Resident put on every 15 minutes checks.
-on a specified date, Resident #2 was discovered by Staff #10 with a hand under the clothing of Resident #1 in the lounge. It was also documented that Resident #2 had moved Resident #1's legs onto his/her lap. Doctor informed.
-on a specified date, Resident #2 was observed reaching for Resident #1 and was stopped by Staff #12. Every 15 minute checks continue and a new order for a medication was received.
-on a specified date, Resident #2 was observed "hovering" around nursing station while another resident was behind the nursing station with the gate closed.
-on a specified date, the resident was found with a hand on the lap of Resident #3. Resident #2 removed the hand immediately when Staff #13 approach. Every 15 minute checks continued.
-on a specified date, resident observed with a hand on the thigh of a co-resident. Both residents were redirected. Staff monitoring "closely".
-on a specified date, Resident #2 was found "fondling" Resident #4. Resident #2 refused to be redirected. Every 15 minute checks continue. (Please note: a late entry for a specified date, clarifies that the "fondling" was Resident #2 with a hand in the lap of Resident #4. Every 15 minute checks were implemented. Doctor was called and informed)
-on a specified date, Resident #2 was discovered by a family member of Resident #4 to put a hand under the clothing of Resident #2 after first looking around as if to ensure they would not be seen. Resident stopped when the family member of Resident #4 called out to stop. Close monitoring continued "as per normal".

In an interview on a specified date, Staff #14 indicated that the plan of care was to keep Resident #2 away from Resident #1 and #4.

In an interview on a specified date, Staff #10 indicated that in order to keep Resident #1 and #4 safe from Resident #2 on night shift if they are still up in their wheelchairs, the staff will put them behind the nursing station and close the half gate. There are only 2 personal support workers on night shift and the Registered Nurse is not on the unit the entire shift.

In an interview on a specified date, Staff #15 and 16 indicated that they had been doing every 15 minute checks on Resident #2 for a couple of weeks. Staff # 15 indicated that Resident #2 gravitates toward Resident #1 or any resident of the opposite sex that is in a wheelchair especially when no staff are around. Staff #15 stated that they make sure Resident #2 is not sitting near any members of the opposite sex in the lounge. Staff #16 agreed with these statements.

The Plan of Care indicated:
Focus-Responsive Behaviours Symptoms: Resident #2 wanders the unit very frequently. The resident has a history of being sexually inappropriate toward co-residents on the unit. This is due to a specified diagnosis. The resident is easily redirected.
Goals-Minimize risks and decrease behaviours through review date.
Interventions- Resident #2 will leave bedroom wearing only underwear. Staff to remind not to wander without clothing on. Resident to return to bedroom immediately if found wandering in underwear and assist with putting clothing on
-q 15min checks initiated
-When Resident #2 is seen displaying sexually inappropriate behaviours, staff are to intervene and inform the resident that the behaviour is not acceptable. Report any inappropriate behaviours to registered staff immediately and initiate q 15 min checks.

Resident #2 has a known history of sexually inappropriate behaviour. The plan of care for this resident was not reassessed and different interventions were not implemented when the sexual behaviour continued except for some medication adjustments. The staff continued to separate the residents involved, implement or continue every 15 minute checks of Resident #2 after 10 sexually inappropriate incidents with no reassessment of the effectiveness of these interventions. After the 11th sexually inappropriate incident, Resident #2's Plan of Care was updated to include 1:1 staffing to monitor Resident #2 at all times, a referral to Psychiatric Assessment Services for the Elderly (PASE), an order for long acting medication.[s. 53. (4) (c)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1.The licensee has failed to ensure that Resident #1, #3, and #4's substitute decision-maker were notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and (b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

After a review of the Clinical record, there was no evidence that Resident #1's substitute decision-maker (SDM) was notified after the following incident of sexual abuse by Resident #2:

On a specified date, Resident #2 was observed by Staff #10 to be touching Resident #1.

After a review of the Clinical record, no evidence that Resident #3's substitute decision-maker (SDM) was notified after the following incident of sexual abuse by Resident #2:

-on a specified date, Resident #2 was observed with a hand in the lap of Resident #3.

After a review of the Clinical record, no evidence that Resident #4's substitute decision-maker (SDM) was notified after the following incident of sexual abuse by Resident #2:

-on a specified date, Resident #2 was found with a hand in the lap of Resident #4. The physician was notified, Resident #2 was placed on every 15 minute checks, and the SDM of Resident #2 was notified. The SDM of Resident #4 was not notified.[s. 97. (1) (b)]

Additional Required Actions:

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

Issued on this 21st day of November, 2014

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PATRICIA BELL (571)
Inspection No. / No de l'inspection :	2014_328571_0022
Log No. / Registre no:	O-003132-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 20, 2014
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE COBOURG 130 NEW DENSMORE ROAD, COBOURG, ON, K9A-5W2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LYNDA DAVLUT

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

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

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 :

To achieve compliance with the duty to protect residents from sexual abuse by other residents, the licensee shall:
1. Prevent Resident #2 from being alone with Residents of the opposite sex, being seated near Residents of the opposite sex unsupervised or be in any situation where Resident #2 could behave sexually inappropriately towards another Resident.
2. Develop strategies to minimize sexual behaviours displayed by Resident #2 including, psychological, pharmaceutical, social, behavioural and physical interventions.
3. Develop responsibilities of each staff discipline in preventing further occurrence of sexual abuse from Resident #2 towards another Resident.
4. Continuously monitor above steps to ensure that the plan is relevant if/when contributing factors change.

Grounds / Motifs :

1. 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".

This non-compliance is supported by the following findings:

Family member (F10) of Resident #4, submitted a written complaint to the home on a specified date as they had witnessed inappropriate sexual touching of Resident #1 by Resident #2 on a specified date. The home subsequently submitted a Critical Incident report to the director.

During an interview with F10, they indicated that on a specified date in the

evening, Resident #2 walked slowly toward Resident #1 who was sitting beside the nursing station in a wheelchair. Resident #2 proceeded to look around and then put a hand underneath the clothing of Resident #1. F10 called out to Resident #2 to stop. The resident stopped and immediately walked towards F10 with an angry look in their eyes. F10 walked away from the resident and then returned to the nursing station to watch over Resident #1 until the Charge Nurse or a Personal Support Worker returned. F10 stated that they believed Resident #1 was upset as the resident began to rock back and forth in the wheelchair faster than usual and gripped the arms of the chair tightly. In addition, F10 disclosed that their family member, Resident #4, had been sexually assaulted by Resident #2 in the past.

A review of the Clinical Record indicated:

Resident #1 has a specified diagnosis and spends time in a wheelchair.

Resident #4 has a specified diagnosis, is wheelchair bound and has a history of sexual abuse by Resident #2.

In a telephone interview on a specified date, the DOC indicated that Resident #1 and #4 were incapable of giving consent.

Resident # 2 has a specified diagnosis, and is ambulatory. Resident#2 has a history of sexually inappropriate behaviour and was referred to PASE for the following incidents:
-the resident was suspected of removing Resident #4's clothing while he/she was lying in bed on a specified date although it was unwitnessed, Resident #4 was found undressed with face flushed, Resident #2 stated he/she had "patted" Resident #4
-Resident #2 was seen by a psychiatrist on a specified date after an incident occurring on a specified date, when the Resident #2 was seen having a hand under another resident's clothing
-a review by a Social Worker from the PASE dated on a specified date,after the incident that occurred, indicated that Resident #2 is "aware of the social nuances of engaging in "Sexual Touching/Actions" and is a risk for further actions.

A review of the Clinical Record for Resident #2 indicated the following sexual/inappropriate/suspicious behaviour directed towards Resident #1:

-on a specified date, Resident #2 was found standing over Resident #1 in their wheelchair. Resident #1's seat belt was undone. Resident #2 was put on every 15 minutes checks.
-on a specified date, Resident #2 was discovered by Staff #10 touching Resident #1 in the lounge. It was also documented that Resident #2 had moved Resident #1's legs onto his/her lap. Doctor informed by fax. On the fax cover sheet Staff #20 indicated that Resident #2 had been exhibiting sexual disinhibition in form of touching residents of the opposite sex who are unable to object/defend themselves" and that the behaviour appears to occur at a certain time of day.
-on a specified date, Resident #2 was observed reaching for Resident #1 and was stopped by Staff #12. Every 15 minute checks continue and a new order for medication was received.
-on a specified date, Resident #2 was observed "hovering" around the nursing station while Resident #1 was behind the nursing station with the gate closed.
-on a specified date- Resident #2 was discovered by the family of Resident #4 to put a hand under the clothing of Resident #1 after first looking around as if to ensure he/she would not be seen. Resident stopped when F10 called out to stop. Close monitoring continued "as per normal".

A review of the Clinical Record for Resident #2 indicated the following sexual/inappropriate/suspicious behaviour directed towards Resident #4:

-on a specified date, the resident was observed leaning over Resident #4. Resident #4 was moved closer to the nursing station. Doctor informed by fax and every 15 minute checks started and medication increased.
-on a specified date, Resident #2 found "fondling" Resident #4. Resident #2 refused to be redirected. Every 15 minute checks continue. (Please note: a late entry on a specified date, clarifies that the "fondling" was Resident #2 with a hand in the lap of Resident #4. Every 15 minute checks were implemented. Doctor was called and informed)

A review of the Clinical Record for Resident #2 indicated the following sexual/inappropriate behaviour directed towards unidentified residents:

-on a specified date, Resident was observed touching the leg of a co-resident (not identified). Staff instructed to monitor. Doctor was informed and medication

was decreased
-on a specified date, Resident #2 was observed feeling the leg of another resident (unidentified) who was sitting in a wheelchair with their lower leg exposed. Resident #2 discontinued the behaviour when they saw Staff #11 watching. Every 15 minute checks re-initiated. The doctor discontinued medication, when informed of the resident's behaviours toward co-resident(s)

As evidenced by documented progress notes, plans of care, and staff interview; Resident #2 was known to display sexually inappropriate behaviour towards Residents of the opposite sex in the home including prior documented non-consensual touching of Residents of the opposite sex. The plan of care for this resident was not reassessed and different interventions were not implemented when the sexual behaviour continued except for some medication adjustments. The staff continued to separate the residents involved, implement or continue every 15 minute checks of Resident #2 after 10 sexually inappropriate incidents with no reassessment of the effectiveness of these interventions alone. It wasn't until after the 11th sexually inappropriate incident that the home updated Resident #2's Plan of Care and included 1:1 staffing to monitor Resident #2 at all times on a specified shift, a referral to Psychiatric Assessment Services for the Elderly (PASE), and an order for long acting medication. Therefore, the home failed to protect Residents, in particular Resident #1, and Resident #4 from sexual abuse. (571)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 28, 2014

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that a staff member who has reasonable grounds to suspect that sexual abuse has occurred shall immediately report the suspicion and the information upon which it is based to the Director by:
1. Ensuring a process is in place to report abuse to the Director as per the LTCHA, 2007, S.O. 2007, c.24, s.1., and that staff are educated in this process.
2. Ensuring that staff are retrained on the home's policy to promote zero tolerance of abuse and neglect of residents, specifically the definition of sexual abuse.

Grounds / Motifs :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or a risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director.

A review of Resident Abuse Policy # Oper-02-02-04 includes the following:
Procedure-Responding/Reporting - Suspected or Witnessed Abuse
All Persons in the Home
1. If the abuse was witnessed, separate the resident from the alleged perpetrator (if safe to do so)
2. Stay at the scene to provide comfort and reassurance to the resident as needed.
3. Immediately report (verbally) any suspected or witnessed abuse:
-to the Administrator, Director of Care, or their designate (eg. supervisor)
-the Administrator, Director of Care, or their designate must report the incident, as required by provincial legislation and jurisdictional requirements, including but not limited to: ...MOHLTC Director through the Critical Incident Reporting System/after hours pager
4. Do not disturb any evidence

A review of the progress notes for Resident #2 indicated that on a specified date, Staff #10 had witnessed Resident #2 touching Resident # 1.

No report of this incident can be found in the Critical Incident System. (571)

2. A review of the Clinical Records indicate that Staff #17 was the Registered Nurse in charge of the home on the evening on a specified date. Staff #17 became aware that Resident #2 had put a hand under the clothing of Resident #1. Staff #17 completed an incident report yet failed to report this incident immediately to the Director. The incident was reported late on a specified date. (571)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 02, 2015

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee shall ensure that for Resident #2 who was demonstrating responsive behaviours, specifically, sexually inappropriate behaviour:
1. The behavioural triggers for the resident are identified.
2. Actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

Grounds / Motifs :

1. The licensee has failed to ensure that behavioural triggers have been identified for Resident #2 who was demonstrating responsive behaviours, specifically, sexually inappropriate touching:

Resident # 2 has a specified diagnosis and a history of sexually inappropriate behaviours.

Review of the Plan of Care indicated:
-Focus-Responsive Behaviours Symptoms: Resident #2 wanders the secure unit very frequently and can be resistive to personal care and bathing. Resident #2 has a history of being sexually inappropriate toward resident's of the opposite sex on the unit. Is easily redirected.
-Interventions-q 15min checks
-When Resident #2 is seen displaying sexually inappropriate behaviours, staff

are to intervene and inform the resident that their behaviour is not acceptable. Report any inappropriate behaviours to registered staff immediately and initiate q 15 min checks

No triggers were identified in Resident #2's Plan of Care. (571)

2. The licensee has failed to ensure that for Resident #2 who was demonstrating sexually inappropriate behaviour, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

A review of the Clinical Record for Resident #2 indicated the following:

-on a specified date, Resident #2 was observed touching the leg of a co-resident. Staff instructed to monitor. Doctor was informed and medication decreased
-on a specified date, Resident #2 was observed leaning over Resident #4. Resident #4 was moved closer to the nursing station. Doctor informed by fax and every 15 minute checks started-medication increased.
-on a specified date, Resident #2 was observed feeling the leg of another resident who was sitting in a wheelchair with their lower leg exposed. Resident #2 discontinued the behaviour when he/she saw Staff #11 watching. Every 15 minute checks re-initiated. The doctor discontinued a medication, when informed of the resident's behaviours toward co-resident(s).
-on a specified date, Resident #2 was found standing over Resident #1 in their wheelchair. Resident #1's seat belt was undone. Resident put on every 15 minutes checks.
-on a specified date, Resident #2 was discovered by Staff #10 with a hand under the clothing of Resident #1 in the lounge. It was also documented that Resident #2 had moved Resident #1's legs onto his/her lap. Doctor informed.
-on a specified date, Resident #2 was observed reaching for Resident #1 and was stopped by Staff #12. Every 15 minute checks continue and a new order for a medication was received.
-on a specified date, Resident #2 was observed "hovering" around nursing station while another resident was behind the nursing station with the gate closed.
-on a specified date, the resident was found with a hand on the lap of Resident #3. Resident #2 removed the hand immediately when saw Staff #13 approached. Every 15 minute checks continued.

-on a specified date, resident observed with a hand on the thigh of a co-resident. Both residents were redirected. Staff monitoring "closely".
-on a specified date, Resident #2 was found "fondling" Resident #4. Resident #2 refused to be redirected. Every 15 minute checks continue. (Please note: a late entry for a specified date, clarifies that the "fondling" was Resident #2 with a hand in the lap of Resident #4. Every 15 minute checks were implemented. Doctor was called and informed)
-on a specified date, Resident #2 was discovered by a family member of Resident #4 to put a hand under the clothing of Resident #2 after first looking around as if to ensure he/she would not be seen. Resident stopped when the family member of Resident #4 called out to stop. Close monitoring continued "as per normal".

In an interview on a specified date, Staff #14 indicated that the plan of care was to keep Resident #2 away from Resident #1 and #4.

In an interview on a specified date, Staff #10 indicated that in order to keep Resident #1 and #4 safe from Resident #2 on night shift if they are still up in their wheelchairs, the staff will put them behind the nursing station and close the half gate. There are only 2 personal support workers on night shift and the Registered Nurse is not on the unit the entire shift.

In an interview on a specified date, Staff #15 and 16 indicated that they had been doing every 15 minute checks on Resident #2 for a couple of weeks. Staff # 15 indicated that Resident #2 gravitates toward Resident #1 or any resident of the opposite sex that is in a wheelchair especially when no staff are around. Staff #15 stated that they make sure Resident #2 is not sitting near any members of the opposite sex in the lounge. Staff #16 agreed with these statements.

The Plan of Care indicated:
Focus-Responsive Behaviours Symptoms: Resident #2 wanders the unit very frequently. The resident has a history of being sexually inappropriate toward co-residents on the unit. The resident is easily redirected.
Goals-Minimize risks and decrease behaviours through review date.
Interventions- Resident #2 will leave bedroom wearing only underwear. Staff to remind the resident not to wander without clothing on. Resident to return to bedroom immediately if found wandering in underwear and assist with putting clothing on

-q 15min checks initiated
-When Resident #2 is seen displaying sexually inappropriate behaviours, staff are to intervene and inform the resident that the behaviour is not acceptable. Report any inappropriate behaviours to registered staff immediately and initiate q 15 min checks.

Resident #2 has a known history of sexually inappropriate behaviour. The plan of care for this resident was not reassessed and different interventions were not implemented when the sexual behaviour continued except for some medication adjustments. The staff continued to separate the residents involved, implement or continue every 15 minute checks of Resident #2 after 10 sexually inappropriate incidents with no reassessment of the effectiveness of these interventions. After the 11th sexually inappropriate incident, Resident #2's Plan of Care was updated to include 1:1 staffing to monitor Resident #2 at all times, a referral to Psychiatric Assessment Services for the Elderly (PASE), and an order for long acting medication.
(571)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 28, 2014

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,

(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and

(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Order / Ordre :

The licensee shall ensure that a process is in place to ensure that when an alleged, suspected, or witnessed incident of sexual abuse occurs, the substitute-decision maker is notified as per O. Reg 79/10, s. 97 (1) and that staff are educated about the process.

Grounds / Motifs :

1. The licensee has failed to ensure that Resident #1, #3, and #4's substitute decision-maker were notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and (b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

After a review of the Clinical record, there was no evidence that Resident #1's substitute decision-maker (SDM) was notified after the following incident of sexual abuse by Resident #2:

On a specified date, Resident #2 was observed by Staff #10 to be touching Resident #1.

After a review of the Clinical record, no evidence that Resident #3's substitute decision-maker (SDM) was notified after the following incident of sexual abuse by Resident #2:

-on a specified date, Resident #2 was observed with a hand in the lap of Resident #3.

After a review of the Clinical record, no evidence that Resident #4's substitute decision-maker (SDM) was notified after the following incident of sexual abuse by Resident #2:

-on a specified date, Resident #2 was found with a hand in the lap of Resident #4. The physician was notified, Resident #2 was placed on every 15 minute checks, and the SDM of Resident #2 was notified. The SDM of Resident #4 was not notified.

(571)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 02, 2015

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 20th day of November, 2014

Signature of Inspector /
Signature de l'inspecteur :

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

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