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 9, 2016	2016_291194_0017	022948-16	Complaint

Licensee/Titulaire de permis

The Corporation of the City of Peterborough and The Corporation of the County of Peterborough
881 Dutton Road PETERBOROUGH ON K9H 7S4

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

FAIRHAVEN
881 Dutton Road PETERBOROUGH ON K9H 7S4

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

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 27, 28, 29, August 01, 02 and 03, 2016

Also inspected: Log #022948-16 complaint alleged resident/resident sexual abuse, #020749-16, #020747-16, #022881-16, #023012-16, #023928-16, #023929-16, #023934-16, #023939-16, Critical Incidents alleged resident/resident sexual abuse, #022624-16 Critical Incident alleged staff to resident neglect.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Resident Care (DRC), Resident Care Manager (RCM), Chief Operating Officer (COO), Residents, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Registered Practical Nurse and PSW/Behavioural Support Ontario(BSO)

The inspector also observed staff to resident provision of care. Reviewed identified resident's clinical health records, Abuse policy, and Licensee's internal investigation into abuse.

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

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to protect resident #002 from abuse by resident #001

Log #22948-16 involving resident #001

O. Reg 79/10 s.2(1) defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a person other than a license or staff member.

Resident #001 has minimal cognitive impairment with a current CPS score of "1" an is responsible for decision related to all care. Resident #001 has a history of sexual in appropriate behaviour. Resident #001 is independent with most care, ambulates with walker or wheelchair. DRC has indicated to inspector that resident #001 is POA.

Resident #002 has moderate cognitive impairment with current CPS core of "3". Resident #002 is wheelchair dependent but able to ambulate on the unit without assistance. DRC has indicated to inspector #194 that resident #002 is cognitively impaired and unable to provide consent.

On an identified date inspector #117 conducted a telephone interview with the PSW #104. PSW #104 indicated being informed by PSW #124 that on an identified date, resident#001 was inappropriate towards resident #002 and the family member intervened and removed resident #001 from resident #002's room then reported incident to RPN #105, who reported to RN #106.

On July 27, 2016 during entrance interview with Administrator, Director of Resident Care (DRC) and Chief Operations officer (COO), inspector #194 was informed that on an identified date DRC was called at home by charge RN #106. DRC indicated that she was informed by RN #106 that PSW #104 had left the building stating, having to leave that it was a personal matter involving resident #001.

DRC informed inspector #194 that one to one monitoring was initiated for a period of two days for resident #001. DRC indicated that this was put into place because resident #001 had a past history of inappropriate sexual behaviour. DRC feared PSW #104 had not disclosed inappropriate sexual behaviour involving resident #001 and wanted to be sure the other residents were safe. DRC indicated that no inappropriate sexual behaviour has been noted since the one to one monitoring has been in place.

During telephone interview with family members; it was indicated that on an identified date family member and co-resident were coming down the hall when family member witnessed resident #001's hand on resident #002's leg and was moving up the resident

#002's leg. Family member observed resident #002 pushing resident #001's hand away. Family member told resident #001 "you shouldn't be doing that" and resident #001 "took off". The inspector was informed by family members that the incident was reported the next day to RPN #117. Both family members stated they have never witnessed resident #001 being sexually inappropriate before or since the incident.

During an interview with inspector #194, RPN #117 indicated that on an identified date (the following day) the family member of co-resident came to the unit to inform RPN #117 that a few days ago, the family member had witnessed resident #001 touching resident #002 inappropriately and had intervened. RPN #117 indicated that no details were given and did not request any further information. RPN #117 indicated to inspector that the incident was reported to RN #123, called POA and also informed RPN #110 the oncoming nurse for the unit as it was the end of the shift.

During a telephone interview with inspector #194, RN #123 indicated having no recollection of being informed by RPN #117 of inappropriate sexual behaviour involving resident #001 on an identified date.

During an interview PSW #124 indicated to inspector #194 being informed by RPN #105 during shift report on an identified date, that there had been a sexual assault between resident #001 and #002.

On an identified date inspector #194 interviewed a family member who had witnessed an incident of alleged sexual abuse involving resident#001. Family member indicated to inspector witnessing resident #001's hand on resident #002's leg and was moving up the leg. Family member indicated that resident #002 pushed resident #001's hand away.

The licensee failed to protect resident #002 from resident #001 by not immediately investigating the incident, reporting to the Director under LTCHA, 2007, implementing specific interventions and re-initiating Care Tips Sheet for resident #001 until sixteen days after the alleged sexual abuse was reported. (Refer to WN#2, WN#3, WN#4, WN#5,WN#6)

The licensee failed to protect resident #005, #006, #007, #010, #011, #012 from abuse by resident #004

Log #022881-16 involving resident #004 and #006

Resident #004 has cognitive impairment. Resident #004 is independent with wheelchair and is capable of transferring without assistance, requires constant supervision with dressing, and supervision with minimal set up or assistance with eating.

Resident #006 has cognitive impairment.

Critical incident(CIR)for resident to resident alleged sexual abuse was submitted to the Director. The CIR indicated that PSW #127 entered resident #004's room and found resident #006 on top of resident #004. Both residents were dressed. The critical incident indicated that residents were calm and had no recollection of the incident.

Log #023012-16 involving resident #004 and #005

Resident #005 has significant cognitive impairment.

Critical incident(CIR)for resident to resident alleged sexual abuse was submitted to the Director. The CIR indicated that on an identified date PSW #136 witnessed resident #004 in the dining room grabbing resident #005's breasts. The critical incident indicates there were no ill effects noted for either resident.

Upon entering the home, inspector #194 requested the home's investigation into the incidents that occurred on an identified date. Inspector was provided with the licensee's internal investigation reports, access to resident #004's progress notes and informed that one to one monitoring for resident #004 had been initiated on an identified date.

PSW #127's statement, indicated that PSW #127 heard a bed alarm coming from resident #004's room, upon entering the room PSW #127 found resident #006 sitting on resident #004's lap. Resident #006 who was naked from the waist down, was screaming and hitting resident #004 who was also naked. PSW #127 indicated that removing resident #006 and assisted the resident back to the bedroom. During interview with inspector #194, PSW #127 repeated the information noted in the statement provided to the home.

PSW #136's statement, indicated that PSW #136 witnessed resident #005 trying to pass resident #004 between the dirty kitchen cart and a dining room table, therefore both residents were caught in a tight spot. Because resident #005 could not get past resident#004's wheelchair, resident #004 was grabbing resident #005's breasts, without letting go. Resident #005 was trying to push resident #004 away. Resident #004 did not

stop until PSW #136 was able to push resident #004 away.

On an identified date one to one monitoring commenced for Resident #004 and the following was indicated in the documentation:

Log #023012-16 involving resident #006, Log #023929-16 involving resident #007, Log #023928-16 involving resident #010, Log #023934-16 involving resident #011, Log #023939-16 involving resident #014.

On first day of one to one monitoring, resident continues to be sexually inappropriate grabbing staff and co resident breasts. Interview with PSW #124 was conducted and PSW #124 was unable to remember who the residents were that were touched by resident #004.

On second day of one to one monitoring, when in the dining room resident grabbed a co-resident breast. The PSW #137 was not available for interview. During an interview with Inspector #194, on August 02, 2016, PSW #133 indicated that on the second day of one to one monitoring at the lunch meal resident #004 was witnessed grabbing resident #006's breasts. PSW #133 indicated that resident #004 was very quick and resident #006 did not react to the touching. PSW #133 removed resident #006 from the table for the remainder of the meal.

On the third day of one to one monitoring resident groped two females and one male resident. During an interview with inspector #194 PSW #132 indicated that the female residents involved were resident #010 and #011 and the male resident was #012. PSW #132 indicated that when pushing resident #004 in the wheelchair in front of the dining room, resident #004 put a hand flat upon resident #010's breast, who was sitting in a tilt wheelchair outside the dining room, PSW #132 indicated that he removed resident #004's hand and resident #010 did not have any reaction to the touch. PSW # 132 indicated as they kept walking by resident #004 again place a hand flat upon resident #011's breast, also sitting in a tilt wheelchair outside the dining room. PSW# 132 indicated that resident #004's hand was removed and that resident #011 did not have a reaction to the touch. PSW #132 indicated that as they were walking up the hall, resident #012 was coming towards them, as resident #012 passed by the wheelchair, resident #004 reached out and grabbed resident #012 by the buttocks. PSW #132 indicated that resident #012 did not have any reaction to the touching. PSW #132 indicated to inspector that resident #004 was very quick and it was very difficult to ensure that the resident's hands did not touch co residents.

On fourth day of one to one monitoring PSW #135 and resident were walking in the halls, resident #004 grabbed resident #007's on the buttocks and then when they returned to the resident's room, resident #004 put a hand on resident #014's leg near the groin area. During an interview with inspector #194, PSW #135 indicated that the first incident occurred before breakfast in the hallway, resident #004 was being pushed in the wheelchair as they passed by resident #007 resident #004 grabbed resident #007's buttocks. PSW # 135 indicated that the second incident occurred after lunch upon return to resident #004's room. Resident #014 was sitting in resident #004's recliner chair and upon entering the room resident #004 wheeled up to resident #014 and placed a hand on resident # 014's leg near the groin area. PSW #135 indicated that neither resident #007 or #014 had any reaction to the touching.

All PSW staff interviewed related to the incidents recorded in the one to one documentation indicated that they reported the incidents to the RPNs. All incidents except for the incident noted on first day of one to one monitoring indicated to have been reported to RPN #130. When interviewed RPN #130 indicated not being notified of the incidents and that the one to one documentation had not been reviewed at the end of the shift.

Interview with DRC and RCM #135 was conducted on August 02, 2016 to discuss the entries noted in the one to one documentation. Neither were aware that incidents had occurred and no report to Director had been initiated for the incidents documented.

The licensee failed to comply with:

LTCHA s. 23. (1) Every licensee of a long-term care home shall ensure that, (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone. (Refer to WN #3)
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 a risk of harm to the resident.(Refer to WN #4)
LTCHA s.20(1) Without in anyway restricting the generality of the duty provided for in section s.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. (Refer to WN #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 any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. (Refer to WN #6)
O. Reg 79/10 s. 54 (a)Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents including;
(a)identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(Refer to WN #5) [s. 19. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

Review of "Zero tolerance of abuse and neglect " RCM-RR-590 dated December 2015 was reviewed.

All staff of Fairhaven must report any act of resident abuse to their supervisor as soon as incident occurs.

-report any witnessed, suspected or alleged abuse to your supervisor/manager immediately.
-complete a detailed description using the Incident investigation Form including where the incident happened, who was involved, when it happened, what occurred and what interventions were put in place.
- in the event of any alleged incident of resident abuse, the supervisor/manager will notify Ministry of Heath and Long Term Care immediately and document in PCC.

Clinical staff responsible for care of the resident(s) harmed by abuse or neglect
-provide interventions for the resident or residents who have been allegedly abused or neglected and their roommates where appropriate
-document details of incident using Incident investigation Form and in PCC.Communicate the status of the resident's health condition, further assessments arranged, and health investigation findings to the supervisor/manager and CEO.

Def'n of sexual abuse:
any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

RESPONSE TO REPORT ABUSE

A report of a resident abuse may come to the attention of the supervisor/manager from a number of sources: the resident, family or friends, staff member or volunteer, visitor or by direct observation.

immediate response:
-the supervisor/manager will notify senior management and CEO
-the supervisor/manager will inform all parties involved and begin investigation by having persons involved completed in detail the incident investigation form immediately while those who have knowledge of the incident are still on duty or in the building
-supervisor/manager will inform resident SDM. Upon home becoming aware of the other alleged, suspected or witnessed incident of abuse or neglect of the resident's the SDM will be notified with in12 hours and upon completion of the investigation.
-Fairhaven 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 Fairhaven suspects may constitutes a criminal offence.
-in the event of any alleged incident of resident abuse , the supervisor/manager will notify

MOHLTC immediately and document in PCC. RCM will submit a CIS within 10 days or earlier date if required by senior manager.

The licensee has failed to ensure that the homes' Zero Tolerance of neglect and abuse policy contains and explanation of the duty under s. 24 of the Act to make mandatory reports. On July 27, 2016 inspector #194 reviewed Fairhaven's Zero Tolerance of neglect and abuse policy , # RCM-RR-590, revised December 01, 2015. A review of the abuse policy did not include an explanation of the duty under s.24 of the Long Term Homes Act to make mandatory reports to the Director. The home Duty to Report policy indicates;

A report of a resident abuse may come to the attention of the supervisor/manager from a number of sources: the resident, family or friends, staff member or volunteer, visitor or by direct observation.

-In the event of any alleged incident of resident abuse, the supervisor/manager will notify the Ministry of Health and Long-Term Care immediately and document in PCC.

Log #022948-16 involving resident #001

On an identified date family members reported to RPN #117 that resident #001 had been sexually inappropriately towards resident #002.(Refer to WN #1)

A reported incident of alleged sexual abuse between resident #001 and resident #002 was received on an identified date, an investigation into the incident, notification of the Director under LTCHA, 2007, Police and an Incident investigation Form were not initiated as directed by the policy. [s. 20. (1)]

2. Log #022881-16 and #023012-16 involving resident #004

Resident #004 was placed on one to one monitoring on an identified date, after two separate incidents that day of sexually abusing co-residents reported by Critical incident reports (CIR). Review of the one to one binder was completed by inspector and noted six separate incidents of sexual abuse involving resident #004 on three consecutive days were documented. (Refer to WN#1)

The licensee failed to comply with their policy when RPN #130 did not immediately report the incidents of sexual abuse documented by PSW's on three consecutive days to

supervisor/manager. Immediate notification to the Director under LTCHA, 2007, completion of the Incident investigation form and an immediate investigation into the reported sexual abuses did not occur. [s. 20. (1)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Log #022948-16 involving resident #001

On an identified date family members reported to RPN #117 that resident #001 had been sexually inappropriately towards resident #002. (Refer to WN #1)

A reported incident of alleged resident to resident sexual abuse was reported to RPN #117 on an identified date and investigation was not initiated. [s. 23. (1) (a)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Log #022948-16 involving resident #001

On an identified date family members reported to RPN #117 that resident #001 had been sexually inappropriately towards resident #002. (Refer to WN #1)

A reported incident of alleged resident to resident sexual abuse was reported to RPN #117 on an identified date the incident was not immediately reported to the Director under LTCHA, 2007. [s. 24. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents #001 and #002. Steps were not taken to identifying factors based on an interdisciplinary assessment, information provided to the licensee by family members on an identified date and through staff observation that could potentially trigger such altercations.

Log #022948-16 involving resident #001

On an identified date family members reported to RPN #117 that resident #001 had been sexually inappropriately towards resident #002. (Refer to WN #1)

The plan of care for resident #001 indicated inappropriate sexual behaviour (verbal and physical) related to resident and staff.
-staff are to remind the resident that it is inappropriate to hug staff, resident or visitors and offer to shake the resident's hand when resident is asking for a hug
-set limits or acceptable behaviour be direct and explain that it is inappropriate to touch female staff or residents
-refer to care tips
-monitor resident's interactions with female staff, visitors and residents and ensure a staff is present when the potential for resident to be alone with a female exists. Report any concerns with sexually inappropriate behaviour to the RPN immediately.
-utilize door alarm during the night to alert staff that resident is awake and exiting the room. Turn on daily at HS and turn off in the am

-resident has a binder at the care center for staff to utilize daily, staff should review care tips prior to care and utilize the behaviour charting to document any inappropriate sexual behaviours in addition to reporting them to the RHA, RPN

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #001 and resident #002 when interventions for resident #001 were not implemented for seventeen days after report of alleged sexual abuse. (Refer to WN #1) [s. 54. (a)]

2. Log #022881-16 and #023012 involving resident #004

On an identified date, one to one monitoring was initiated for resident #004 related to two separate incidents of sexual abuse towards co residents in the home, reported in CIRs. (Refer to WN #1)

Review of the one to one monitoring notes for the period of eight days for resident #004 was completed by inspector # 194 and identified that the six incidents of alleged sexual abuse occurred after one to one monitoring was implemented. (Refer to WN #1)

On August 02, 2016 during interview, both DRC and RCM #135 confirmed that no interventions related to the one to one documentation for resident #004 the period of eight days had been implemented. August 02, 2016 (six days after the one to one monitoring for resident #004 was initiated) after review of the one to one documentation information with inspector #194, the following additional interventions were implemented for resident #004.

-Ensuring to maintain eyes on your assigned resident at all times.
-Report any incident so verbal aggression,physical aggression and sexually inappropriate comments or touching to the RPN immediately.
-Utilize the behaviour sheets in the one to one binder to document all details pertaining to the incident and note the time the incident occurred as well as the time the RPN was made aware.
-complete and incident investigation form as soon as possible if required; ensure it is completed in full before leaving the RHA (Resident Home area)
-monitor resident and maintain at least an arms' length of distance between resident and any co-residents, staff or visitor when passing in the corridor or sitting near.
-be aware of your body position in relation to the resident at all times (especially the resident's hands) Avoid reaching across resident or bending over in front of resident

-redirect resident from high traffic areas by offering to push resident in the opposite direction
-one to one monitoring is in place to prevent recurrence of incidents, if incidents/issues are at risk of happening remove the resident to an area of low traffic (activity room, garden, bedroom) if needed to keep other residents safe
-limit the amount of time resident must be in dining room awaiting meal service to decrease the potential for incident to occur, offer meal to resident immediately once in dining room when appropriate.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #004 and co-resident when the one to one monitoring documentation for resident #004 identifying ongoing sexual abuse was not reviewed by registered staff. [s. 54. (a)]

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force 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 offence

Log #022948-16 involving resident #001

On an identified date family members reported to RPN #117 that resident #001 had been sexually inappropriately towards resident #002. (Refer to WN #1)

A reported incident of alleged resident to resident sexual abuse was reported to the RPN #117 on an identified date the incident was not immediately reported to the police. [s. 98.]

Issued on this 9th 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) :	CHANTAL LAFRENIERE (194)
Inspection No. / No de l'inspection :	2016_291194_0017
Log No. / Registre no:	022948-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 9, 2016
Licensee / Titulaire de permis :	The Corporation of the City of Peterborough and The Corporation of the County of Peterborough 881 Dutton Road, PETERBOROUGH, ON, K9H-7S4
LTC Home / Foyer de SLD :	FAIRHAVEN 881 Dutton Road, PETERBOROUGH, ON, K9H-7S4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JOY L. HUSAK

To The Corporation of the City of Peterborough and The Corporation of the County of Peterborough, 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 :

The licensee shall:

1. Immediately upon receiving this Compliance Order, ensure that all residents exhibiting responsive behaviours 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. The licensee's "Zero Tolerance of Abuse and Neglect" RCM-RR-590 policy is revised to include an explanation of the duty under s.24 of the LTCHA, 2007 to make mandatory reports, as required under s.20 of the same Act;

3. All staff, including members of the management team, are re-educated on the revised licensee's abuse policy, ensuring that the following topics are covered:
a. definition and identification of resident sexual abuse,
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.

4. Monitoring system is implemented whereby daily audits are conducted by members of the management team for the purpose of assessing compliance with all aspects of the revised licensee's abuse policy.

Grounds / Motifs :

1. The licensee failed to protect resident #002 from abuse by resident #001

Log #22948-16 involving resident #001

O. Reg 79/10 s.2(1) defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a person other than a license or staff member.

Resident #001 has minimal cognitive impairment with a current CPS score of "1" an is responsible for decision related to all care. Resident #001 has a history of sexual in appropriate behaviour. Resident #001 is independent with most care, ambulates with walker or wheelchair. DRC has indicated to inspector that resident #001 is POA.

Resident #002 has moderate cognitive impairment with current CPS core of "3". Resident #002 is wheelchair dependent but able to ambulate on the unit without assistance. DRC has indicated to inspector #194 that resident #002 is cognitively impaired and unable to provide consent.

On an identified date inspector #117 conducted a telephone interview with the PSW #104. PSW #104 indicated being informed by PSW #124 that on an identified date, resident#001 was inappropriate towards resident #002 and the family member intervened and removed resident #001 from resident #002's room then reported incident to RPN #105, who reported to RN #106.

On July 27, 2016 during entrance interview with Administrator, Director of Resident Care (DRC) and Chief Operations officer (COO), inspector #194 was informed that on an identified date DRC was called at home by charge RN #106. DRC indicated that she was informed by RN #106 that PSW #104 had left the building stating, having to leave that it was a personal matter involving resident #001.

DRC informed inspector #194 that one to one monitoring was initiated for a period of two days for resident #001. DRC indicated that this was put into place because resident #001 had a past history of inappropriate sexual behaviour. DRC feared PSW #104 had not disclosed inappropriate sexual behaviour involving resident #001 and wanted to be sure the other residents were safe. DRC indicated that no inappropriate sexual behaviour has been noted since the one to one monitoring has been in place.

During telephone interview with family members; it was indicated that on an identified date family member and co-resident were coming down the hall when

family member witnessed resident #001's hand on resident #002's leg and was moving up the resident #002's leg. Family member observed resident #002 pushing resident #001's hand away. Family member told resident #001 "you shouldn't be doing that" and resident #001 "took off". The inspector was informed by family members that the incident was reported the next day to RPN #117. Both family members stated they have never witnessed resident #001 being sexually inappropriate before or since the incident.

During an interview with inspector #194, RPN #117 indicated that on an identified date (the following day) the family member of co-resident came to the unit to inform RPN #117 that a few days ago, the family member had witnessed resident #001 touching resident #002 inappropriately and had intervened. RPN #117 indicated that no details were given and did not request any further information. RPN #117 indicated to inspector that the incident was reported to RN #123, called POA and also informed RPN #110 the oncoming nurse for the unit as it was the end of the shift.

During a telephone interview with inspector #194, RN #123 indicated having no recollection of being informed by RPN #117 of inappropriate sexual behaviour involving resident #001 on an identified date.

During an interview PSW #124 indicated to inspector #194 being informed by RPN #105 during shift report on an identified date, that there had been a sexual assault between resident #001 and #002.

On an identified date inspector #194 interviewed a family member who had witnessed an incident of alleged sexual abuse involving resident#001. Family member indicated to inspector witnessing resident #001's hand on resident #002's leg and was moving up the leg. Family member indicated that resident #002 pushed resident #001's hand away.

The licensee failed to protect resident #002 from resident #001 by not immediately investigating the incident, reporting to the Director under LTCHA, 2007, implementing specific interventions and re-initiating Care Tips Sheet for resident #001 until sixteen days after the alleged sexual abuse was reported. (Refer to WN#2, WN#3, WN#4, WN#5,WN#6)

The licensee failed to protect resident #005, #006, #007, #010, #011, #012 from abuse by resident #004

Log #022881-16 involving resident #004 and #006

Resident #004 has cognitive impairment. Resident #004 is independent with wheelchair and is capable of transferring without assistance, requires constant supervision with dressing, and supervision with minimal set up or assistance with eating.

Resident #006 has cognitive impairment.

Critical incident(CIR)for resident to resident alleged sexual abuse was submitted to the Director. The CIR indicated that PSW #127 entered resident #004's room and found resident #006 on top of resident #004. Both residents were dressed. The critical incident indicated that residents were calm and had no recollection of the incident.

Log #023012-16 involving resident #004 and #005

Resident #005 has significant cognitive impairment.

Critical incident(CIR)for resident to resident alleged sexual abuse was submitted to the Director. The CIR indicated that on an identified date PSW #136 witnessed resident #004 in the dining room grabbing resident #005's breasts. The critical incident indicates there were no ill effects noted for either resident.

Upon entering the home, inspector #194 requested the home's investigation into the incidents that occurred on an identified date. Inspector was provided with the licensee's internal investigation reports, access to resident #004's progress notes and informed that one to one monitoring for resident #004 had been initiated on an identified date.

PSW #127's statement, indicated that PSW #127 heard a bed alarm coming from resident #004's room, upon entering the room PSW #127 found resident #006 sitting on resident #004's lap. Resident #006 who was naked from the waist down, was screaming and hitting resident #004 who was also naked. PSW #127 indicated that removing resident #006 and assisted the resident back to the bedroom. During interview with inspector #194, PSW #127 repeated the information noted in the statement provided to the home.

PSW #136's statement, indicated that PSW #136 witnessed resident #005 trying to pass resident #004 between the dirty kitchen cart and a dining room table, therefore both residents were caught in a tight spot. Because resident #005 could not get past resident#004's wheelchair, resident #004 was grabbing resident #005's breasts, without letting go. Resident #005 was trying to push resident #004 away. Resident #004 did not stop until PSW #136 was able to push resident #004 away.

On an identified date one to one monitoring commenced for Resident #004 and the following was indicated in the documentation:

Log #023012-16 involving resident #006, Log #023929-16 involving resident #007, Log #023928-16 involving resident #010, Log #023934-16 involving resident #011, Log #023939-16 involving resident #014.

On first day of one to one monitoring, resident continues to be sexually inappropriate grabbing staff and co resident breasts. Interview with PSW #124 was conducted and PSW #124 was unable to remember who the residents were that were touched by resident #004.

On second day of one to one monitoring, when in the dining room resident grabbed a co-resident breast. The PSW #137 was not available for interview. During an interview with Inspector #194, on August 02, 2016, PSW #133 indicated that on the second day of one to one monitoring at the lunch meal resident #004 was witnessed grabbing resident #006's breasts. PSW #133 indicated that resident #004 was very quick and resident #006 did not react to the touching. PSW #133 removed resident #006 from the table for the remainder of the meal.

On the third day of one to one monitoring resident groped two females and one male resident. During an interview with inspector #194 PSW #132 indicated that the female residents involved were resident #010 and #011 and the male resident was #012. PSW #132 indicated that when pushing resident #004 in the wheelchair in front of the dining room, resident #004 put a hand flat upon resident #010's breast, who was sitting in a tilt wheelchair outside the dining room, PSW #132 indicated that he removed resident #004's hand and resident #010 did not have any reaction to the touch. PSW # 132 indicated as they kept walking by resident #004 again place a hand flat upon resident #011's breast, also sitting in a tilt wheelchair outside the dining room. PSW# 132 indicated that

resident #004's hand was removed and that resident #011 did not have a reaction to the touch. PSW #132 indicated that as they were walking up the hall, resident #012 was coming towards them, as resident #012 passed by the wheelchair, resident #004 reached out and grabbed resident #012 by the buttocks. PSW #132 indicated that resident #012 did not have any reaction to the touching. PSW #132 indicated to inspector that resident #004 was very quick and it was very difficult to ensure that the resident's hands did not touch co residents.

On fourth day of one to one monitoring PSW #135 and resident were walking in the halls, resident #004 grabbed resident #007's on the buttocks and then when they returned to the resident's room, resident #004 put a hand on resident #014's leg near the groin area. During an interview with inspector #194, PSW #135 indicated that the first incident occurred before breakfast in the hallway, resident #004 was being pushed in the wheelchair as they passed by resident #007 resident #004 grabbed resident #007's buttocks. PSW # 135 indicated that the second incident occurred after lunch upon return to resident #004's room. Resident #014 was sitting in resident #004's recliner chair and upon entering the room resident #004 wheeled up to resident #014 and placed a hand on resident # 014's leg near the groin area. PSW #135 indicated that neither resident #007 or #014 had any reaction to the touching.

All PSW staff interviewed related to the incidents recorded in the one to one documentation indicated that they reported the incidents to the RPNs. All incidents except for the incident noted on first day of one to one monitoring indicated to have been reported to RPN #130. When interviewed RPN #130 indicated not being notified of the incidents and that the one to one documentation had not been reviewed at the end of the shift.

Interview with DRC and RCM #135 was conducted on August 02, 2016 to discuss the entries noted in the one to one documentation. Neither were aware that incidents had occurred and no report to Director had been initiated for the incidents documented.

The licensee failed to comply with:

LTCHA s. 23. (1) Every licensee of a long-term care home shall ensure that, (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i)

abuse of a resident by anyone. (Refer to WN #3)
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 a risk of harm to the resident.(Refer to WN #4)
LTCHA s.20(1) Without in anyway restricting the generality of the duty provided for in section s.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. (Refer to WN #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 any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. (Refer to WN #6)
O. Reg 79/10 s. 54 (a)Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents including;
(a)identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(Refer to WN #5) [s. 19. (1)]

An order has been issued to the licensee related to the six incidents of unreported sexual abuse identified between the period of July 27 to July 29, 2016 involving resident #004, as well as one reported incident of alleged sexual abuse involving resident #001 July 8, 2016. The incidents of alleged resident to resident sexual abuse which were not reported or immediately investigated by the home are placing the residents at high risk for injury. Non compliance related to s.20 (non compliance with the licensee's abuse policy) has been issued on July 23, 2014, November 24, 2014, and November 5, 2015. An compliance order for s.19 (Duty to protect)has been issued on January 5, 2016. (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 09, 2016

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
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 9th day of September, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Chantal Lafreniere

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