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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 25, Jul 25, 2014	2014_347197_0015	O-000571-14	Resident Quality Inspection

Licensee/Titulaire de permis

MANORCARE PARTNERS
6257 Main Street, Stouffville, ON, L4A-4J3

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

STIRLING MANOR NURSING HOME
218 EDWARD STREET, P.O. BOX 220, STIRLING, ON, K0K-3E0

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

JESSICA PATTISON (197), AMBER MOASE (541), BARBARA ROBINSON (572), SUSAN DONNAN (531)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): June 23 - 27, 30, July 2, 3, 2014

A critical incident inspection and a complaint inspection were completed concurrently with the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, the RAI Supervisor, the Life Enrichment Supervisor, the Environmental Supervisor, the Office Clerk, the Office Manager, the Nutrition Manager, the Registered Dietitian, the Physiotherapist, Registered Nurses, Registered Practical Nurses, Personal Support Workers/Health Care Aids, Life Enrichment staff, Dietary Aids, Resident Council President, residents and family members.

During the course of the inspection, the inspector(s) conducted a full tour of the home, observed resident care and services including dining and medication administration, reviewed relevant policies, procedures and meeting minutes, reviewed food temperature records and texture modified menus.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 5 in that the home was not kept safe and secure for its residents.

On June 25, 2014, the access doors to the laundry chutes on the 2nd and 3rd floors of the home were observed to be closed, but not locked. These doors were easily opened by Inspectors #572 and #197 by sliding down a button and then turning a knob. Inspectors were able to look down the laundry chute opening and see the cement floor below. Residents were noted by Inspector #197 to be wandering in the

area of the laundry chute door on the 3rd floor and there were no staff in the immediate area.

The Administrator of the home was notified of the Inspectors' observations of the laundry chute access doors. [s. 5.]

2. On June 25th, 2014, Inspector #531 noted during Resident Observation that the toilet tank cover was missing in a resident bathroom. Two electric razors were stored on the shelf above the tank.

On June 26th, 2014, Inspector #531 observed the toilet tank cover remained missing and both electric razor cords plugged in to the outlet, one cord attached to the razor stored on the shelf, and the second cord was hanging loosely down beside the toilet tank.

On June 26th, 2014, Inspector #197 observed a resident bathroom with Inspector #531 and noted 1 electric razor and 1 electric razor cord both plugged in directly above an open toilet tank full of water. The residents that share this bathroom are cognitively impaired and the Administrator informed the Inspectors that these residents use the electric shavers independently. At the time the Inspectors were observing the bathroom one of the residents was wandering in the bathroom. Inspectors were concerned that that if the resident was using the electric shaver independently and dropped it in the toilet tank they could be at risk of electrocution. Immediate risk was removed by Inspector #197 by unplugging both cords and moving the razors to the bathroom counter away from the open water of the toilet tank.

The Administrator was notified and immediately addressed the issue. The Administrator and Director of Nursing indicated about 15 minutes later that the toilet tank cover had been replaced by maintenance. Toilet tank cover was then observed by Inspector #197 to be in place. [s. 5.]

3. On June 25, 2014, at approximately 1500 hours Inspector #541 observed Resident #6286 sitting at a table in the dining room unsupervised eating the powdered beverage thickener. The inspector informed staff member #S124 who removed the beverage thickener from the resident. [s. 5.]

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg. 79/10, s. 16 whereby the licensee did not ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

On June 25, 2014, Inspector #572 observed resident room 212 on the second floor and found that both windows had intact window screens but each opened with the crank approximately 32 centimetres.

On June 26, 2014, the window in resident room 321 on the third floor was measured by Inspector #541 to open with the crank 32 centimetres.

Throughout the inspection period of June 30 - July 3, 2014 many residents, some cognitively impaired, were observed to be wandering on the 2nd and 3rd floors of the home where windows were observed to open more than 15 centimetres.

Inspector #197 spoke with the Administrator of the home about windows on the 2nd and 3rd floor opening more than 15 cm. She was unaware of this and spoke to the Environmental Supervisor, who then removed the cranks from all of these windows as a temporary fix to ensure resident safety. The Administrator further indicated that the home is purchasing kits to put on the windows to restrict the opening to no more than 15 centimetres. She stated it would take approximately 6-8 weeks before these kits would arrive and be installed. A compliance date of September 5, 2014 was agreed upon. [s. 16.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s.19 (1)(a) whereby residents were not protected from sexual abuse.

The licensee has failed to comply with LTCHA 2007, s.19 (1)(a) whereby residents were not protected from sexual abuse.

Under O.Reg. 79/10, sexual abuse is defined as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member".

A review of the health record for Resident #3 was conducted and the the following information was found:

1. The progress notes state that on a particular date, staff #S102 observed Resident #3 in Resident #6250's room touching the resident in a sexual manner. Staff #S102 "removed resident from area and spoke very directly explaining that this is considered inappropriate behaviour."
In an interview with Inspector #572 on July 2, 2014, staff #S102 stated that this incident was reported to the nurse in charge that shift, staff #S123. Staff #S102 stated that since the DOC reads the progress notes daily, it was assumed that the DOC was also aware. Staff #S102 indicated now recognizing that this incident would be considered sexual abuse.
In an interview with Inspector #572 on July 3, 2014, the nurse in charge, staff #S123, indicated not recalling this incident. On July 2, 2014, Inspector #572 interviewed the

DOC who indicated not being aware of this or any incidents of abuse related to Resident #3, other than an incident that she reported to the Director on another date. No further action was taken.

2. On a particular date, the progress notes document that staff #S106 observed Resident #3 attempting to touch other residents in a sexual manner and was immediately sent back to their floor.

3. Resident #3 was observed going into residents' rooms, as documented in the progress notes on a particular date. The resident was redirected but returned to the rooms when nursing staff were not visible. Resident #3 was then taken back to their home area and told that these actions were not acceptable. Resident #3 was placed on q15 minute checks to ensure they were not going into co-residents' rooms uninvited.

4. On a specified date, staff #S121 documented an incident that was reported by a PSW, staff #S124. Resident #2 told staff #S124 that Resident #3 touched Resident #2 in a sexual manner. Staff #S121 documented that Resident #2 identified Resident #3 as the one who touched them.

Inspector #572 conducted interviews on July 2, 2014, and the following information was gathered:
-Staff #S121 and #S124 clarified that Resident #2 actually did not positively identify Resident #3. They stated that Resident #3 was the only resident walking in the area of the resident's room at the time and had been known to be sexually inappropriate. Staff #S121 spoke to the DOC about the incident within a few days, but stated that there were no further actions to be taken since the resident could not be positively identified.

-The DOC indicated not being aware of this or any incidents of abuse related to Resident #3, other than the incident that she reported to the Director on another specified date.
-Staff #S124 indicated reporting the incident to staff #S121 and to the nurse in charge, staff #S123.

During a telephone interview on July 3, 2014, staff #S123 indicated receiving the information about the incident and passed it on to the evening RN in charge, staff #S122. No further action was taken as staff #S123 believed that this would be done by staff #S122.

On July 2, 2014, staff #S122 indicated in a telephone interview recalling the incident as being reported, and said that the only resident in the area that fit Resident #2's description was Resident #3. Staff #S122 considered Resident #2 a reliable historian for information at the time and was upset after the incident.
Staff #S122 thought that the day shift nurse in charge, staff #S123, had completed any actions required including notifications of the incident.
This incident was documented in the progress notes of Resident #3 but there was no documentation of the incident in Resident #2's progress notes.

5. The progress notes for Resident #3 state that on a particular date, Resident #3 was alleged to have touched another resident in a sexual manner, but denied doing so and the incident was unwitnessed. Resident #3 was told that this can be classified as assault, and the resident continued to deny any action. Resident #3 was placed on checks every 15 minutes while awake for safety.

6. On another date, the progress notes state that staff #S102 was informed that Resident #3 had inappropriately touched two residents, Resident #2 and Resident #6253. Staff #S102 removed Resident #3 from the area. Staff #S102 documented "q15 minute checks were already in place, which were ineffective. Closely monitoring resident has been initiated." Staff then placed Resident #2 and Resident #6253 in the dining room for safety. Staff #S102 notified the DOC, physician, as well as the SDM of each resident. The DOC completed a Critical Incident Report which was submitted to the Ministry. Police were not notified.
Following this incident referrals were completed and a medication change occurred.

7. On a specified date, staff #S100 documented in the progress notes observing Resident #3 sexually touching another resident. Resident #3 admitted to touching Resident #10 without permission. The documentation also states that the RN in charge immediately examined the resident involved and notified both residents' SDMs, and that the physician asked for the police to be notified if this behaviour occurred again. No further action was taken.

During this critical incident inspection of alleged sexual abuse, actual harm and/or risk of harm was demonstrated as vulnerable and/or cognitively impaired residents were recipients of the sexual abuse. A pattern was demonstrated as four incidents of physical sexual abuse and three attempted sexual abuse incidents occurred and one resident had a recurrent incident of sexual abuse.

The licensee failed to protect residents from sexual abuse including one documented recurrent incident of abuse as evidenced by the following:
-The Director was not immediately notified of alleged, suspected, or witnessed incidents of sexual abuse of Residents #6250, #6253, #2, #10, and unidentified residents that resulted in harm or risk of harm to residents (as identified in WN #8).
- The licensee failed to immediately notify the SDM of Resident #3 (and identified residents #6250 and #10) of every alleged, suspected, or witnessed incidents of sexual abuse (as identified in WN #13).
-The licensee failed to ensure that the appropriate police force was immediately notified of all seven of the alleged, suspected, and witnessed incidents of resident to resident sexual abuse that the licensee suspects may constitute a criminal offence (as identified in WN #9).
-The licensee's policy "Abuse Policy (HR A-1)" was not complied with (as identified in WN #7).

Non-compliance was previously identified under LTCHA, 2007, s.24 (1) and O.Reg.79/10, s. 98 during inspections completed on April 23, 2014 (Inspection # 2013_179103_0017) and June 6, 2014 (Inspection # 2014_236572_0010) in relation to the reporting of incidents of abuse.

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 3(1)(11)(iv) whereby the resident has not had his or her personal health information kept confidential.

On June 24th, 2014, staff member #S100 administered breakfast medication to Residents #6237 and #6240 and left their personal health information pertaining to medication open and visible on the Electronic Medication Management System Screen.

On June 24th, 2014, staff member #S102 administered breakfast medication to Resident #9 and left personal health information pertaining to medication open and visible on the Electronic Medication Management System screen.

On June 25th, 2014, staff member #S105 administered noon medication to Resident #2 and #6280 and left their personal health information pertaining to medication open and visible on the Electronic Medication Management System screen.

On June 26th, 2014, staff member #S101 administered breakfast medication to residents #3, #4 and #5, while leaving their personal health information pertaining to medication open and visible on the Electronic Medication Management System screen.

During the times that resident personal health information was left on the screen numerous residents were passing by the medication cart to go into the dining room, in one instance two family members were waiting by the cart to speak to the nurse and in another, two men from Motion Specialties were waiting by the medication cart.

On June 27th, 2014, staff members #S100 and #S101 were observed placing resident individual medication packages in the regular garbage.

On June 27th, 2014, interviews with staff members #S100 and #S101 and the Director of Nursing on July 2, 2014, confirmed that resident individual medication administration packages are placed in the regular garbage. [s. 3. (1) 11. iv.]

2. The licensee has failed to comply with LTCHA 2007 c.8 s.3(1)14 whereby they did not ensure that every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

On June 24th, 2014, while conducting an interview with resident #6291 in their room with the door closed, staff member #S120 entered the room without knocking or apologizing to resident for interrupting the interview.

On June 25th, 2014, while conducting an interview with resident #6258 in their room with the door closed, staff member #S120 entered the residents room without knocking or apologizing to resident for interrupting interview. [s. 3. (1) 14.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference and that each resident has the right to have his or her personal health information kept confidential, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 6(1)(c) in that a resident's plan of care does not provide clear direction to staff.

Resident #6237's current care plan printed July 3, 2014 states the resident has a diet order for pureed diet with thickened fluids to consistency of honey.

The diet census sheet from the kitchen also states that the resident is to receive thickened fluids to honey consistency.

Inspectors #197 and #541 observed Resident #6237 to receive regular thin fluids with the lunch meals on June 23 and July 2, 2014.

On July 3, 2014, Inspector #531 interviewed Resident #6237 regarding fluids at which time the resident stated that he/she is provided thickened fluids in the form of a shake during meals and as a snack and recieves "honey thickened drinks" but refuses them as he/she does not like thickened fluids.

Interviews with the Registered Dietitian and Nutrition Manager confirmed that the resident is to receive thickened fluids, however the resident will sometimes choose to have regular thin fluids which staff will provide for the resident. The Nutrition Manager stated that the direction to allow the resident to have thin fluids if Resident #6237 chooses is not written anywhere to provide clear direction to staff. [s. 6. (1) (c)]

2. The licensee has failed to comply with LTCHA 2007, s. 6(7) whereby the care set out in the plan of care is not provided to the resident as specified in the plan.

The care plan for Resident #6258 indicates specific times throughout the day for staff to take the resident to the bathroom, as well as upon request and if up at night.

Inspector #541 observed Resident #6258 on June 30 and July 2, 2014 for approximately two hours on each day. Resident #6258 was not taken to the bathroom at all during this observation time and more specifically, not at a particular time that was outlined in the care plan.

On July 2, 2014, staff member #S119 stated in an interview that Resident #6258 has no set times to go to the bathroom and that the resident is taken when exhibiting behaviors that indicate having to go. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written plan of care for each resident provides clear direction to staff and that the care set out in the plan of care is provided to residents as specified in the plan, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with s. 15(2)(c) in that the home, furnishings and equipment are not maintained in a safe condition and in a good state of repair.

The following observations were made during the inspection period:

1st Floor

Room 104 - privacy curtain has some small holes and is stained (541)

Common Areas - in main lounge hardwood chair with numerous paint chips, 6 wing back chairs with numerous chips on the legs, pink chair in the hallway in disrepair, entrance to dining room floor surface cracked and chipped.

Second Floor

Room 205 - dark marks on edges of floor near walls, floor tiles cracked, paint peeling in large area at top of wall, scuffed areas on door frame (572)

Room 212 - wallpaper ripped in bathroom, baseboard off on one side, tile missing on wall, paint chipped, in bedroom floor tiles cracked with dark marks especially along wall edges, paint chipped(572)

Room 213 - dark marks on floor, paint chipped and worn, cracked tiles on floor in bedroom area, in residents' bathroom opening in wall with pipes protruding, floor tiles cracked with many dark marks especially along baseboard which is pulling out under toilet (572)

Room 214 - dark marks on tiles in bedroom area, and paint chipped, holes in the ceiling in residents' bathroom. (572)

Room 215 - dark marks on floor, floor tiles chipped and cracked, paint peeling on wall and ceiling in bathroom (572)

Room 216 - floor stained, bathroom floor in disrepair, dirt filled crack at bathroom entrance, left interior wall piece of base board missing below electrical box, exposed cable cord protruding from the window frame, rusted electric heater, piece of bathroom trim missing, toilet tank cover missing, wallpaper missing and in disrepair, corner trim torn and hanging at the door entrance. (531)

Common Areas - in hallway dark marks visible along edges of floor along baseboard, baseboard peeling off in small areas, scuff marks on baseboard, doors scuffed; in lounge/dining room furniture scuffed, paint chipped, upholstery of chair ripped. Tiles cracked and small pieces missing on floor throughout halls, especially outside tub room, spa room has paint chipped on furniture and floor, marks evident, tub room has duct tape over what appears to be a small opening in tub near top rim, entrance to dining room floor surface cracked and chipped, sink behind the nurses desk does not fit the vanity properly, the tap is rusty and is leaking.

Third Floor

Room 318 - electrical "box" (looks like a telephone connection) has cover off and wires exposed, bathroom vanity has finish missing and wood is exposed along the

entire front and side edge of vanity, tile inside bathroom door is in disrepair (541)

Room 324 - numerous marks on the wall behind resident's easy chair, also gouges out of plaster and paint peeling off the wall, beside
resident bed there are large holes in the wall where it appears pictures used to hang (541)

Room 325 - bathroom ceiling plaster is cracked and water-stained, bathroom floor is in disrepair, pieces missing from tiles and there is a hole in the floor against the back wall of the bathroom where a pipe is coming up, the floor tile at the head of resident's bed has a large piece missing (541)

Room 327 - cracked floor tiles in residents bathroom and just outside in bedroom area, toilet tank cover cracked and covered with duct tape (197)

Room 330 - cracked floor tiles throughout room, water damaged area on ceiling above a resident's bed (197)

Common Areas - the floor in the hallway appears slanted, many floor tiles in the hallway are cracked and worn, open area in ceiling by nursing station (wires visible), dark marks visible where baseboards meet the floor, corners of baseboard missing just outside nursing station and inside nursing station, edges of cupboards in nursing station are worn [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment are maintained in a safe condition and good state of repair, to be implemented voluntarily.

WN #7: 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 failed to comply with LTCHA, s. 20(1) as the written policy to promote zero tolerance of abuse and neglect of resident was not complied with.

Review of the home's policy "Abuse Policy (HR A-1)" indicated:
-Procedure 2- ensure the safety of resident, remove risk and ensure interventions are instituted to prevent reoccurrence.
-Procedure 5- the Supervisor that receives an abuse report will prepare an Incident Summary Report on MedeCare with the assistance of the individual who reported the incident, the affected individual, and any witnesses.
-Procedure 13- the Administrator, Director of Nursing, or designate will then inform the family or responsible party for the residents involved in the incident.
-Procedure 14- all cases of abuse or suspected abuse will be reported to the Stirling – Rawdon Police by the Administrator or Director of Nursing or Nurse in Charge.
-Procedure 15- any person who has reasonable grounds to suspect abuse must report to the Director immediately

Refer to WN #8, 9 & 13.
-Six incidents of sexual abuse were not reported to the police.
-Four incidents of sexual abuse were not reported to SDMs of the residents involved.
-Five incidents of sexual abuse were not reported to the Director.
-Removing risk and implementing interventions did not prevent reoccurrence for three months.
-Supervisors did not create Incident Summary Reports in MedeCare for every incident of sexual abuse.
-The Administrator and Director of Nursing were not informed of all incidents of alleged or witnessed abuse. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #8: 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 comply with LTCHA 2007,s. 24 (1)(2) whereby the licensee did not ensure that an incident of abuse of a resident was immediately reported to the Director.

Review of Resident #3's progress notes indicated the following incidents:

1. On a specified date, Staff #S102 observed Resident #3 in Resident #8's room touching the resident in a sexual manner. Staff member #S102 indicated recognizing that this incident would be considered sexual abuse in an interview on July 2, 2014.

2. On a specified date, staff #S106 observed Resident #3 attempting to touch other residents in a sexual manner. The resident was immediately removed from the area.

3. On another date, staff member #S121 documented an incident that was reported by staff member #S124. Resident #2 told staff member #S124 that Resident #3 went into their room and touched them in a sexual manner.

4. On a specified date, Resident #3 was alleged to have touched another resident in a sexual manner, but the resident denied doing so and the incident was unwitnessed. Resident #3 was told that this can be classified as assault, and the resident continued to deny any action. Resident #3 was placed on checks every 15 minutes while awake for safety.

5. On another date, staff member #S100 observed Resident #3 "inappropriately touching a resident". The resident was escorted back to their room." The RN in charge documented immediately examining the resident involved and notified both residents' SDMs, and that the physician asked for the police to be notified if this behaviour occurs again. No further action was taken.

In an interview on on July 2, 2014, the DOC indicated not being aware of any of the above incidents and therefore, the incidents were not reported to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that abuse of a resident that results in harm or risk of harm to a resident is immediately reported to the Director, to be implemented voluntarily.

WN #9: 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 failed to comply with O.Reg 79/10 s. 98 whereby the licensee did not ensure that the appropriate police force was immediately notified of an incident of abuse of a resident.

Review of Resident #3's progress notes shows the following incidents:

1. On a specified date, Staff #S102 observed Resident #3 in Resident #8's room touching the resident in a sexual manner. Staff member #S102 indicated in an interview on July 2, 2014, recognizing that this incident would be considered sexual abuse.

2. On a specified date, staff #S106 observed Resident #3 trying to touch other residents in a sexual manner. Resident #3 was immediately removed from the area.

3. On another date, staff member #S121 documented an incident that was reported to them by staff member #S124. Resident #2 told staff member #S124 that Resident #3 went into their room and touched them in a sexual manner.

4. On a specified date, Resident #3 was alleged to have touched a resident in a sexual manner, but Resident #3 denied doing so and the incident was unwitnessed. Resident #3 was told that this can be classified as assault, and the resident continued to deny any action. Resident #3 was placed on checks every 15 minutes while awake for safety.

5. On another date, staff #S102 was informed that Resident #3 had inappropriately touched two residents, Resident #2 and Resident #6253.

6. On a specified date, staff member #S100 observed Resident #3 "inappropriately touching a resident". The documentation states that as the RN in charge she immediately examined the resident involved and notified both residents' SDMs, and that the physician asked for the police to be notified if this behaviour occurs again. No further action was taken.

In an interview on July 2, 2014, the DOC indicated not being aware of any of these incidents except for one that she had reported to the Director and also confirmed that the police were not notified for any of the incidents. [s. 98.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the appropriate police force is immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 130(2) whereby access to the medication storage area on the first floor was not restricted to persons who may dispense, prescribe or administer drugs in the home.

On June 27th, 2014, staff #S100 and #S101 both confirmed that staff #S118 had access to the aluminum drug storage cupboard located in the maintenance service area.
On June 27th, 2014, staff #S100 provided the inspector access to the locked drug destruction storage cupboard in the maintenance service area with staff #S118's access key that was hanging on the wall in the vicinity of the cupboard. Staff #S100 confirmed that staff #S118 is not a member of the registered staff.

On July 2, 2014, the Director of Nursing confirmed that staff member #S118 has an access key to the drug storage area on the first floor. The Director of Nursing further confirmed that staff #S118 is not a member of their registered staff and is not able to dispense, prescribe or administer drugs in the home. [s. 130. 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that access to medication storage areas are restricted to persons who may dispense, prescribe or administer drugs in the home, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
1. That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 136(2)(1) whereby the drug destruction policy does not provide clear direction for the safe and secure storage of drugs until they are destroyed.

On June 27th, 2014, inspector #531 observed the aluminium drug destruction storage cupboard approximately 44cm wide by 42 cm length with front door enclosures that were joined by a pad lock located in the first floor maintenance room. The doors appeared to have heaved leaving a 10cm by 10 cm gap at the top of the frame which provided access to the storage cupboard and visibility of drugs. The medications had no evidence of being altered to discourage consumption. The cupboard containing the drugs was not secure. [s. 136. (2) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the drug destruction policy provides clear direction for the safe and secure storage of drugs that are no longer dispensed until they are safely destroyed, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 73(2)(b) whereby no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

On June 25th, 2014, Resident #6250 was observed in a dining room with breakfast on the table for 15 minutes while waiting for staff #S111 to provide the assistance required by the resident. Staff #S111 was feeding Resident #1 at the time.

On June 26th, 2014, both Resident #1 and #6250 were observed in a dining room with their breakfast in front of them. Staff #S111 was providing assistance to resident #6250. Resident #1 waited approximately 10 minutes for staff #S111 to provide the assistance required.

On June 26th, 2014, during an interview with staff #S111, she confirmed that she was alone and could assist only one resident at a time. [s. 73. (2)]

WN #13: 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 failed to comply with O.Reg 79/10 s. 97 (1)(a) whereby the licensee did not ensure that the resident's substitute decision maker, if any, and any other person specified by the resident was notified of any alleged, suspected, or witnessed incident of abuse of a resident.

Review of Resident #3's progress notes show the following incidents:

1. On a specified date, Staff #102 observed Resident #3 in Resident #8's room touching the resident in a sexual manner. On July 2, 2014, Staff #102 indicated now recognizing that this incident would be considered sexual abuse.

2. On a specified date, staff #S106 observed Resident #3 attempting to touch other residents in a sexual manner.

3. On another date, staff member #S121 documented an incident that was reported by staff member #S124. Resident #2 told staff member #S124 that Resident #3 entered their room and touched them in a sexual manner.

4. On a specified date, Resident #3 was alleged to have touched a resident in a sexual manner, but denied doing so and the incident was unwitnessed. Resident #3 was told that this can be classified as assault, and the resident continued to deny any action. Resident #3 was placed on checks every 15 minutes while awake for safety.

On July 2, 2014, the DOC indicated not being aware of any of these incidents and therefore, the incidents were not reported to the substitute decision makers of the residents. [s. 97. (1) (a)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 129 (1)(a)(ii) whereby drugs that are stored in an area or a medication cart are secure and locked.

On June 30th, 2014 topical treatment medication were left unlocked on the treatment cart on the second floor home area. [s. 129. (1) (a)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10, s. 229 (10) (3) whereby residents are not offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Resident #6289 did not have any information in their personal health record to indicate that they were offered immunization against tetanus and diphtheria.
On July 2, 2014, the Director of Nursing confirmed that the home does not offer residents immunizations against tetanus and diphtheria. [s. 229. (10) 3.]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
LTCHA, 2007 S.O. 2007, c.8 s. 5.	CO #901	2014_347197_0015	197

Issued on this 25th day of August, 2014

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA PATTISON (197), AMBER MOASE (541), BARBARA ROBINSON (572), SUSAN DONNAN (531)
Inspection No. / No de l'inspection :	2014_347197_0015
Log No. / Registre no:	O-000571-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 25, Jul 25, 2014
Licensee / Titulaire de permis :	MANORCARE PARTNERS 6257 Main Street, Stouffville, ON, L4A-4J3
LTC Home / Foyer de SLD :	STIRLING MANOR NURSING HOME 218 EDWARD STREET, P.O. BOX 220, STIRLING, ON, K0K-3E0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CHARMAINE JORDAN

To MANORCARE PARTNERS, 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 : 901

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee shall ensure that the laundry chute access doors located on the 2nd and 3rd floors of the home are immediately secured to restrict unsupervised resident access to the laundry chute at all times.

The licensee shall take immediate action to ensure resident safety until the access doors to the laundry chute are secured.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA 2007, s. 5 in that the home was not kept safe and secure for its residents.

On June 25, 2014, the access doors to the laundry chutes on the 2nd and 3rd floors of the home were observed to be closed, but not locked. These doors were easily opened by Inspectors #572 and #197 by sliding down a button and then turning a knob. Inspectors were able to look down the laundry chute opening and see the cement floor below. Residents were noted by Inspector #197 to be wandering in the area of the laundry chute door on the 3rd floor and there were no staff in the immediate area.

The Administrator of the home was notified of the Inspectors' observations of the laundry chute access doors. (197)

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

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 :

O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Order / Ordre :

The licensee shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimeters. The home shall also establish a regular window audit process to ensure windows do not open more than 15 centimeters.

Grounds / Motifs :

1. The licensee has failed to comply with O.Reg. 79/10, s. 16 whereby the licensee did not ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

On June 25, 2014, Inspector #572 observed resident room 212 on the second floor and found that both windows had intact window screens but each opened with the crank approximately 32 centimetres. (572)

2. On June 26, 2014, the window in resident room 321 on the third floor was measured by Inspector #541 to open with the crank 32 centimetres. (541)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 05, 2014

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to include the following:
1) The development of a monitoring process to ensure that:
a) Every incident of alleged, suspected or witnessed incident of abuse is immediately investigated.
b) The resident's SDM is immediately notified of every incident of alleged, suspected or witnessed incident of abuse.
c) The Director is immediately notified if there are reasonable grounds to suspect abuse of a resident that resulted in harm or risk of harm to a resident.
d) The appropriate police force is immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that may constitute a criminal offense.
e) A written report is submitted to the Director with respect to the alleged, suspected or witnessed incident of abuse or a resident by anyone which shall include:
i) A description of the incident and the individuals involved.
ii) Action taken in response to the incident.
iii) Analysis and follow up action.
iv) The name and title of the person making the report.
v) The results of every investigation undertaken in response to an alleged, suspected or witnessed incident of abuse.
2) The revision of the home's policy and decision tree related to abuse and neglect of a resident (Abuse Policy, HR A-1) to include clear direction related to responding to, investigating, and reporting alleged, suspected or witnessed abuse of a resident by another resident.
3) Staff education content to include:
a) Identification of incidents/actions that constitute sexual abuse (as defined in O.Reg.79/10 s.2.(1)) as opposed to behaviours that may be considered socially inappropriate, with a focus on residents who have a cognitive impairment.
b) Legislated reporting requirements of all incidents of alleged, suspected or witnessed incidents of abuse of a resident.
c) The revised version of the home's Abuse Policy.

The plan shall identify the time line for completing the tasks as well as the person responsible for completing the tasks.

The plan shall be submitted by fax to 613-569-9670 with attention to Barbara Robinson, LTC Homes Inspector, on or before August 8, 2014.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA 2007, s.19 (1)(a) whereby residents were not protected from sexual abuse.

The licensee has failed to comply with LTCHA 2007, s.19 (1)(a) whereby residents were not protected from sexual abuse.

Under O.Reg. 79/10, sexual abuse is defined as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member".

A review of the health record for Resident #3 was conducted and the the following information was found:

1. The progress notes state that on a particular date, staff #S102 observed Resident #3 in Resident #6250's room touching the resident in a sexual manner. Staff #S102 "removed resident from area and spoke very directly explaining that this is considered inappropriate behaviour."
In an interview with Inspector #572 on July 2, 2014, staff #S102 stated that this incident was reported to the nurse in charge that shift, staff #S123. Staff #S102 stated that since the DOC reads the progress notes daily, it was assumed that the DOC was also aware. Staff #S102 indicated now recognizing that this incident would be considered sexual abuse.
In an interview with Inspector #572 on July 3, 2014, the nurse in charge, staff #S123, indicated not recalling this incident. On July 2, 2014, Inspector #572 interviewed the DOC who indicated not being aware of this or any incidents of abuse related to Resident #3, other than an incident that she reported to the Director on another date. No further action was taken.

2. On a particular date, the progress notes document that staff #S106 observed Resident #3 attempting to touch other residents in a sexual manner and was immediately sent back to their floor.

3. Resident #3 was observed going into residents' rooms, as documented in the progress notes on a particular date. The resident was redirected but returned to the rooms when nursing staff were not visible. Resident #3 was then taken back to their home area and told that these actions were not acceptable. Resident #3 was placed on q15 minute checks to ensure they were not going into co-

residents' rooms uninvited.

4. On a specified date, staff #S121 documented an incident that was reported by a PSW, staff #S124. Resident #2 told staff #S124 that Resident #3 touched Resident #2 in a sexual manner. Staff #S121 documented that Resident #2 identified Resident #3 as the one who touched them.

Inspector #572 conducted interviews on July 2, 2014, and the following information was gathered:
-Staff #S121 and #S124 clarified that Resident #2 actually did not positively identify Resident #3. They stated that Resident #3 was the only resident walking in the area of the resident's room at the time and had been known to be sexually inappropriate. Staff #S121 spoke to the DOC about the incident within a few days, but stated that there were no further actions to be taken since the resident could not be positively identified.
-The DOC indicated not being aware of this or any incidents of abuse related to Resident #3, other than the incident that she reported to the Director on another specified date.
-Staff #S124 indicated reporting the incident to staff #S121 and to the nurse in charge, staff #S123.

During a telephone interview on July 3, 2014, staff #S123 indicated receiving the information about the incident and passed it on to the evening RN in charge, staff #S122. No further action was taken as staff #S123 believed that this would be done by staff #S122.
On July 2, 2014, staff #S122 indicated in a telephone interview recalling the incident as being reported, and said that the only resident in the area that fit Resident #2's description was Resident #3. Staff #S122 considered Resident #2 a reliable historian for information at the time and was upset after the incident. Staff #S122 thought that the day shift nurse in charge, staff #S123, had completed any actions required including notifications of the incident.
This incident was documented in the progress notes of Resident #3 but there was no documentation of the incident in Resident #2's progress notes.

5. The progress notes for Resident #3 state that on a particular date, Resident #3 was alleged to have touched another resident in a sexual manner, but denied doing so and the incident was unwitnessed. Resident #3 was told that this can be classified as assault, and the resident continued to deny any action. Resident #3 was placed on checks every 15 minutes while awake for safety.

6. On another date, the progress notes state that staff #S102 was informed that Resident #3 had inappropriately touched two residents, Resident #2 and Resident #6253. Staff #S102 removed Resident #3 from the area. Staff #S102 documented "q15 minute checks were already in place, which were ineffective. Closely monitoring resident has been initiated." Staff then placed Resident #2 and Resident #6253 in the dining room for safety. Staff #S102 notified the DOC, physician, as well as the SDM of each resident. The DOC completed a Critical Incident Report which was submitted to the Ministry. Police were not notified. Following this incident referrals were completed and a medication change occurred.

7. On a specified date, staff #S100 documented in the progress notes observing Resident #3 sexually touching another resident. Resident #3 admitted to touching Resident #10 without permission. The documentation also states that the RN in charge immediately examined the resident involved and notified both residents' SDMs, and that the physician asked for the police to be notified if this behaviour occurred again. No further action was taken.

During this critical incident inspection of alleged sexual abuse, actual harm and/or risk of harm was demonstrated as vulnerable and/or cognitively impaired residents were recipients of the sexual abuse. A pattern was demonstrated as four incidents of physical sexual abuse and three attempted sexual abuse incidents occurred and one resident had a recurrent incident of sexual abuse.

The licensee failed to protect residents from sexual abuse including one documented recurrent incident of abuse as evidenced by the following:
-The Director was not immediately notified of alleged, suspected, or witnessed incidents of sexual abuse of Residents #6250, #6253, #2, #10, and unidentified residents that resulted in harm or risk of harm to residents (as identified in WN #8).
- The licensee failed to immediately notify the SDM of Resident #3 (and identified residents #6250 and #10) of every alleged, suspected, or witnessed incidents of sexual abuse (as identified in WN #13).
-The licensee failed to ensure that the appropriate police force was immediately notified of all seven of the alleged, suspected, and witnessed incidents of resident to resident sexual abuse that the licensee suspects may constitute a criminal offence (as identified in WN #9).

-The licensee's policy "Abuse Policy (HR A-1)" was not complied with (as identified in WN #7).

Non-compliance was previously identified under LTCHA, 2007, s.24 (1) and O.Reg.79/10, s. 98 during inspections completed on April 23, 2014 (Inspection # 2013_179103_0017) and June 6, 2014 (Inspection # 2014_236572_0010) in relation to the reporting of incidents of abuse. (572)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 29, 2014

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
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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 25th day of June, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jessica Pattison

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