Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 3, 8, 2015	2015_396103_0043	O-002313-15	Critical Incident System

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

THE VILLAGE OF TAUNTON MILLS
3800 Brock Street North WHITBY ON L1R 3A5

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 2, 3, 6, 7, 2015

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Physician, Neighbourhood Coordinators (NC), Recreation staff, Director of Care (DOC), the Administrator and the General Manager (GM).

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.

- 7 WN(s)
- 2 VPC(s)
- 2 CO(s)
- 0 DR(s)
- 0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 54.	CO #901	2015_396103_0043	103

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 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 :

The licensee has failed to ensure steps are taken with Resident #2 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.

Resident #2 was admitted to the home on an identified date, had identified diagnoses and was noted to use a mobility aide to ambulate. The resident's health care record was reviewed for a period of three months and throughout that time frame there were numerous documented incidents that included:
- witnessed inappropriate touching/sexual comments toward female residents,
- incidents of increased banging of mobility aide on the floor,
- female residents stating they were afraid of the resident,
- verbal/physical altercations between the resident and staff when they attempted to redirect the resident, and
-a verbal altercation with the resident's room mate.

Resident #2's documentation indicated staff were concerned with an increase in the resident banging their mobility aide on the floor and two incidents whereby the resident, when provoked, attempted to use the mobility aide as a weapon.

S#101 and S#102 were interviewed and confirmed Resident #2 has used the mobility aide in the hall with both residents and staff in a manner that suggests the resident may be attempting to trip them.

Staff reported they are to monitor the resident closely around residents and to try to redirect them away from potentially harmful interactions. However the staff also stated the resident can be difficult to redirect especially on evenings and nights. There is documented evidence to suggest the resident has become more difficult to redirect and has responded with verbal and physical aggression toward staff.

S#106 works closely with the Behavioral Supports Ontario (BSO) team and was interviewed to determine what interventions are currently in effect to manage Resident #2's behaviours. The staff member stated the resident is currently on every 30 minute checks on evenings and nights; receives 1:1 friendly visits and is involved in the walk

with wheels club on a weekly basis. The Direct Observation System (DOS) monitoring has been completed as of an identified date and there is a meeting with the BSO team scheduled for July 7, 2015 to discuss Resident #2 and to develop a plan to manage the resident's current behaviours.

Since an identified date, despite the current level of monitoring, there have been five documented incidents whereby the resident attempted to inappropriately touch female co-residents. Additionally, there has been one documented incident whereby Resident #2 pushed a staff member to the floor while she attempted to redirect him/her out of a female co-resident room during the night. [s. 54. (b)]

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 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 :

The licensee has failed to ensure Resident's #1, #3, #4 and #7 were protected from abuse.

Sexual abuse is defined in the Long Term Care Homes Act, S.O. 2007, Chapter 8, s. 2 (1) 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.

The home submitted a critical incident report (CIR) on a specified date for a resident to resident abuse. The General Manager (GM) was interviewed and indicated RN S#116 had contacted her by phone on the evening of the alleged incident and stated a co-

resident had witnessed Resident #2 touching Resident #1 over her clothes. The GM indicated the MOHLTC and Resident #1's family member were notified the following day, seventeen hours after the alleged incident occurred. Additionally, the police were not immediately notified because the GM stated the family of Resident #1 requested the police not be notified. The police subsequently were notified by an anonymous caller and came to the home three days after the alleged sexual abuse.

During this inspection, Resident #2's health care record was reviewed from April 1, 2015 to date of this inspection. There were several documented incidents of inappropriate touching involving Resident #2 and other co-residents. Specifically, three incidents documented on three identified dates (as described in WN #1) involving co-residents #3, #4 and #7 were not investigated, and there was no notifications made to the MOHLTC, the police or the family members.

Additionally at the time of this inspection, the home did not ensure steps were being taken to minimize the reoccurrence of further incidents of sexual abuse. The physician was adjusting the resident's medication and had recently added an anti-hormonal medication, but the resident continued to be observed seeking out female co-residents. On an identified date, Resident #2 became aggressive with a staff member while they attempted to redirect the resident out of a female co-resident's room on the night shift. An immediate order was issued to ensure 1:1 monitoring would be in place until such time, the home had a comprehensive, documented clinical assessment that clearly delineates the resident's care needs in relation to responsive behaviours and the strategies required to prevent, minimize or respond to the responsive behaviours have been fully implemented.

As a result of reviewing the scope and severity of the incidents and the home's compliance history, this inspector identified a compliance order was warranted. There were repeated incidents involving Resident #2 documented from April 1, 2015 to date of this inspection involving four different female residents. The licensee has failed to protect Resident #1, #3, #4 and #7 from sexual abuse by:

-failing to immediately notify the MOHLTC of the witnessed incident of abuse on an identified date(outlined in WN#3)
-failing to immediately notify the appropriate police force of an alleged incident of abuse on an identified date that the GM and Administrator believed were reportable to police. (outlined in WN #4)
-failing to ensure three incidents on identified dates of alleged sexual abuse witnessed by

staff were immediately investigated (outlined in WN #6)
-failing to report the alleged incidents of sexual abuse on three identified dates to the MOHLTC, the police and the family members (outlined in WN #3, #4 and #7)
-failing to ensure the home's abuse policy contains information that is consistent with the legislated requirements related to the notification of police and the SDM's (outlined in WN #5)
-failing to comply with the home's abuse policy in regards to the need to immediately report all alleged, suspected or witnessed incidents of abuse immediately to the Director (MOHLTC) (outlined in WN #5)
-failing to ensure all allegations of resident abuse are immediately investigated (outlined in WN #6)
-failing to ensure all staff receive annual abuse training (outlined in WN #5)
-failing to ensure steps are taken with Resident #2 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. (outlined in WN #1)

The home's compliance history was reviewed and the following supports the ongoing identified risk associated with the non compliances:

-in July 2013, the home received a WN and a VPC for failing to notify the appropriate police force of an allegation of abuse,
-in July 2013, the home received a WN for failing to immediately report an allegation of abuse to the Director (MOHLTC)
-in July 2012, the home received a WN and a VPC related to responsive behaviours and failure to identify behavioural triggers.

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. 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 :

The licensee has failed to ensure that the person who had reasonable grounds to suspect the abuse of a resident that resulted in harm or risk of harm was immediately reported to the Director.

Resident #2 was admitted to the home on an identified date and had identified diagnoses. During a health care record review, this inspector noted that on an identified date, Resident #2 was observed by staff touching the upper thighs of Resident #7. S#108 was interviewed and stated a PSW had observed this and reported the incident to her. S#108 stated Resident #7 has a cognitive impairment and at the time of the incident did not appear to be harmed. According to S#108 she advised staff to monitor Resident #2 closely and to try and keep the resident away from the female residents.

On the following day, Resident #2 was observed by staff to touch the breasts of Resident #4. S#108 stated this resident also has a cognitive impairment and appeared to be

unharmed by the incident. S#108 once again directed staff to monitor Resident #2 closely. S#108 stated she believed these incidents did constitute inappropriate sexual touching and that the incidents would need to be reported. She stated she believes she recorded the incidents in the 24 hour shift report but was unsure if she notified anyone from management in regards to the two incidents.

The DOC was interviewed and stated she did recall being made aware of the two incidents involving Resident #2 and also agreed the incidents fit the definition of sexual abuse. The DOC stated she did not report the incidents to the MOHLTC because she felt the incidents were being managed by the home [redacted] Neither incidents have been reported to the MOHLTC to date of this inspection.

On another identified date, Resident #8, reported to staff that he/she witnessed Resident #2 touching Resident #1's over clothing. RN S#116 informed the General Manager (GM) S#100 of the allegation immediately after ensuring the resident's safety. In an interview with RN S#116, she stated she was advised by the GM that she and the Administrator would come to the home in the morning and make the necessary notifications.

In an interview with the GM, she stated she contacted the Administrator by telephone following the notification of the incident by the RN and that she received a follow up call from the Administrator stating she had handled the situation. The GM stated she notified the MOHLTC the following day, approximately seventeen hours after the incident. The GM stated that she was aware the notification to the MOHLTC should have been immediate.

Additionally, there was a documented incident on another identified date whereby Resident #2 was observed by staff to have their hand between Resident #3's legs and was seen moving the hand upward toward the resident's pubic area. The DOC stated she was unaware of that incident because she was away on holidays. S#105 was interviewed and stated Resident #2 was being monitored closely by staff and being redirected from the female residents where possible. The MOHLTC, to date of this inspection, was not notified of this witnessed incident. [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 the person who had reasonable grounds to suspect resident abuse occurred immediately reports the suspicions to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

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.

On two consecutive identified dates, the incidents involving Resident #2 (as outlined in WN #1.) were not reported to the police to date of this inspection. In an interview with the DOC, she agreed the two incidents would have been reportable, but at the time of the incidents, the DOC stated she believed they may have occurred because of Resident #2's poor vision. The DOC was reminded that the reporting includes alleged, suspected or witnessed incidents of abuse.

On another identified date, Resident #8 reported he/she witnessed Resident #2 touching Resident #1's pubic area. The home failed to report the incident to the police. In an interview with the GM and the Administrator, both agreed the incident would be reportable to police. criminal offence. The GM reported that when she spoke with the family of Resident #1, she was asked not to contact the police and she honoured that request. The GM was reminded the notification of the police in any alleged, suspected or witnessed incident of abuse is a legislated responsibility of the home. The Administrator stated the police were eventually notified by means of an anonymous caller and the police came to the home.

The witnessed incident on an identified date (as described in WN#1) was not reported to the appropriate police to date of this inspection. [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 all alleged, suspected or witnessed incidents of abuse or neglect of a resident that may constitute a criminal offence are immediately reported to the appropriate police force, to be implemented voluntarily.

WN #5: 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).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

The home's written policy, "Prevention of Abuse in Long-Term Care, Tab 04-06", updated on January 20, 2015 was not complied with.

The policy indicates, under "Procedure, Resident to Resident", when receiving a report of suspected abuse, the team member will immediately involve their direct Manager and notify the Ministry. The policy indicates, the following constitutes Mandatory Reporting under the LTCHA, s. 24:
-abuse of a resident by anyone.

The policy further states that upon receiving a report of suspected abuse, the team member will immediately involve their charge nurse and/or Neighbourhood Coordinator. If after hours, the team will advise the on-call leadership team member and will report the incident to the Ministry of Health and Long Term Care using the Mandatory Reporting Line.

The incidents on three identified dates (outlined in WN #1) involving Resident #2 were not reported to date of this inspection to the MOHLTC. Additionally, the incident dated on another identified date was not reported to the MOHLTC until approximately seventeen hours following the allegations of sexual abuse involving Resident #2.

The policy indicates under "Procedure-Team Leader and/or Charge Nurse", after ensuring all parties are safe and secure , and all parties have been notified, the Charge Nurse and/or Team Leader will initiate an internal investigation and complete an Incident Report, Critical incident Report and Investigation Tool before leaving the Village. Team members who have any knowledge of the incident will remain at the Village until the investigator dismisses them.

The three incidents on identified dates had no documentation to reflect the completion of an Incident report, Critical incident report or Investigation Tool.

The policy indicates, under "Team Member Education", that annually the team members will receive training on topics including but not limited to,

-the policy to promote zero tolerance of abuse and neglect of residents.

The home's records for abuse training were reviewed by this inspector for 2014 and 2015. It was noted that a total of twelve staff members did not complete abuse training in 2014. The policy further indicates, each departmental leader is responsible for maintaining current records of this and all team member education and must ensure Team members participate in on-line training annually. [s. 20. (1)]

The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents comply with any requirements that are provided for in the regulations and shall deal with any additional matters as may be provided for in the regulations.

The home's "Prevention of Abuse in Long-Term Care, tab 04-06" policy fails to accurately

reflect the legislated requirements including but not limited to the notification of the police and the substitute decision makers/Powers of Attorney.

O. Reg 79/10 s. 98 (police notification) states, "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."

The home's policy states under "Procedure-General Manager/Director of Care/Neighbourhood Co-ordinator/Designate/On-call Manager", if a criminal offence has taken place (e.g. sexually, physically, theft), call the police immediately. Otherwise confer with the Director of Operations as to whether or not police should be contacted.

The policy fails to identify the any alleged, suspected or witnessed incidents of abuse or neglect that the licensee suspects may constitute a criminal offence should be immediately reported to the police. The home is not obligated to determine if the incident constitutes a criminal offence, only that there is suspicion that it may constitute a criminal offence.

O. Reg 79/10 s. 97(1) (notification of SDM) indicates, "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 a 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 alleged, suspected or witnessed incident of abuse or neglect of the resident."

The home's abuse policy states to notify immediately the Substitute Decision Maker and/or Power of Attorney if there is physical injury, pain, and/or distress that is harmful to the health and well-being of a resident. The policy does not include the legislated requirement/timeframes to notify the SDM or Power of Attorney upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of a resident that did not result in injury or pain/distress. [s. 20. (2)]

WN #6: 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 :

The licensee has failed to ensure that every alleged, suspected or witnessed incident of resident abuse that the licensee knows of, was immediately investigated.

On two identified, consecutive dates, there were documented incidents in Resident #2's health care record that indicated the resident was observed with his hands between the upper thighs of Resident #7 and had touched the breast of Resident #4. The DOC stated she had been notified of both incidents and agreed they would be considered inappropriate and were of a sexual nature. The DOC was asked to provide this inspector with any investigation notes for these two incidents. The DOC provided a handwritten note, internal incident reports and the BSO notes where the resident's behaviours were discussed. These notes stated a DOS had been completed during the identified, consecutive dates, and there had been one incident of touching female co-resident. The second incident was not included in the notes. The DOC failed to provide this inspector with any documentation that indicated the two incidents were investigated by the home.

The DOC stated she was away on holidays during the documented incident on the identified date involving Resident #2, whereby the resident was observed by staff to have their hand between Resident #3's legs and moving it upward toward the resident's public area. S#105 was interviewed and stated Resident #2 was being monitored closely by staff and Resident #2 was being redirected from the female residents where possible. There was no evidence to support the incident was ever investigated. [s. 23. (1) (a)]

WN #7: 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 :

The licensee has failed to ensure that the resident's SDM was notified within 12 hours upon becoming aware of an alleged, suspected or witnessed incident of abuse.

On three identified dates, there were documented incidents involving Resident #2 (as outlined in WN #1).

The DOC was interviewed and stated she does recall being made aware of the two incidents involving Resident #2 on two of the identified dates and also agreed the incidents fit the definition of sexual abuse. At no time following these incidents were the SDM's of the residents notified.

On an identified date, Resident #8, reported to staff that he/she witnessed Resident #2 touching Resident #1's [redacted] over clothing RN #116 informed the General Manager (GM) S#100 of the incident immediately after ensuring the resident's safety. In an interview with RN S#116 she stated she was advised by the GM that she would come to the home in the morning and would speak with the family of Resident #1 at that time.

In an interview with the GM, she advised the family of Resident #1 was not notified until the following day approximately seventeen hours after the alleged incident . The home failed to notified the SDM of an allegation of sexual abuse within twelve hours of becoming aware of the suspected abuse. [s. 97. (1) (b)]

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

Issued on this 28th day of July, 2015

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

Darlene Murphy

Original report signed by the inspector.

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) :	DARLENE MURPHY (103)
Inspection No. / No de l'inspection :	2015_396103_0043
Log No. / Registre no:	O-002313-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 3, 8, 2015
Licensee / Titulaire de permis :	OAKWOOD RETIREMENT COMMUNITIES INC. 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	THE VILLAGE OF TAUNTON MILLS 3800 Brock Street North, WHITBY, ON, L1R-3A5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~EMILY VASEY (ACTING)~~ Jillian Heaver

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

Order # / Ordre no : 901

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. 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.

Order / Ordre :

The licensee is hereby ordered to immediately ensure there is 1:1 monitoring of Resident #2 in place 24/7 to minimize the risk of harm to co-residents.

The 1:1 monitoring will not be altered or discontinued until such time the resident has a comprehensive, documented clinical assessment that clearly delineates the resident's care needs in relation to responsive behaviours and the strategies required to prevent, minimize or respond to the responsive behaviours have been fully implemented.

Grounds / Motifs :

1. The licensee has failed to ensure steps are taken with Resident #2 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.

Resident #2 was admitted to the home on an identified date, had identified diagnoses and was noted to use a mobility aide to ambulate. The resident's health care record was reviewed for a period of three months and throughout that time frame there were numerous documented incidents that included:

- witnessed inappropriate touching/sexual comments toward female residents,
- incidents of increased banging of mobility aide on the floor,
- female residents stating they were afraid of the resident,
- verbal/physical altercations between the resident and staff when they attempted to redirect the resident, and
-a verbal altercation with the resident's room mate.

Resident #2's documentation indicated staff were concerned with an increase in the resident banging their mobility aide on the floor and two incidents whereby the resident, when provoked, attempted to use the mobility aide as a weapon.

S#101 and S#102 were interviewed and confirmed Resident #2 has used the mobility aide in the hall with both residents and staff in a manner that suggests the resident may be attempting to trip them.

Staff reported they are to monitor the resident closely around residents and to try to redirect them away from potentially harmful interactions. However the staff also stated the resident can be difficult to redirect especially on evenings and nights. There is documented evidence to suggest the resident has become more difficult to redirect and has responded with verbal and physical aggression toward staff.

S#106 works closely with the Behavioral Supports Ontario (BSO) team and was interviewed to determine what interventions are currently in effect to manage Resident #2's behaviours. The staff member stated the resident is currently on every 30 minute checks on evenings and nights; receives 1:1 friendly visits and is involved in the walk with wheels club on a weekly basis. The Direct Observation System (DOS) monitoring has been completed as of an identified date and there is a meeting with the BSO team scheduled for July 7, 2015 to discuss Resident #2 and to develop a plan to manage the resident's current behaviours.

Over an identified period of time, despite the current level of monitoring, there have been five documented incidents whereby the resident attempted to inappropriately touch female co-residents. Additionally, there has been one documented incident whereby Resident #2 pushed a staff member to the floor while she attempted to redirect him/her out of a female co-resident room during the night. [s. 54. (b)]

(103)

2.
(103)

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

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with LTCHA, 2007 s. 19 (1) to ensure all residents are protected from sexual abuse.

The licensee shall ensure the plan includes:

1) the development and implementation of a monitoring process to ensure:
a) the person who had reasonable grounds to suspect the abuse of a resident that resulted in harm or risk of harm immediately reports the suspicion to the Director,
b) 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,
c) every alleged, suspected or witnessed incident of sexual abuse that the licensee is aware of is immediately investigated,
d) the resident's substitute decision maker/Power of Attorney or any other person specified by the resident are notified:
-immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of a 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 residents health or well-being; and
-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.

2) The home shall ensure the abuse policy, "Prevention of Abuse in Long-Term

Care, Tab 04-06" shall comply with any requirements that are provided for in the regulations and shall deal with any additional matters as may be provided for in the regulations.

The policy should accurately reflect the legislated requirements in regards to the notification of the police and the substitute decision makers/Powers of Attorney. All staff and management shall have the revised abuse policy reviewed and documented records should be available to reflect the review of the revised abuse policy.

3) Develop and implement specific measures to be in place when the home's abuse policy is not complied with.

4) The 1:1 monitoring will not be altered or discontinued until such time the resident has a comprehensive, documented clinical assessment that clearly delineates the resident's care needs in relation to responsive behaviours and the strategies required to prevent, minimize or respond to the responsive behaviours have been fully implemented.

5) The plan should also identify who is responsible for ensuring the completion of each item listed above

The plan shall be submitted by fax at 613-569-9670 and sent Attention:Inspector Darlene Murphy on or before July 15, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure Resident's #1, #3, #4 and #7 were protected from abuse.

Sexual abuse is defined in the Long Term Care Homes Act, S.O. 2007, Chapter 8, s. 2 (1) 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.

The home submitted a critical incident report (CIR) on a specified date for a resident to resident abuse. The General Manager (GM) was interviewed and indicated RN S#116 had contacted her by phone on the evening of the alleged incident and stated a co-resident had witnessed Resident #2 touching Resident

over her clothing.

#1 . The GM indicated the MOHLTC and Resident #1's family member was notified the following day, seventeen hours after the alleged incident occurred. Additionally, the police were not immediately notified because the GM stated the family of Resident #1 requested the police not be notified. The police subsequently was notified by an anonymous caller and came to the home three days after the alleged sexual abuse.

During this inspection, Resident #2's health care record was reviewed from April 1, 2015 to date of this inspection. There were several documented incidents of inappropriate touching involving Resident #2 and other co-residents. Specifically, three incidents documented on three identified dates (as described in WN #1) involving co-residents #3, #4 and #7 were not investigated, and there was no notifications made to the MOHLTC, the police or the family members.

Additionally at the time of this inspection, the home did not ensure steps were being taken to minimize the reoccurrence of further incidents of sexual abuse. The physician was adjusting the resident's medication and had recently added an anti-hormonal medication, but the resident continued to be observed seeking out female co-residents. On an identified date, Resident #2 became aggressive with a staff member while they attempted to redirect the resident out of a female co-resident's room on the night shift. An immediate order was issued to ensure 1:1 monitoring would be in place until such time, the home had a comprehensive, documented clinical assessment that clearly delineates the resident's care needs in relation to responsive behaviours and the strategies required to prevent, minimize or respond to the responsive behaviours have been fully implemented.

As a result of reviewing the scope and severity of the incidents and the home's compliance history, this inspector identified a compliance order was warranted. There were repeated incidents involving Resident #2 documented from April 1, 2015 to date of this inspection involving four different female residents. The licensee has failed to protect Resident #1, #3, #4 and #7 from sexual abuse by:

-failing to immediately notify the MOHLTC of the witnessed incident of abuse on an identified date(outlined in WN#3)
-failing to immediately notify the appropriate police force of an alleged incident of abuse on an identified date that the GM and Administrator believed were reportabl to police. (outlined in WN #4)
-failing to ensure three incidents on identified dates of alleged sexual abuse

witnessed by staff were immediately investigated (outlined in WN #6)
-failing to report the alleged incidents of sexual abuse on three identified dates to the MOHLTC, the police and the family members (outlined in WN #3, #4 and #7)
-failing to ensure the home's abuse policy contains information that is consistent with the legislated requirements related to the notification of police and the SDM's (outlined in WN #5)
-failing to comply with the home's abuse policy in regards to the need to immediately report all alleged, suspected or witnessed incidents of abuse immediately to the Director (MOHLTC) (outlined in WN #5)
-failing to ensure all allegations of resident abuse are immediately investigated (outlined in WN #6)
-failing to ensure all staff receive annual abuse training (outlined in WN #5)
-failing to ensure steps are taken with Resident #2 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. (outlined in WN #1)

The home's compliance history was reviewed and the following supports the ongoing identified risk associated with the non compliances:

-in July 2013, the home received a WN and a VPC for failing to notify the appropriate police force of an allegation of abuse,
-in July 2013, the home received a WN for failing to immediately report an allegation of abuse to the Director (MOHLTC)
-in July 2012, the home received a WN and a VPC related to responsive behaviours and failure to identify behavioural triggers.
(103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 01, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 3rd day of July, 2015

Signature of Inspector / Signature de l'inspecteur : Darlene Murphy

Name of Inspector / Nom de l'inspecteur : DARLENE MURPHY

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