Ministry of Health and Long-Term Care
Long-Term Care Homes Division
Long-Term Care Inspections Branch

Ministère de la Santé et des Soins de longue durée
Division des foyers de soins de longue duree
Inspection de soins de longue durée

Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	Licensee Copy/Copie du Titulaire ☒ **Public Copy/Copie Public**
Name of Director:	Wendy Lewis
Order Type:	□ Amend or Impose Conditions on Licence Order, section 104 □ Renovation of Municipal Home Order, section 135 x Compliance Order, section 153 □ Work and Activity Order, section 154 □ Return of Funding Order, section 155 □ Mandatory Management Order, section 156 □ Revocation of Licence Order, section 157 □ Interim Manager Order, section 157
Intake Log # of original inspection (if applicable):	009358-18
Original Inspection #:	2018_524500_0008
Licensee:	The Wexford Residence Inc. 1860 Lawrence Avenue East, TORONTO, ON, M1R-5B1
LTC Home:	The Wexford 1860 Lawrence Avenue East, SCARBOROUGH, ON, M1R-5B1
Name of Administrator:	Sandy Bassett

Background:
Ministry of Health and Long-Term Care (MOHLTC) Inspectors #500, #566 and #652 conducted an inspection at The Wexford on the following dates: May 9, 10, 11, 14, 15, 16, 17, 18, 22, 2018 (2018_524500_0008). The inspection was a Resident Quality Inspection at which time three additional Intake logs were also inspected concurrently – two critical incidents (Log #007726-16 and #007131-18) and one complaint (Log #025150-17). During the inspection, the Inspector determined that the Licensee, The Wexford Residence Inc. (The Wexford or the Licensee) failed to comply with certain provisions (as identified below) of the *Long-Term Care Homes Act, 2007* (LTCHA) and issued Compliance Order #001.

Compliance Order #001 relates to *LTCHA,* s.19 (1) and reads as follows:

The licensee must be compliant with s.19 (1) of the *LTCHA*.

The licensee shall prepare, submit and implement a plan to ensure that all residents are protected from sexual abuse, and all other forms of abuse, by tenants living in the apartment in the same building and protected from all visitors to the home. The plan must include, but is not limited, to the following:

- Develop and implement short-term and long-term strategies and interventions to ensure residents' safety from any kind of abuse
- Develop and implement a tracking system in order to supervise residents who are ambulatory and are allowed to leave the unit independently
- Create a detailed description of all required steps to execute this action plan including the timelines, the person responsible to complete the action, and a completion date to ensure all residents' safety from tenants and visitors in order to protect them from any kind of abuse
- Evaluate the effectiveness of this plan and keep this record including the date of evaluation, people who participated in the evaluation, a requirement for any improvements if there are any based on the results of the evaluation, and the timeline to implement these improvements.

Please submit the written plan for achieving compliance for inspection #2018_524500_0008 to Nital Sheth, LTC Homes Inspector, MOHLTC, by email to TorontoSAO.moh@ontario.ca by June 22, 2018.

This order must be complied by September 28, 2018

Following the conclusion of a Director's review under s. 163 of the *LTCHA*, the above order has been altered and substituted with the Director's Order below.

Order: #001	#001 – The Wexford Residence Inc.

To The Wexford Residence Inc. you are hereby required to comply with the following order(s) by the date(s) set out below:

Pursuant to:

The Director is issuing Director's Order #001 after finding that the Licensee failed to comply with the *Long-Term Care Homes Act, 2007* (LTCHA) 2007 c.8 s.19 (1) which states:

Duty to protect

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.

Order

Director's Order #001 is being made pursuant to section 153(1)(a) of the LTCHA.

The Licensee shall be compliant with s. 19(1) of the *LTCHA*.

Specifically, to ensure that residents are protected from abuse by anyone, the Licensee shall conduct a risk assessment of all long-term care units located on the 2nd, 3rd, 4th, 5th, 6th and 7th floors to determine all potential risks related to abuse. As part of this risk assessment, areas of focus are to include, but are not limited to the following:

1. Entrance and access to long-term care units.
2. The use of shared space that residents must traverse to access services offered by the licensee as required under the *LTCHA.*
3. Staff monitoring of video surveillance.

The Licensee shall keep a record of the risk assessment, findings and any actions taken to address the risk(s) of abuse to residents.

This order must be complied with by: October 5, 2018

Grounds:

The Licensee has failed to comply with subsection 19(1) of the *Long-Term Care Homes Act, 2007* (*LTCHA*) as Resident #016 was sexually abused by a tenant living in the building operated by the Licensee.

Sexual abuse under subsection 2(1) of Ontario Regulation 79/10 (Regulation) under the *LTCHA* is defined as:

> (a) subject to subsection (3), any consensual or non- consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or
>
> (b) 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 critical incident report received by the Director in 2018 indicated that Resident #016, who lived in the long-term care unit of the building, reported to the nurse manager that they were touched inappropriately by a tenant. The tenant resided in the tenant residence on the same floor and the resident indicated that the incident occurred in front of the elevator.

Video surveillance of the area in front of the elevator identified the tenant exiting from the elevator on a specific floor and encountering Resident #016. The tenant opened their arms as if to embrace the resident. The resident attempted to walk passed the tenant and pressed the elevator button. The tenant then grabbed the resident's arms and hit their buttocks twice. Following this the tenant could be seen lifting up the resident's clothing and reaching their hand underneath. The tenant then attempted to pull the resident towards the tenant side of the building. Resident #016 managed to break free from the tenant's grip and walked into the long-term care unit.

A review of the resident's records identified that Resident #016 is mildly cognitively impaired.

During an interview with the Inspector, Resident #016 stated that the tenant touched them inappropriately, lifted up their clothing and touched them inappropriately. The resident stated that the same tenant touched them inappropriately earlier in the year and that they told the receptionist but that she did not do anything. The resident further stated the following: "Once I met the tenant in September last year, they were pressing my chest, it happened in their room. I went to their room, they pulled me into the room. The tenant took me to the room. They pulled my shirt and pressed my chest. I did not tell someone. I went to their room because they called me. They gave me cookies and I did not take."

During a tour of the building, the Inspectors identified the following:

- There are 6 floors that house both the long-term care units on one side and the tenant residences on the other side of the building. These include the 2nd, 3rd, 4th, 5th, 6th and 7th floors.

- Upon exiting the elevator on these floors a person would have to walk a short distance to the left to enter the long-term care unit through a door, or walk to the right to the individual tenant residences.
- There are surveillance cameras in front of the elevators with monitors on each of the long-term care units. The monitors are located in the nursing station and are not regularly viewed by staff.
- All long-term care units can be accessed by anyone by pressing a red button to release the magnetic lock. Once inside the unit, there is a keypad with a code posted that once entered, will automatically open the door to allow people to exit the unit.
- There were no audible alarms on the 2nd, 3rd, 5th and 6th floors. There were alarms on the 4th and 7th floor as these long-term care units are considered to be secured by the Licensee. The Inspectors triggered the alarms on these 2 units and no staff attended the entrance to identify why the alarms were sounding.
- The 1st floor of the building contains many services for residents that are required by the *LTCHA.* These include but are not limited to activity and spiritual programs.

During an interview with the Tenant Coordinator, they indicated that the Executive Director for the Licensee was responsible for the entire building which includes the long-term care home and the common/shared areas of the building. They further stated that as the Tenant Coordinator, they were responsible for all tenants and residents attending the Activity Centre as well as people attending from the community.

During an interview with RPN #118, they stated that when Resident #016 leaves the unit, they requires supervision for safety and that it is hard if the resident doesn't tell them when they are leaving. They told the Inspector that there was a receptionist downstairs on the 1st floor and if Resident #016 signed out, the receptionist would call the nursing station.

During an interview with the Environmental Services Manager they told the Inspector that all entrance doors to the long-term care units were not locked overnight.

During an interview with the DOC they told the Inspector that since the incident of sexual abuse that occurred in 2018, the home did not have any formal measures in place to protect residents from abuse by anyone, including tenants and visitors. They also stated that Resident #016 was vulnerable and that they failed in their duty to protect Resident #016 from abuse.

A review of the home's policy #6.46, entitled "Zero Tolerance of Abuse and Neglect of Residents", reviewed January 12, 2018, indicated that the home is committed to zero tolerance of abuse or neglect of its residents. All residents have the right to live in a home environment that treats them with dignity, respect and free from any form of abuse or neglect at all times, and in all circumstances.

The application of factors taken into account under section 299(1) of the Regulation requires a Compliance Order to be issued. The severity of the issue relates to the confirmed sexual abuse of Resident #016 by a tenant living in the building; scope is isolated to one resident and the Licensee

has a level 4 history as they had ongoing non-compliance with this section of the *LTCHA* in 3 or more inspections.

This order must be complied with by:	October 5, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Long-Term Care Inspections Branch
347 Preston Street, 4th Floor, Suite 420
Ottawa ON K1S 3J4
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.

Issued on this 2nd day of August, 2018	
Signature of Director:	
Name of Director:	**Wendy Lewis**

Version date: July 27, 2016