Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 26, 2016	2016_356618_0013	008928-16	Critical Incident System

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

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

HAWTHORNE PLACE CARE CENTRE
2045 FINCH AVENUE WEST NORTH YORK ON M3N 1M9

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

CECILIA FULTON (618)

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): May 9,10,11,12,13,16,17,18, 19, 2016.

This inspection was related to Resident abuse.

During the course of the inspection, the inspector(s) spoke with Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Director of Care (DOC) and Administrator.
During the course of the inspection, the inspector observed Residents and Resident Home areas and conducted record review.

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.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

Part One of the Long Term Care regulations defines sexual abuse 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.

Review of Critical Incident Report revealed that Resident #002 was found in the room of Resident #001 and that Resident #001 was removing a piece of clothing from Resident #002.

Record review and staff interviews revealed that Resident #002 has cognitive impairment and was known to exhibit behaviours, none of which were sexual in nature. Minimum Data Set (MDS) data revealed that Resident #002 had severely impaired decision and communication abilities.

Resident #001 has cognitive impairment and was known to exhibit socially inappropriate behaviour including sexual advancement towards female co-residents. They were under frequent observations and being followed by the Behavioural Support Team.

Interview with staff #101 revealed that at 0930 hours on an identified date, they noticed people behind the curtain in Resident #001's room.

Upon investigation they found Resident #002 sitting on the bed of Resident #001. Resident #001 was removing a piece of clothing from Resident #002 exposing an identified body part.

Staff #101 took Resident #002's hand in an attempt to lead them out. Resident #001 grabbed Resident #002's arm and prevented them from standing up. Staff #101 verbally redirected Resident #001 and took Resident #002's hand and directed them to stand and leave the room.

Resident #002 was put on frequent observation and did not appear to suffer any negative consequences from the encounter.

On that same morning at approximately 1030 hours Resident #001 was observed taking Resident #002 by the hand and directing them into their room.

Staff #101 saw this and went quickly to get another staff member to assist and then entered Resident #002's room to find Resident #001 on the bed kicking at Resident #002

who was standing over them. Both residents were fully clothed.

Resident #002 was removed from the situation without injury.

Resident #001 was given a PRN sedative and Administrator was informed of incident.

Review of the home's investigation and interview with DOC and Administrator confirmed that the home did not protect Resident #002 from sexual abuse. [s. 19. (1)]

Issued on this 26th day of May, 2016

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

Original report signed by the inspector.