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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 12, 2013	2013_163189_0016	T-139-13, T-233-13	Critical Incident System

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8

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

LEISUREWORLD CAREGIVING CENTRE - VAUGHAN
5400 Steeles Avenue West, Woodbridge, ON, L4L-9S1

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

NICOLE RANGER (189)

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): June 24, 25, 26, 28, July 5, July 8, July 9, July 10, 2013

During the course of the inspection, the inspector(s) spoke with Director of Administration, Director of Care, Nurse Manager, Registered Staff, Personal Support Workers

During the course of the inspection, the inspector(s) Conducted a tour of resident and common area, Reviewed health care records, Reviewed policy on Prevention of Abuse and Neglect, Reviewed policy on Responsive Behaviours

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

Responsive Behaviours

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

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

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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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. Resident # 3 is cognitively well with a CPS score of 1.

In 2013, resident #3 was found by PSW #1 in resident #8 room, sitting on the bed. PSW called RPN # 1 to come and observe. RPN #1 reported to the inspector that on that day, he/she witnessed resident #3 place his/her left hand around resident #8's neck, and his/her right hand was fondling the upper part of resident #8's body, then his/her right hand moved in between resident #8's legs. RPN #1 reported that he/she approached resident # 3 and asked what he/she is doing, resident # 3 stated "we are good friends we are doing our own thing, there is nothing wrong". RPN #1 informed resident that he/she should not do it again and removed resident #8 out of the room. RPN #1 informed he/she reported the incident to the Power of Attorney (POA) and to Nurse Manager #2.

In 2013, around 13:39h, RPN # 2 documented that resident #3 was seen several times beside resident # 8. RPN #3 reported to the inspector that at 19:10h, resident #1 was sitting in the wheelchair in an identified room and resident #8 was found sitting on the bed. RPN #3 reported that he/she witnessed resident #3 touching resident #8 around his/her abdomen area. Resident #8 was wearing clothes and resident #3 was noted with his/her pants open. RPN #3 asked resident #3 what he/she was doing in the room and resident reported that he/she was using the washroom and found resident #8 sitting on the bed. RPN #3 informed the resident that his/her behaviour is inappropriate and separated the residents. RPN #3 stated that he/she contacted the POA for resident #3. Progress notes for this incident reports POA informed RPN #3 that he/she already received information regarding previous similar incident this week and he/she hopes staff will monitor resident against this behaviour as he/she is cognitive and needs to be watched for this behaviour.

In 2013, PSW # 2 was in the hallway walking towards the t.v room. PSW #2 informed inspector that he/she noticed resident #9 sitting in his/her wheelchair facing the t.v room and resident #3 was sitting beside him/her. PSW # 2 informed inspector that he/she witnessed resident #3 rubbing resident #9's leg. PSW #2 called RPN # 4 to come and observe. RPN #4 reported to the inspector that he/she also witnessed resident #3 touching resident #9 inappropriately with his/her hands rubbing inside resident #9 legs and he/she reported this to Nurse Manager #1 who came and spoke with the resident.

In 2013, PSW # 1 found resident #3 seated in his/her wheelchair beside resident #10

in the t.v lounge with his/her hands between resident #10's legs and his/her hands on top of resident #10 chest moving in a forward and backward motion. PSW #1 reported to the inspector that he/she quickly separated the residents and asked resident #3 what he/she was doing and the resident did not respond. PSW #1 reported that he/she informed RPN #3 of the incident. RPN #3 informed inspector that he/she notified Nurse Manager #2 of the incident.

In 2013, PSW #2 was walking in the hallway towards the dinning room. PSW #2 reported to the inspector when he/she was in the dining room, he/she noticed resident #8 sitting in the dining room and resident #3 sitting beside him/her with his/her hands on resident #8's chest. PSW #2 reported to inspector that he/she told PSW #3 who was also present to move resident #8 away from resident #3. PSW #3 informed inspector that he/she reported it to PSW # 5 who was to follow up and report it to the charge nurse.

During interviews with inspector, PSW # 1, PSW #2, PSW #3 PSW #4 and PSW #5 reported that they witnessed resident # 3 sexually touch three residents on the unit. All PSW's reported that resident #3 is cognitively aware of his/her actions. All PSW's reported to the inspector that resident #3 will target other residents who are cognitively impaired, especially resident #8. PSW's reported that they keep resident #8 inside the nursing station so that resident #8 is away from resident #3 and can be monitored. PSW #4 informed inspector that resident #3 said inappropriate comments to the staff. When asked by the Inspector if PSW's documented resident #3 behaviours, PSW's reported that there are incidents they did not document. This was confirmed when Inspector reviewed behavioural documentation in Point of Care.

All staff reported that they are aware of resident #3 behaviours and they did not report three incidents to the Director of Care(DOC) or Administrator. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The plan of care for resident #3 directs staff to monitor behaviour episodes and document behaviour and potential causes.

During interview with inspector, PSW # 1, PSW #2, PSW #3, PSW # 4 and PSW #5 reported that they witnessed resident #3 with sexual inappropriate behaviours with three residents. Inspector confirmed five incidents of sexual inappropriate behaviour.

Inspector reviewed PSW's daily behavioural report for a three month period in 2013. PSW's documented three out of five incidents of sexual inappropriate behaviours. PSW's reported that they did not document all incidents of resident #3's sexual inappropriate behaviours. [s. 6. (7)]

2. The licensee failed to ensure that the resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when: (b) the resident's care needs changed.

Plan of care for resident #3 behaviours states staff are to monitor behaviour episodes and document behaviour and potential causes.

During a three month period in 2013, there were five incidents of sexual inappropriate behaviours for resident #3. Plan of care was not reviewed and revised, and there were no reassessment conducted for resident #3 behaviours. [s. 6. (10) (b)]

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 care set out in the plan of care is provided to the resident as specified in the plan of care, and to ensure that the resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs changed, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that 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.

During a three month period in 2013, there were five incidents of sexual abuse involving resident #3.

The licensee did not investigate the incidents of sexual inappropriate behaviours that occurred on within this time period. Staff were aware of the incidents and no investigation was conducted. [s. 23. (1) (a)]

2. The licensee failed to ensure appropriate actions were taken for the five incidents of sexual abuse that occurred with three residents. There were no interventions and monitoring in place to respond to resident #3 sexual inappropriate behaviours. [s. 23. (1) (b)]

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 alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: abuse of a resident by anyone, and to ensure that appropriate action is taken in response to every such incident, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that 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:
(2) Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

In 2013, resident #3 was found in the t.v room to be rubbing in between resident #9's legs. This incident was witnessed by PSW #2 and RPN #4. Nurse Manager #1 was informed of the incident and spoke with the resident. This incident was not immediately reported to the Administrator and staff did not immediately report the suspicion and the information upon which it was based to the Director.

In 2013, resident #3 was found in the t.v room to be rubbing in between resident #10's legs in a back and forth motion and hands on top of resident #10 chest. This incident was witness by PSW #1. RPN #3 and Nurse Manager # 2 were informed of the incident. This incident was not immediately reported to the Administrator and staff did not immediately report the suspicion and the information upon which it was based to the Director.

In 2013, resident #3 was found in the dining room to be rubbing resident #8's chest. This incident was witness by PSW # 2 and PSW #3. PSW #3 reported this to PSW #5. This incident was not reported to the Administrator and staff did not immediately report the suspicion and the information upon which it was based to the Director.

Inspector confirmed with Director of Administration the above staff received training on abuse and mandatory reporting under section 24 prior to these incidents. [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 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: (2) Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the following are developed to meet the needs of residents with responsive behaviours:
(2) written strategies, including techniques and interventions, to prevent, minimize or respond to responsive behaviours

During a three month period in 2013, there are five incidents of sexual inappropriate behaviours for resident #3. There is no strategies, techniques or interventions to prevent , minimize or respond to the resident #3 behaviours. [s. 53. (1) 2.]

2. The licensee failed to ensure that the following are developed to meet the needs of residents with responsive behaviours:
(3) Resident monitoring and internal reporting protocols

Licensee policy V3-092 "Responsive Behaviours Management" under section "Preventative Strategies and Monitoring" states nursing staff are to monitor resident behaviour, followed by appropriate assessments, and to ensure PSW's document in the behaviour section of the documentation system and report any changes to registered staff.

During interview with inspector, PSW # 1, PSW #2, PSW #3, PSW # 4 and PSW #5 reported that they witnessed resident #3 with sexual inappropriate behaviours with three residents. Inspector confirmed five incidents of sexual inappropriate behaviour during an three month period in 2013.

Inspector reviewed PSW's daily behavioural report documentation. PSW documented three out of five incidents of sexual inappropriate behaviours. PSW's reported that they did not document all incidents of resident #3 sexual inappropriate behaviours. [s. 53. (1) 3.]

3. The licensee failed to ensure that the following are developed to meet the needs of residents with responsive behaviours:
(4) Protocols for the referral of residents to specialized resources where required

Licensee policy V3-092 "Responsive Behaviours Management" under "Utilization of Internal and External resources" states nursing staff are to refer residents to internal or external resources as required.

During a three month period in 2013, there are five incidents of sexual inappropriate behaviours for resident #3.
Behavioural Support Nurse (BSO) stated that as per policy, if a resident had more than one incident of inappropriate behaviours, resident is to be followed by the Behavioural Nurse on a consistent basis, as the resident is high risk, and a referral to external resources is required.

Behavioural Support nurse reported that it is an expectation of the staff to inform him/her of the residents behaviours and confirmed to the inspector that resident #3 was not referred to specialized resources as he/she was aware of one incident and staff did not report the other four incidents to him/her. [s. 53. (1) 4.]

4. The licensee failed to ensure that for each resident demonstrating responsive behaviours:
(c) Actions are taken to respond to the needs of the residents, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

During a three month period in 2013, there are five incidents of sexual inappropriate behaviours for resident #3. There is no action, no assessments, no reassessments and no interventions taken to respond to resident #3 behaviours. [s. 53. (4) (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 following are developed to meet the needs of residents with responsive behaviours: written strategies, including techniques and interventions, to prevent, minimize or respond to responsive behaviours, to ensure that resident monitoring and internal reporting protocols are conducted, to ensure that protocols for the referral of residents to specialized resources where required are conducted and to ensure that actions are taken to respond to the needs of the residents, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

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

Findings/Faits saillants :

1. The licensee failed to ensure that the appropriate police force is immediately notified of any alleged, suspected or witness incident of abuse or neglect of a resident that the licensee suspect may constitute a criminal offence.

Resident # 3 is cognitively well with a CPS score of 1.

During a three month period in 2013, Resident #3 was found to be sexually inappropriate with Resident #8, Resident #9 and Resident #10. These five incidents were not reported to the appropriate police force immediately. Director of Administration informed the inspector that the police were notified later in 2013. [s. 98.]

Issued on this 22nd day of August, 2013

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NICOLE RANGER (189)
Inspection No. / No de l'inspection :	2013_163189_0016
Log No. / Registre no:	T-139-13, T-233-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 12, 2013
Licensee / Titulaire de permis :	2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP 302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8
LTC Home / Foyer de SLD :	LEISUREWORLD CAREGIVING CENTRE - VAUGHAN 5400 Steeles Avenue West, Woodbridge, ON, L4L-9S1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~DEBORAH FLEMING~~

To 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

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 ensure that Resident #8 and Resident #9 is protected from abuse by anyone.

The licensee shall prepare, submit and implement a plan to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. This plan shall include but not limited to : Measures that address the duty under section 24 to make mandatory reports, Zero tolerance of abuse and neglect of residents, Shall immediately investigate every alleged, suspected or witnessed incident that the licensee knows of, or that is reported to the licensee.

Submit compliance plan to Nicole.Ranger@ontario.ca by July 26, 2013

Grounds / Motifs :

1. Resident # 3 is cognitively well with a CPS score of 1.

In 2013, resident #3 was found by PSW #1 in resident #8 room, sitting on the bed. PSW called RPN # 1 to come and observe. RPN #1 reported to the inspector that on that day, he/she witnessed resident #3 place his/her left hand around resident #8's neck, and his/her right hand was fondling the upper part of resident #8's body, then his/her right hand moved in between resident #8's legs. RPN #1 reported that he/she approached resident # 3 and asked what he/she is doing, resident # 3 stated "we are good friends we are doing our own thing, there is nothing wrong". RPN #1 informed resident that he/she should not do it again and removed resident #8 out of the room. RPN #1 informed he/she reported the incident to the Power of Attorney (POA) and to Nurse Manager #2.

In 2013, around 13:39h, RPN # 2 documented that resident #3 was seen several times beside resident # 8. RPN #3 reported to the inspector that at 19:10h, resident #1 was sitting in the wheelchair in an identified room and resident #8 was found sitting on the bed. RPN #3 reported that he/she witnessed resident #3 touching resident #8 around his/her abdomen area. Resident #8 was wearing clothes and resident #3 was noted with his/her pants open. RPN #3 asked resident #3 what he/she was doing in the room and resident reported that he/she was using the washroom and found resident #8 sitting on the bed. RPN #3 informed the resident that his/her behaviour is inappropriate and separated the residents. RPN #3 stated that he/she contacted the POA for resident #3. Progress notes for this incident reports POA informed RPN #3 that he/she already received information regarding previous similar incident this week and he/she hopes staff will monitor resident against this behaviour as he/she is cognitive and needs to be watched for this behaviour.

In 2013, PSW # 2 was in the hallway walking towards the t.v room. PSW #2 informed inspector that he/she noticed resident #9 sitting in his/her wheelchair facing the t.v room and resident #3 was sitting beside him/her. PSW # 2 informed inspector that he/she witnessed resident #3 rubbing resident #9's leg. PSW #2 called RPN # 4 to come and observe. RPN #4 reported to the inspector that he/she also witnessed resident #3 touching resident #9 inappropriately with his/her hands rubbing inside resident #9 legs and he/she reported this to Nurse Manager #1 who came and spoke with the resident.

In 2013, PSW # 1 found resident #3 seated in his/her wheelchair beside resident #10 in the t.v lounge with his/her hands between resident #10's legs and his/her hands on top of resident #10 chest moving in a forward and backward motion. PSW #1 reported to the inspector that he/she quickly separated the residents and asked resident #3 what he/she was doing and the resident did not respond. PSW #1 reported that he/she informed RPN #3 of the incident. RPN #3 informed inspector that he/she notified Nurse Manager #2 of the incident.

In 2013, PSW #2 was walking in the hallway towards the dinning room. PSW #2 reported to the inspector when he/she was in the dining room, he/she noticed resident #8 sitting in the dining room and resident #3 sitting beside him/her with his/her hands on resident #8's chest. PSW #2 reported to inspector that he/she told PSW #3 who was also present to move resident #8 away from resident #3.

PSW #3 informed inspector that he/she reported it to PSW # 5 who was to follow up and report it to the charge nurse.

During interviews with inspector, PSW # 1, PSW #2, PSW #3 PSW #4 and PSW #5 reported that they witnessed resident # 3 sexually touch three residents on the unit. All PSW's reported that resident #3 is cognitively aware of his/her actions. All PSW's reported to the inspector that resident #3 will target other residents who are cognitively impaired, especially resident #8. PSW's reported that they keep resident #8 inside the nursing station so that resident #8 is away from resident #3 and can be monitored. PSW #4 informed inspector that resident #3 said inappropriate comments to the staff. When asked by the Inspector if PSW's documented resident #3 behaviours, PSW's reported that there are incidents they did not document. This was confirmed when Inspector reviewed behavioural documentation in Point of Care.

All staff reported that they are aware of resident #3 behaviours and they did not report three incidents to the Director of Care(DOC) or Administrator. [s. 19. (1)] (189)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2013

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 12th day of July, 2013

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : NICOLE RANGER

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