Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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
Apr 7, 2015	2015_286547_0002	O-000576-14, O-004947-14, O-006346-14	Critical Incident System

Licensee/Titulaire de permis

CITY OF OTTAWA
Long Term Care Branch 275 Perrier Avenue OTTAWA ON K1L 5C6

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

GARRY J. ARMSTRONG HOME
200 ISLAND LODGE ROAD OTTAWA ON K1N 5M2

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

LISA KLUKE (547)

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): January 9-20, 2015

Unannounced inspection for the following Critical Incidents was conducted during the course of this inspection. Log #O-000576-14, O-004947-14 and O-006346-14.Several observations of Resident to Resident interactions, staff to resident interaction, record review of resident health profiles, review of the training material regarding doors and alarms, review of several policies and procedures,

During the course of the inspection, the inspector(s) spoke with the Administrator, both Managers of Resident Care, Registered and non-registered Nursing staff, a geriatric psychiatry outreach nurse, the manager of environmental services with the City of Ottawa, a Receptionist, a Housekeeping staff, a private caregiver, residents and families.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **1 VPC(s)**
- **1 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 comply with the LTCHA 2007, Chapter 8, s. 19(1) in that the licensee did not protect Resident #002, #004 and #005 from Resident to Resident sexual

abuse.

Sexual abuse is defined in O.Reg. 79/10, s.2.(1)as "any form of 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".

During this critical incident inspection of resident to resident sexual abuse, actual harm and or risk of harm was demonstrated as two vulnerable and cognitively impaired residents were recipients of the sexual abuse. These incidents re-occurred over several months for Resident #004 and Resident #005 while Resident #003 was residing in the home.

Resident #003’s health records indicated Resident #003 with the use of a wheelchair, was able to move freely in the home. This resident was admitted to the home on a specified date in March, 2007. Resident #003 was being followed by the Geriatric Psychiatry Team from the Royal Ottawa Hospital for management of responsive behaviours.

Inspector #547 reviewed Resident #003’s health records from a specified date in May, 2014 to a specified date in October, 2014 and the following incidents were found:

-On a specified date in May, 2014 an incident report indicated that Resident # 003 went behind Resident #004 and inappropriately put his/her left hand on his/her breast.

-On a specified date in June, 2014 an incident report indicated that Resident #003 inappropriately touched Resident #004.

-On a specified date in July, 2014 an observation note indicated the resident was followed by the Royal Ottawa Hospital Psychiatry Outreach Program with recommendations to monitor Resident #003’s inappropriate sexual behaviour with behaviour mapping and staff were advised to be vigilant when Resident #003 is near co-residents.

-On a specified date in August, 2014 an incident report indicated that a food service attendant saw Resident #003’s hand on Resident #003’s private area. Inspector #547 requested clarity for the Resident numbers in this incident report with Staff #107 on a specified date in January, 2015 who indicated that this incident report should read: Resident #003’s hand on Resident #004’s private area.

-On a specified date in August, 2014 Resident #003 continued to exhibit behaviours towards co- residents, and was intercepted four times on the day shift.
-On another specified date in August, 2014 Resident #003 was admitted to a Hospital for management of responsive behaviours and returned to the home on a specified date in October, 2014.

-On four specified dates in October, 2014 progress notes indicated Resident #003 was found touching Resident #004 on the breast on each of these days whereby Resident #003 was redirected on each occasion by staff. Resident #003 was placed on 1:1 supervision on one of these specified dates in October, 2014 and attempted to touch Resident #004 inappropriately twice again and required further re-direction.

-On another specified date in October, 2014 a progress note indicated that Resident #003 remained on 1:1 supervision, however while coming out of the dining room with fast hand movement,Resident #003 grabbed Resident #005's breast.

During this inspection, Inspector #547 observed Resident #004 to be confined to a wheelchair and record review of the Resident's health records indicated that Resident #004 was cognitively impaired. Inspector #547 reviewed Resident #005's health records that indicated this resident was also cognitively impaired. Inspector #547 attempted to interview both Resident #004 and Resident #005 however interviews were not possible due to their cognitive impairment.

-On January 15, 2015 it was noted in the unit's shift report book that Resident #002's family member had called on a specified date in August, 2014 reporting that Resident#002 had informed the family member of being touched on the breast by a co-resident on the unit. During an interview with Inspector #547 on a specified date in January, 2015 Staff #107-a Manager of Resident Care indicated that she had never been made aware of this complaint by Resident #002's family, no progress notes in the Resident's health records or any incident report was initiated regarding this alleged incident of sexual abuse.

The licensee failed to protect residents from sexual abuse as evidenced by the following:

-The licensee failed to immediately notify the Substitute Decision Makers of Resident #004 and Resident #005 of every alleged, suspected, or witnessed incidents of sexual abuse (as identified in WN #5).

-The licensee failed to ensure that the appropriate police force was immediately notified of all eight of the witnessed incidents of resident to resident sexual abuse. (as identified in WN #6).

-The Director was not immediately notified of the witnessed incidents of sexual abuse of Residents #004 and #005 to protect these residents. (as identified in WN #4)

- The licensee's policy for "Abuse-#750.65" was not complied with (as identified in WN #3).

- The licensee's policy for "Complaint-#750.43" was not complied with (as identified in WN #7).

- Non-compliance was previously identified under LTCHA, 2007, s.19 (1) during an inspection completed on October 19, 2012 (Inspection # 2012_199161_0002). [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).

Findings/Faits saillants :

1. The Licensee has failed to ensure that s. 6.(7) the care set out in the plan of care was provided to Resident #002 as specified in the plan.

Resident #002 was admitted to the home on a specified date in April 2014 to the home diagnosed with Vascular Dementia. This resident was an exit seeker, and required a bracelet alarm system for safety. Resident #002 eloped from the home on a specified date in September, 2014 with the safety bracelet attached and functional.

On a specified date in January, 2015 Inspector #547 reviewed the home's investigation notes regarding Resident #002's elopement from the home which stated:

-Resident #002 required re-direction several times from the home's elevator on the morning of this specified date in September, 2014 however was successful in going to the main floor of the home after lunch.
-At a specified time in this day, the front door alarms were triggered, and Staff #109 was leaving the front entrance for break. Staff #109 utilized the swipe card twice to open the front doors, and when this was not successful, he/she tried to disengage the keypad alarm. During this period, Staff #110 was seated at the reception desk and indicated to Staff #109 the proper code to disengage the bracelet keypad alarm system. Staff #109 disengaged the bracelet alarm and left for break from the front doors of the home and greeting Resident#002 as Staff #109 was leaving the building.

On a specified date in January, 2015 Inspector #547 noted in Resident #002's plan of care in place for this specified date September, 2014 that the Resident had a restraint order for bracelet restraint.

On a specified date in January, 2015 Inspector #547 interviewed Staff #107 who indicated that all staff in the home participated in doors and alarms training in September 2013 and provided records to Inspector #547 that both Staff #109 and Staff #110 received this training.

On a specified date in January, 2015 Inspector #547 interviewed Staff # 112 who indicated that all residents wearing the bracelet alarm system in the home is recorded in a binder at reception, with their picture, and room number in case they require re-direction to their unit. Staff #112 indicated that all staff have access to view this binder and are aware that it is kept at the reception desk to verify residents with bracelet alarm systems. Staff #112 indicated that the home is secured with a key pad alarm system when a resident wearing the bracelet alarm approaches the front entrance that will keep the front doors locked until this alarm is disengaged.

Staff #109 did not follow this resident plan of care regarding maintaining the resident's safety and recognize the bracelet alert alarm and safely redirecting the resident to his/her unit prior to disengaging the door locking mechanisms in the home to go for break. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care regarding residents that use a bracelet alarm system,is provided to these residents by all nursing staff for resident safety, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Abuse policy and procedure #750.65 instituted or otherwise put in place are complied with.

On a specified date in January, 2015 Inspector #547 was conducting a review of one of the unit's shift report book and noted that Resident #002's family had called on a specified date in August, 2014 reporting that the Resident had informed the family of being touched on the breast by a co-resident on the unit.

Inspector #547 interviewed Staff #107 who reported that she had never been made aware of this complaint. Staff #107 then reviewed Resident #002's progress notes and no indication of any phone call, investigation commenced or follow-up with Resident #002's family regarding this call of concern.

On a specified date in January, 2015 Inspector #547 interviewed Staff #104 and Staff #111 who indicated that they did witness Resident #003 inappropriately touch co-resident's breasts, and had reported this to the Registered Nursing staff in the home. It was noted upon review of this unit's shift report book, that resident to resident abuse had

been reported eight times from specified dates between May and October 2014.

Interviews with Staff #100, Staff #103 and Staff #107,indicated that the incidents involved with Resident #003's inappropriate touching of co-resident's breasts would be classified as non-consensual touching. These Registered Nursing staff members reviewed the definition of sexual abuse with Inspector #547 and indicated these incidents involving Residents #004 and #005 met the definition of sexual abuse and should have been reported to management of the home and to the Director.

On this same date, Staff #107 provided Inspector #547 the home's policy and procedure regarding Abuse #750.65 last updated November 2014 indicated that:

- Residents will not be subjected to any form of physical, emotional, sexual, verbal or financial abuse or neglect form other residents. Definitions of types of abuse are attached to this policy on page 5 as Appendix A.

- This policy further states on page 2 under Duty to Report; The reporting of any alleged harm, abuse or neglect done to a resident is mandatory by the following:

1. Internally by telling a charge nurse or manager, as appropriate and
2. Directly to the MOHLTC.

The Operational Procedure on page 3 states:

#4. Immediately report the allegation to the Administrator and Manager of Resident Care and
#5. Have the staff member reporting the allegation immediately write a report of what they saw or heard.
#8. Manager of Resident Care or designate will complete a Critical Incident report to the Director. [s. 20. (1)]

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 has failed to ensure that any person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director regarding the witnessed sexual abuse of Resident #004 and #005 on several occasions by Resident #003.

On a specified date in January, 2015 Inspector #547 interviewed both Staff #107 and Staff #108 regarding Resident #003's responsive behaviours of inappropriately touching co-resident's breasts. Both Staff #107 and #108 indicated that this behaviour had been going on for several months, with several changes in plan of care prior to the Resident's discharge in October 2014 to a specialized behaviour management unit in another home. Both Staff #107 and Staff #108 indicated that this resident was also admitted to a Hospital between August and October,2014 for management of this same responsive behaviour towards Resident's #004 and #005.

On a specified date in January, 2014 Inspector #547 conducted a record review of Resident #003's progress notes and unit shift report book whereby it was noted that Resident #003 inappropriately touched: Resident #004's breasts on a specified date in May and another specified date in June, 2014; Resident #005 on a specified date in August, 2014 and then sent to hospital for psychiatric assessment of Resident#003's responsive behaviours. Resident #003 returned to the home on a specified date in

October, 2014. Resident #003 inappropriately touched Resident #004's breasts again on four specified dates in October, 2014 and Resident #005's breasts on another specified date also in October, 2014.
Out of each of these instances of non-consensual sexual touching, only one critical incident report was sent by the home to the Director.

On January 15, 2015 Inspector #547 interviewed Staff #104 and Staff #111 who indicated that they did witness Resident #003 inappropriately touch female resident's breasts, and reported this to the Registered Nursing staff in the home as per their home policy on Abuse. Record review of the seventh floor shift report book noted that resident to resident abuse had been reported and written into the shift report book for the seventh floor.

On January 15, 2015 during interviews with Staff #100, Staff#101, Staff #103, Staff #107 and Staff #108 that the incidents involved with Resident #003's inappropriate sexual touching of Resident #004 and Resident #005's breasts would be classified as non-consensual touching. These Registered Nursing staff members also indicated that these incidents met the definition of sexual abuse and should have been reported to management of the home, and to the Director but staff concentrated more on Resident #003's responsive behaviours. These Registered Nursing staff members further indicated that the female residents had dementia and that they did not recall these events.

On January 20, 2014 during an interview with Inspector #547, Staff #107- a Manager of Resident Care indicated that once Staff #101 informed her on October 7, 2014, four days after the incidents began, of the inappropriate touching of Residents #004 and #005, that she submitted the critical incident report on October 8, 2014 to the Director.

The home's Administrator confirmed that no other critical incident had been completed for any of the other incidents than the October 3, 2014 report. [s. 24. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #004's and Resident #005's Substitute Decision Makers and any other person specified by those residents were notified within 12 hours upon becoming aware of the alleged, suspected or witnessed incidents of abuse or neglect of these residents.

There was no documented evidence provided by the home during this inspection or during record review of Resident #004's health records, that the Substitute Decision Maker of Resident #004 was ever notified of the alleged, suspected, or witnessed incidents of sexual abuse on five specified dates between May and October, 2014. [s. 97. (1) (b)]

2. There was no documented evidence provided by the home during this inspection or during record review of Resident #005's health records, that the Substitute Decision Maker of Resident #005 was ever notified of the alleged, suspected, or witnessed incident of sexual abuse on a specified date in October, 2014. [s. 97. (1) (b)]

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 was immediately notified of alleged, suspected or witnessed incidents of resident to resident sexual abuse that the licensee suspects may constitute a criminal offence.

There was no documented evidence provided by the home that the police were notified of the witnessed incidents of resident to resident sexual abuse for Resident #004 that occurred once in May, twice in June , once in August, and four times in October, 2014. [s. 98.]

2. There was also no documented evidence provided by the home that the police were notified of the witnessed incidents of resident to resident sexual abuse for Resident #005 that occurred twice in October, 2014. [s. 98.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every verbal complaint made to a staff member in the home by Resident #002's family on a specified date in August, 2014 during the evening shift concerning a co-resident having touched Resident #002's breasts.

On a specified date in January, 2015 Inspector #547 reviewed this resident's unit shift report book and noted that Resident #002’s family had called on a specified date in August, 2014 reporting that Resident#002 had informed the family of being touched on the breast by a co-resident on the unit.

On a specified date in January, 2015 Inspector #547 interviewed Staff #107-a Manager of Resident Care who indicated that she had never been made aware of this complaint from any staff member to this date. Staff #107 indicated that staff document all complaints in an incident report within their electronic documentation system, as well as inform a manager who will begin the investigation. Staff #107 reported that this complaint was not transferred to the resident's progress notes, no incident report was filed, and no call was placed to the Manager on call. This complaint has not been investigated, or resolved to this date. [s. 101. (1) 1.]

Issued on this 8th day of April, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA KLUKE (547)
Inspection No. / No de l'inspection :	2015_286547_0002
Log No. / Registre no:	O-000576-14, O-004947-14, O-006346-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 7, 2015
Licensee / Titulaire de permis :	CITY OF OTTAWA Long Term Care Branch, 275 Perrier Avenue, OTTAWA, ON, K1L-5C6
LTC Home / Foyer de SLD :	GARRY J. ARMSTRONG HOME 200 ISLAND LODGE ROAD, OTTAWA, ON, K1N-5M2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MARLYNNE FERGUSON

To CITY OF OTTAWA, 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) (a)

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 is hereby ordered to ensure:

All staff shall complete a mandatory, comprehensive and interactive education session offered in various formats to meet the learning needs of adult learners on all forms of resident abuse. The education should include but not limited to:

1. How to identify all forms of resident abuse as defined in O.Reg 79/10 s.2,
2. The mandatory reporting obligations as outlined in the LTCHA, 2007 s.24 indicates that a person who has reasonable ground to suspect that abuse of a resident by anyone or neglect by staff member has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director,
3. The development of a monitoring process to ensure that:
a) every incident of alleged, suspected or witnessed incident of abuse is immediately investigated,
b) the resident's Substitute Decision Maker (SDM) is notified of every incident of alleged, suspected or witnessed incident of abuse,
c) the appropriate police force have been notified of all alleged, suspected, or witnessed incidents of sexual abuse that the licensee suspects may constitute a criminal offence,
d) a written report is submitted to the Director with respect to the alleged, suspected or witnessed incident of abuse or a resident by anyone which shall include:
- a description of the incident and the individuals involved,
- action taken in response to the incident,
- analysis and follow-up action,
- the name and title of the person making the report,
- that the Director is informed of the results of every investigation undertaken in response to an alleged, suspected or witnessed incident of abuse.
4. Ensure that staff education is provided with the home's Abuse policy #750.65, which includes in Appendix A- identification of definitions of all forms of abuse as defined in O.Reg.79/10 s.2.(1). Appendix B should also be included- with the Abuse decision trees and legislated reporting requirements of all incidents of alleged, suspected or witnessed incidents of sexual abuse of a resident by anyone as indicated in LTCHA, 2007 s.24.

Grounds / Motifs :

1. The licensee has failed to comply with the LTCHA 2007, Chapter 8, s. 19(1) in that the licensee did not protect Resident #002, #004 and #005 from Resident to

Resident sexual abuse.

Sexual abuse is defined in O.Reg. 79/10, s.2.(1)as "any form of 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".

During this critical incident inspection of resident to resident sexual abuse, actual harm and or risk of harm was demonstrated as two vulnerable and cognitively impaired residents were recipients of the sexual abuse. These incidents re-occurred over several months for Resident #004 and Resident #005 while Resident #003 was residing in the home.

Resident #003's health records indicated Resident #003, with the use of a wheelchair, was able to move freely in the home. This resident was admitted to the home on a specified date in March 2007. Resident #003 was being followed by the Geriatric Psychiatry Team from the Royal Ottawa Hospital for management of responsive behaviours.

Inspector #547 reviewed Resident #003's health records from a specified date in May, 2014 to a specified date in October, 2014 and the following incidents were found:

-On a specified date in May, 2014 an incident report indicated that Resident # 003 went behind Resident #004 and inappropriately put his/her left hand on his/her breast.

-On a specified date in June, 2014 an incident report indicated that Resident #003 inappropriately touched Resident #004.

-On a specified date in July, 2014 an observation note indicated Resident#003 was followed by the Royal Ottawa Hospital Psychiatry Outreach Program with recommendations to monitor the resident's inappropriate sexual behaviour with behaviour mapping and staff were advised to be vigilant when Resident #003 is near co-residents.

-On a specified date in August, 2014 an incident report indicated that a food service attendant saw Resident #003's hand on Resident #003's private area. Inspector #547 requested clarity for the Resident numbers in this incident report with Staff #107 on a specified date in January, 2015 who indicated that this

incident report should read: Resident #003's hand on Resident #004's private area.

-On a specified date in August, 2014 Resident #003 continued to exhibit behaviours towards co- residents, and was intercepted four times on the day shift, with no incident.

-On a specified date in August, 2014 Resident #003 was admitted to a Hospital for management of his/her responsive behaviours and returned to the home on a specified date in October, 2014.

-On four specified dates in October, 2014 progress notes indicated Resident #003 was found touching Resident #004 on the breast on each of these days whereby Resident #003 was redirected on each occasion by staff. Resident #003 was placed on 1:1 supervision on one of these specified dates in October, 2014 and attempted to touch Resident #004 inappropriately twice again and required further re-direction.

-On another specified date in October, 2014 a progress note indicated that Resident #003 remained on 1:1 supervision, however while coming out of the dining room with fast hand movement he/she grabbed Resident #005's breast.

During this inspection, Inspector #547 observed Resident #004 to be confined to a wheelchair and record review of the Resident's health records indicated that Resident #004 was cognitively impaired. Inspector #547 reviewed Resident #005's health records that indicated this resident was also cognitively impaired. Inspector #547 attempted to interview both Resident #004 and Resident #005 however interviews were not possible due to their cognitive impairment.

-On a specified date in January, 2015 it was noted in this unit's shift report book that Resident #002's family member had called on a specified date in August, 2014 reporting that the Resident had informed this family member that Resident #002 had been touched on the breast by co- resident. During an interview with Inspector #547 on a specified date in January, 2015 Staff #107-a Manager of Resident Care indicated that she had never been made aware of this complaint by Resident #002's family, no progress notes in the Resident's health records or any incident report was initiated regarding this alleged incident of sexual abuse.

The licensee failed to protect residents from sexual abuse as evidenced by the

following:

-The licensee failed to immediately notify the Substitute Decision Makers of Resident #004 and Resident #005 of every alleged, suspected, or witnessed incidents of sexual abuse (as identified in WN #5).

-The licensee failed to ensure that the appropriate police force was immediately notified of all eight of the witnessed incidents of resident to resident sexual abuse. (as identified in WN #6).

-The Director was not immediately notified of the witnessed incidents of sexual abuse of Residents #004 and #005 to protect these residents. (as identified in WN #4)

- The licensee's policy for "Abuse-#750.65" was not complied with (as identified in WN #3).

- The licensee's policy for "Complaint-#750.43" was not complied with (as identified in WN #7).

- Non-compliance was previously identified under LTCHA, 2007, s.19 (1) during an inspection completed on October 19, 2012 (Inspection # 2012_199161_0002). (547)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 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 7th day of April, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Kluke

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