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
Nov 28, 2014	2014_380593_0007	2977-14	Complaint

Licensee/Titulaire de permis

RIVERSIDE HEALTH CARE FACILITIES, INC.
110 VICTORIA AVENUE FORT FRANCES ON P9A 2B7

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

RAINYCREST
550 OSBORNE STREET FORT FRANCES ON P9A 3T2

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

GILLIAN CHAMBERLIN (593)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 19th - 21st, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nursing Staff, Personal Support Workers (PSW), Residents and family members.

The following Inspection Protocols were used during this inspection:

Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **5 WN(s)**
- **0 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. This non-compliance is supported by the following findings:

A complaint was submitted to the Ministry of Health and Long-Term Care in relation to an incident of sexual abuse towards a resident in the home by another resident also residing in the home.

A Critical Incident was submitted to the Ministry of Health and Long-Term Care in relation to the same incident of sexual abuse involving Resident #002 sexually assaulting Resident #001. It was reported that staff member #104 witnessed Resident #002 fondle the breasts of Resident #001 in a common living area of the unit without consent. Staff member #104 intervened and removed Resident #001 from the common living area. It was reported that staff member #105 spoke with Resident #002 about their inappropriate behaviour and at this time Resident #002 became angry and defensive.

Under O.Reg. 79/10, sexual abuse is defined 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".

During an interview with Inspector #593 on October 17, 2014, staff member #104 advised that they witnessed Resident #002 sexually abuse Resident #001. Staff member #104 was seated at the nurse's station and Resident #001 was seated in their wheelchair in view from the nurse's station. Staff member #104 advised that they looked over towards Resident #001 and saw Resident #002 seated next to Resident #001 with their hand up their shirt on their breast. Staff member #104 immediately called out Resident #002's name and told them to stop; they went over towards the two residents and by this time Resident #002 had moved away from Resident #001. Staff member #104 checked

Resident #001 then moved them closer to the nurse's station so that staff could keep closer watch of them. They then reported the incident to the RN on duty. Staff member #104 advised they were aware of the history of Resident #002's inappropriate sexual behaviours and that they believed the touching of Resident #001 by Resident #002 to be non-consensual. Staff member #104 advised that Resident #001 and Resident #002 were not known to have a prior relationship in the home.

During an interview with Inspector #593 on October 02, 2014, staff member #105 advised that they spoke with Resident #002 shortly after the incident occurred. They advised that Resident #002 was not receptive to what they were saying and become angry and defensive stating "I didn't do anything wrong". Staff member #105 further advised that there was no known prior relationship between Resident #001 and Resident #002 and they believed the sexual touching of Resident #001 by Resident #002 to be non-consensual.

During an interview with Inspector #593 on August 18, 2014, complainant and family member #003 advised that Resident #001 was sexually assaulted by a resident known to exhibit sexually inappropriate behaviours towards other residents. As a result Resident #001 was not sleeping well or staying in their room at night as family member #003 believes they were scared since the incident occurred. Family member #003 advised that Resident #001 would not talk about the incident of sexual abuse that occurred as they were embarrassed and has repeated to family member #003 that they wish to die.

Resident #002 is known for their sexually inappropriate behaviours. A review of Resident #002's Plan of Care at the time of the incident found that Resident #002 has sexual behaviours including hugging and kissing other female Residents and socially inappropriate behaviour including fondling cognitively impaired female Residents. As documented, staff are required to monitor Resident #002's interactions with female Residents and that any inappropriate behaviours including touching are to be reported to registered staff.

A review of Resident #002's progress notes found that sexual behaviours had continued since the incident with Resident #002, in 2014 including:

* A staff member overheard Resident #002 ask another resident "would you like to go for a quickie"?

* Resident #002 was observed to lean over and give another resident a kiss.

* A staff member observed Resident #002 rubbing female Resident #004 on their breasts and back, when Resident #002 saw the PSW, they stopped and sat down in the lounge to watch TV.

* A staff member reported that they observed Resident #002 sitting with their arm around a female Resident and then rubbing their arm. When Resident #002 noticed the staff member standing there, they removed their hand from the Resident.

* A staff member reported that a resident was sitting next to Resident #002, when they stood up they were looking at Resident #002 funny and then Resident #002 was motioning for them to sit back down. When Resident #002 noticed the staff member watching them, they let the resident leave the area.

During an interview with Inspector #593 on August 20, 2014, staff member #101 advised that when Resident #002 was first admitted to the home they were warned about their inappropriate sexual behaviours. Staff member #101 advised that there were no incidents initially until Resident #002's medication was decreased which was when their sexual and inappropriate behaviours commenced in the home. Staff member advised that Resident #002 was moved to another unit in the home since the incident with Resident #001 so that staff could keep a closer watch of their behaviours. They further advised that since being moved to the other unit, Resident #002 had been showing interest in another resident also residing in that unit, however there have been no incidents of abuse reported with this resident. Staff member #101 further advised that Resident #002 is very independent, is aware of staff watching them, waiting until there are no staff present before they behave inappropriately and does not show any remorse when spoken to about their inappropriate behaviour. In addition, staff member also stated that they were not confident that this would not happen again to another resident within the home.

A review of Resident #002’s plan of care found that Resident #002 is inappropriate sexually as evidenced by wandering at night and entering other residents' rooms and fondling cognitively impaired residents. The actions as found in the plan of care to address this behaviour included the transfer of Resident #002 to another unit for increased monitoring of inappropriate behaviours and transfer to a room in the center corridor for increased monitoring of inappropriate behaviours.

During an interview with Inspector #593 on August 20, 2014; staff member #106 advised

that since Resident #002 was moved to another unit, staff try to keep them from sitting near other residents so that no inappropriate behaviour can occur. They further advised that Resident #002's room on the other unit had not changed and that their room is not central to the nurse's station as documented in the resident's plan of care. This was confirmed during observations by Inspector #593.

During an interview with Inspector #593 on August 21, 2014; staff member #112 advised that Resident #002 can attend activities if they are supervised by a staff member during the activity, which activation staff are aware of. They further advised that staff are required to monitor Resident #002, ensure that they are not alone with other residents, and redirect them when required.

During an interview with Inspector #593 on August 20, 2014, staff member #113 advised that there was inappropriate behaviour displayed initially when Resident #002 was moved to the other unit of the home, involving Resident #004, who was unaware of the inappropriate behaviour as they believed that Resident #002 was their spouse. Staff member #113 further advised that Resident #002 is well aware of what they are doing. In addition since Resident #002 was transferred to the other unit, staff are required to monitor Resident #002 more closely and they are to make sure that there is always a staff member around Resident #002 for monitoring.

During an interview with Inspector #593 on August 20, 2014; staff member #108 advised that Resident #002 is sneaky about their inappropriate behavior, ensuring no staff members are around before approaching other residents. Staff would take Resident #002 back to their room when displaying inappropriate behaviours, however they would then leave their room and try again. As far as they are aware, the inappropriate behaviours have been evident for at least a few months. Staff member #108 further advised that before the incident occurred with Resident #001, Resident #002 was focusing their behaviours on Resident #005. As a result, Resident #005 was moved to the same unit where both Resident #002 and Resident #005 now reside. In addition, staff member #108 advised that Resident #002 would arrive at the main dining room before meals to assist with putting aprons on residents. Staff stopped this behavior when they realized Resident #002 was touching the residents' breasts under the aprons as they were providing assistance.

During an interview with Inspector #593 on August 20, 2014, staff member #115 advised that Resident #002 was moved to the other unit of the home so that staff could monitor their behaviours more closely, however staff are unable to stop them from sitting near

other residents and staff would move them if they were inappropriate towards another resident. They further advised that there had been no inappropriate behaviour since transferring to the other unit, however Resident #002 is aware of when staff is watching them and will not do anything inappropriate at this time.

During an interview with Inspector #593 on August 21, 2014 staff member #110 advised that staff are required to monitor Resident #002 and that they were transferred to the other unit so that staff could more closely monitor them.

Inspector #593 made the following observations of Resident #002:

* Resident #002 was observed to be seated in a living area of the unit, there were two other residents observed to be sleeping in the area at this time. There were no staff members present in the area at this time.

* Observed a resident seated next to Resident #002 in the living area of the unit, there were no staff members present in the area at this time.

* Resident #002 was observed to be seated next to a resident in the living area of the unit while an activity was taking place.

* Resident #002 was observed to be seated between two other residents, there were no staff members present in the area at this time.

* Resident #002 was observed to be seated in the garden outside of the unit, Inspector #593 observed other residents in this area with no staff members present at this time.

As evidenced by documented progress notes, documented plans of care and staff interviews; Resident #002 was known to exhibit sexually inappropriate behaviours towards residents in the home including non-consensual touching of a sexual nature towards other residents, prior to the incident. Furthermore, Resident #002 was relocated to another unit of the home for closer monitoring however as evidenced by staff interviews and observations by Inspector #593; Resident #002 has been left unsupervised around cognitively impaired residents and as documented in Resident #002's progress notes, the sexually inappropriate behaviour has continued. The licensee has failed to protect Resident #001 from sexual abuse by a resident with known and documented sexually inappropriate behaviours towards other female residents. [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. This non-compliance is supported by the following findings:

A complaint was submitted to the Ministry of Health and Long-Term Care Action line by family member #003 regarding concerns about the care their family member Resident #001 receives in the home specifically related to toileting assistance. During an interview with Inspector #593 August 18, 2014; family member #003 advised that Resident #001 often has to wait for staff assistance to help with toileting and therefore will attempt to go to the bathroom on their own, which has resulted in previous falls. Alternatively, staff have advised Resident #001 to void into their brief which Resident #001 dislikes.

A review of Resident #001's plan of care found that Resident #001 is bladder incontinent, requires one person physical assistance for toileting and will be able to follow a specified toileting routine as follows: before and after meals, before bed and as required at night, toileted at night rounds (approximately 02:30) and as required. Resident #001 is also required to be checked every two hours for wetness.

During an interview with Inspector #593 on August 20, 2014; Resident #001 advised that staff do provide assistance for toileting however they only provide assistance 2-3 times per day; Resident #001 further advised that they will ask staff for help with toileting however they are often too busy to help.

During an interview with Inspector #593 on August 20, 2014; staff member #109 advised regarding Resident #001's toileting schedule that residents who are awake when day

shift staff arrive were toileted after breakfast, the remaining residents were toileted before lunch usually between 10:30 and 11:30. They further advised that Resident #001 would next be toileted after lunch unless the resident asked to be toileted earlier.

During an interview with Inspector #593 on August 20, 2014; staff member #114 confirmed that Resident #001 requires one person assistance for toileting and that Resident #001's toileting schedule is first thing in the morning, before lunch, after lunch, 15:00, after supper and before bed. Staff member #114 further advised that Resident #001 will become anxious if not toileted regularly and if the Resident asks to be toileted they will take them in between the scheduled times.

A review of Resident #002's daily care records found that during August 2014; toileting records were not signed as completed for at least one shift on seven days during this month, to date.

Inspector #593 observed on a day in August, 2014; two staff members assist Resident #001 to be toileted at 10:00. The resident was then observed to be relocated to the common living area of the wing. At 12:00, Resident #001 was taken to their room by staff member #107 for a dressing change followed by relocation to the common dining room for lunch. The resident was not toileted during this time. Post lunch at 13:00, Resident #001 was observed to be returned to the wing common living area, no attempt was observed to toilet Resident #001 at this time. At 14:16, Resident #001 was still observed to be seated in the common living area of the wing with no further attempts of toileting observed since 10:00 that morning.

As such, the licensee has failed to provide toileting assistance to Resident #001 as specified in the plan of care. [s. 6. (7)]

2. This non-compliance is supported by the following findings:

Resident #002 is known for their sexually inappropriate behaviours. A review of Resident #002's plan of care found that Resident #002 is inappropriate sexually, as evidenced by wandering at night and entering other residents' rooms and fondling cognitively impaired residents. The actions as found in the plan of care to address this behaviour include the transfer of Resident #002 to a room in the centre of another unit for increased monitoring of inappropriate behaviours.

During an interview with Inspector #593 on August 20, 2014; staff member #106 advised

that since Resident #002 was moved to the other unit staff try to keep them from sitting near other female Residents so that no inappropriate behaviour can occur. They further advised that Resident #002's room on the unit has not changed and that their room is not central to the nurse's station. This was confirmed during observations by Inspector #593.

Inspector #593 made the following observations of Resident #002:

12:36- Resident #002 was observed to be seated in the common living area of the secure unit, there were two residents observed to be sleeping in the area at this time. There were no staff members present in the area at this time.

12:40- Observed resident seated next to Resident #002 in the living area of the unit. There were no staff members present in the area at this time.

15:01- Resident #002 was observed to be seated next to a resident in the living area of the unit while an activity is taking place.

16:45 - 16:53- Resident #002 is observed to be seated between two female residents, there were no staff members present in the area at this time.

12:28- Resident #002 was observed to be seated in the garden outside of the unit, there were observed to be other residents also in the area and no staff members present at this time.

As evidenced by observations, staff interviews and resident progress notes; Resident #002 does not reside in a room central to the Nurse's station and as observed by Inspector #593, Resident #002 has been left alone with residents with cognitive deficits on multiple occasions and as such, the Licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. This non-compliance is supported by the following findings:

A Critical Incident was submitted to the Ministry of Health and Long-Term Care in relation to an incident of sexual abuse involving Resident #002 sexually assaulting Resident #001. It was reported that staff member #104 witnessed Resident #002 fondle the breasts of Resident #001 in the living area of the unit without consent. Staff member #104 intervened and removed Resident #001 from the common living area. It was reported that staff member #105 spoke with Resident #002 about their inappropriate behaviour and at this time Resident #002 became angry and defensive.

Resident #002 is known for their sexually inappropriate behaviours.

A review of Resident #002's progress notes found that sexual behaviours had continued since the incident with Resident #002 including:

A staff member overheard Resident #002 ask another resident "would you like to go for a quickie"?

Resident #002 was observed to lean over and give another resident a kiss.

A staff member observed Resident #002 rubbing Resident #004 on their breasts and back, when the resident saw the staff member, they stopped and sat down in the lounge to watch TV.

A staff member reported that they observed Resident #002 sitting with their arm around a resident and then rubbing their arm. When Resident #002 noticed the staff member standing there, they removed their hand from the resident.

A staff member reported that a resident was sitting next to Resident #002, when they stood up they were looking at Resident #002 funny and then Resident #002 was motioning for them to sit back down. When Resident #002 noticed the staff member watching them, they let the resident leave the area.

During an interview with Inspector #593 on August 20, 2014; Director of Care staff member #101 advised that when Resident #002 was first admitted to the home they were warned about their inappropriate behaviours. DOC staff member #101 advised that there were no incidents for a while until their medication was decreased which was when their sexual and inappropriate behaviours commenced in the home. DOC staff member advised that Resident #002 was moved to another unit since the incident with Resident #001 so that staff could keep closer watch of their behaviours. They further advised that since being moved to the other unit, the resident has been showing interest in another resident also residing in the unit, however there have been no incidents of abuse reported with this resident. DOC staff member #101 further advised that Resident #002 is very independent, is aware of staff watching them and will wait until there are no staff present before they behave inappropriately and does not show any remorse when spoken to about their inappropriate behaviours. This was also confirmed during interviews with staff members #108 and #115. In addition, DOC staff member also stated that they were not confident that this would not happen again to another resident within the home.

A review of Resident #002's plan of care found that Resident #002 is inappropriate sexually, as evidenced by wandering at night and entering residents rooms and fondling cognitively impaired residents. The actions as found in the plan of care to address this behaviour include transfer of Resident #002 to a room in the centre of the secure unit for increased monitoring of inappropriate behaviours.

During an interview with Inspector #593 on August 20, 2014; staff member #106 advised that since Resident #002 was moved to the other unit staff try to keep them from sitting near other residents so that no inappropriate behaviour can occur. They advised that Resident #002 voiced that they do not belong there but was told they do because Resident #002 likes to touch other residents. Furthermore Resident #002 has been quiet

since moving to the other unit of the home.

During an interview with Inspector #593 on August 20, 2014; staff member #108 advised that Resident #002 is sneaky about their inappropriate behaviors, they would ensure that no staff members were around before approaching other residents. Staff would take Resident #002 back to their room when displaying inappropriate behaviours however they would then leave their room and try again. As far as they are aware, the inappropriate behaviours have been evident for at least a few months. Staff member #108 further advised that before the incident occurred with Resident #001, Resident #002 was focusing their behaviours on Resident #005. As a result, Resident #005 was moved to the same unit where both Resident #002 and Resident #005 now reside.

During an interview with Inspector #593 on August 21, 2014; staff member #112 advised that Resident #002 was moved from one wing to another unit very suddenly without any real explanation as to why they were moved. In addition, Resident #002 told staff member #112 that this unit was hell on earth and that they felt like they were in Jail. Staff member #112 further advised that staff are required to monitor Resident #002, however feels that this is not always done in the most respectful way towards the resident. They feel that the other residents' rights have been placed ahead of Resident #002's and that it is hard for them to be in this unit as they are cognitive. Furthermore, Resident #002 can only attend activities if there is a staff member available to supervise throughout the activity and often this resource is not available.

During an interview with Inspector #593 on August 21, 2014; staff member #110 advised that Resident #002 was very unhappy when they were first transferred to the other unit in the home.

During an interview with Inspector #593 on August 21, 2014; staff member #111 advised that they have some concerns regarding the transfer of Resident #002 to the other unit as there will be less stimulation resulting in boredom which in turn could be a trigger for inappropriate behaviours.

As such, the licensee has failed to ensure steps are taken to minimize the risk of altercations and potentially harmful interactions between and among Residents. [s. 54. (b)]

WN #4: 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. This non-compliance is supported by the following findings:

A Critical Incident was submitted to the Ministry of Health and Long-Term Care in relation to an incident of sexual abuse involving Resident #002 sexually assaulting Resident #001. It was reported that staff member #104 witnessed Resident #002 fondle the breasts of Resident #001 in the living area of the unit without consent.

During an interview with Inspector #593 on August 20, 2014 DOC staff member #101 advised that the RN on duty the night of the incident did not call the resident's family immediately regarding the sexual abuse incident as they believed they had dealt with the situation and felt that the resident's family did not require contacting and it was more important to contact Resident #002's family regarding the incident. DOC staff member #101 further advised that the home's policy is that families are required to be notified immediately if such incidences do occur.

During an interview with Inspector #593 on October 02, 2014; staff member #105 advised that they were on-duty the night the incident occurred. The incident was reported to staff member #105 by staff member #104 and as Resident #002 was upset, staff member #105 called their family. Staff member #105 did not call Resident #001's family and during an interview with Inspector #593 October 02, 2014; advised that this was an

oversight and they realize that the family of Resident #001 should have been contacted to inform them of this incident.

A second incident involving Resident #002 occurred where a staff member observed Resident #002 rubbing Resident #004 on their breasts and back, when Resident #002 saw the staff member, they stopped and sat down on the lounge to watch TV. The family of Resident #004 were contacted regarding this incident and advised that this was being dealt with, however they were not contacted until two days after the incident occurred.

During an interview with Inspector #593 on August 20, 2014, DOC staff member advised that the family should have been notified immediately and that if staff were unable to get into contact with the family, then this should have been documented. A review of Resident #004's progress notes found no documentation regarding the notification of family until the initial notification two days after the incident occurred.

As such, the licensee has failed to immediately notify the Resident's substitute decision maker upon becoming aware of a witnessed abuse of the Resident that caused distress to the Resident. [s. 97. (1) (a)]

WN #5: 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. This non-compliance is supported by the following findings:

A Critical Incident was submitted to the Ministry of Health and Long-Term Care in relation to an incident of sexual abuse involving Resident #002 sexually assaulting Resident #001. It was reported that staff member #104 witnessed Resident #002 fondle the breasts of Resident #001 in the living area of the unit without consent.

A complaint was submitted to the Ministry of Health and Long-Term Care in relation to the same incident of sexual abuse towards Resident #001 in the home by Resident #002 also residing in the home. During an interview with Inspector #593 August 18, 2014; the complainant family member #003 advised that they had to call the Police regarding this incident as the home failed to do so.

The family of Resident #001 contacted the Police regarding the incident of sexual abuse involving Resident #002.

During an interview with Inspector #593 on August 20, 2014 DOC staff member #101 advised that the RN on duty the night of the incident did not call the resident's family or the Police regarding the sexual abuse incident as they had dealt with the situation and felt that the police did not require contacting.

As such, the licensee has failed to ensure the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a Resident that the licensee may constitute a criminal offence. [s. 98.]

Issued on this 12th day of January, 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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GILLIAN CHAMBERLIN (593)
Inspection No. / No de l'inspection :	2014_380593_0007
Log No. / Registre no:	2977-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 28, 2014
Licensee / Titulaire de permis :	RIVERSIDE HEALTH CARE FACILITIES, INC. 110 VICTORIA AVENUE, FORT FRANCES, ON, P9A-2B7
LTC Home / Foyer de SLD :	RAINYCREST 550 OSBORNE STREET, FORT FRANCES, ON, P9A-3T2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Darryl Galusha

To RIVERSIDE HEALTH CARE FACILITIES, INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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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

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 is required to prepare, submit and implement a plan for achieving compliance under s.19 (1) of the LTCHA. This plan is to include:

1. Strategies taken in preventing Resident #002 from being alone with residents or in any situation where Resident #002 could behave sexually inappropriately towards another resident.

2. Strategies taken to minimize inappropriate sexual behaviors displayed by Resident #002 including psychological, pharmaceutical, behavioral and physical intervention.

3. Identification of the sexual behavioral triggers for Resident #002, how these triggers are minimized and the response taken by each staff discipline when triggers are present.

4. Responsibilities of each staff discipline in preventing further occurrence of sexual abuse from Resident #002 towards another resident.

5. Strategies taken to engage Resident #002 regularly in a variety of scheduled and non-scheduled activities ensuring regular mental and physical stimulation to prevent boredom and feelings of isolation.

6. A detailed plan on the steps required to return Resident #002 to the previous wing of the home whilst ensuring the safety of residents within the home OR appropriate justification of why Resident #002 is to remain in the other unit of the home.

7. Strategies taken to ensure continuous monitoring of the above steps to ensure that the plan is relevant if/when contributing factors change.

This plan is to be submitted to Gillian Chamberlin, Long-Term Care Homes Inspector. Ministry of Health and Long-Term Care, gillian.chamberlin@ontario.ca by December 12th, 2014.

Grounds / Motifs :

1. 1. This non-compliance is supported by the following findings:

A complaint was submitted to the Ministry of Health and Long-Term Care in relation to an incident of sexual abuse towards a resident in the home by

another resident also residing in the home.

A Critical Incident was submitted to the Ministry of Health and Long-Term Care in relation to the same incident of sexual abuse involving Resident #002 sexually assaulting Resident #001. It was reported that staff member #104 witnessed Resident #002 fondle the breasts of Resident #001 in a common living area of the unit without consent. Staff member #104 intervened and removed Resident #001 from the common living area. It was reported that staff member #105 spoke with Resident #002 about their inappropriate behaviour and at this time Resident #002 became angry and defensive.

Under O.Reg. 79/10, sexual abuse is defined 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".

During an interview with Inspector #593 on October 17, 2014, staff member #104 advised that they witnessed Resident #002 sexually abuse Resident #001. Staff member #104 was seated at the nurse's station and Resident #001 was seated in their wheelchair in view from the nurse's station. Staff member #104 advised that they looked over towards Resident #001 and saw Resident #002 seated next to Resident #001 with their hand up their shirt on their breast. Staff member #104 immediately called out Resident #002's name and told them to stop; they went over towards the two residents and by this time Resident #002 had moved away from Resident #001. Staff member #104 checked Resident #001 then moved them closer to the nurse's station so that staff could keep closer watch of them. They then reported the incident to the RN on duty. Staff member #104 advised they were aware of the history of Resident #002's inappropriate sexual behaviours and that they believed the touching of Resident #001 by Resident #002 to be non-consensual. Staff member #104 advised that Resident #001 and Resident #002 were not known to have a prior relationship in the home.

During an interview with Inspector #593 on October 02, 2014, staff member #105 advised that they spoke with Resident #002 shortly after the incident occurred. They advised that Resident #002 was not receptive to what they were saying and become angry and defensive stating "I didn't do anything wrong". Staff member #105 further advised that there was no known prior relationship between Resident #001 and Resident #002 and they believed the sexual touching of Resident #001 by Resident #002 to be non-consensual.

During an interview with Inspector #593 on August 18, 2014, complainant and family member #003 advised that Resident #001 was sexually assaulted by a resident known to exhibit sexually inappropriate behaviours towards other residents. As a result Resident #001 was not sleeping well or staying in their room at night as family member #003 believes they were scared since the incident occurred. Family member #003 advised that Resident #001 would not talk about the incident of sexual abuse that occurred as they were embarrassed and has repeated to family member #003 that they wish to die.

Resident #002 is known for their sexually inappropriate behaviours. A review of Resident #002's Plan of Care at the time of the incident found that Resident #002 has sexual behaviours including hugging and kissing other female Residents and socially inappropriate behaviour including fondling cognitively impaired female Residents. As documented, staff are required to monitor Resident #002's interactions with female Residents and that any inappropriate behaviours including touching are to be reported to registered staff.

A review of Resident #002's progress notes found that sexual behaviours had continued since the incident with Resident #002, in 2014 including:

* A staff member overheard Resident #002 ask another resident "would you like to go for a quickie"?

* Resident #002 was observed to lean over and give another resident a kiss.

* A staff member observed Resident #002 rubbing female Resident #004 on their breasts and back, when Resident #002 saw the PSW, they stopped and sat down in the lounge to watch TV.

* A staff member reported that they observed Resident #002 sitting with their arm around a female Resident and then rubbing their arm. When Resident #002 noticed the staff member standing there, they removed their hand from the Resident.

* A staff member reported that a resident was sitting next to Resident #002, when they stood up they were looking at Resident #002 funny and then Resident #002 was motioning for them to sit back down. When Resident #002 noticed the staff member watching them, they let the resident leave the area.

During an interview with Inspector #593 on August 20, 2014, staff member #101 advised that when Resident #002 was first admitted to the home they were warned about their inappropriate sexual behaviours. Staff member #101 advised that there were no incidents initially until Resident #002's medication was decreased which was when their sexual and inappropriate behaviours commenced in the home. Staff member advised that Resident #002 was moved to another unit in the home since the incident with Resident #001 so that staff could keep a closer watch of their behaviours. They further advised that since being moved to the other unit, Resident #002 had been showing interest in another resident also residing in that unit, however there have been no incidents of abuse reported with this resident. Staff member #101 further advised that Resident #002 is very independent, is aware of staff watching them, waiting until there are no staff present before they behave inappropriately and does not show any remorse when spoken to about their inappropriate behaviour. In addition, staff member also stated that they were not confident that this would not happen again to another resident within the home.

A review of Resident #002's plan of care found that Resident #002 is inappropriate sexually as evidenced by wandering at night and entering other residents' rooms and fondling cognitively impaired residents. The actions as found in the plan of care to address this behaviour included the transfer of Resident #002 to another unit for increased monitoring of inappropriate behaviours and transfer to a room in the center corridor for increased monitoring of inappropriate behaviours.

During an interview with Inspector #593 on August 20, 2014; staff member #106 advised that since Resident #002 was moved to another unit, staff try to keep them from sitting near other residents so that no inappropriate behaviour can occur. They further advised that Resident #002's room on the other unit had not changed and that their room is not central to the nurse's station as documented in the resident's plan of care. This was confirmed during observations by Inspector #593.

During an interview with Inspector #593 on August 21, 2014; staff member #112 advised that Resident #002 can attend activities if they are supervised by a staff member during the activity, which activation staff are aware of. They further advised that staff are required to monitor Resident #002, ensure that they are not alone with other residents, and redirect them when required.

During an interview with Inspector #593 on August 20, 2014, staff member #113 advised that there was inappropriate behaviour displayed initially when Resident #002 was moved to the other unit of the home, involving Resident #004, who was unaware of the inappropriate behaviour as they believed that Resident #002 was their spouse. Staff member #113 further advised that Resident #002 is well aware of what they are doing. In addition since Resident #002 was transferred to the other unit, staff are required to monitor Resident #002 more closely and they are to make sure that there is always a staff member around Resident #002 for monitoring.

During an interview with Inspector #593 on August 20, 2014; staff member #108 advised that Resident #002 is sneaky about their inappropriate behavior, ensuring no staff members are around before approaching other residents. Staff would take Resident #002 back to their room when displaying inappropriate behaviours, however they would then leave their room and try again. As far as they are aware, the inappropriate behaviours have been evident for at least a few months. Staff member #108 further advised that before the incident occurred with Resident #001, Resident #002 was focusing their behaviours on Resident #005. As a result, Resident #005 was moved to the same unit where both Resident #002 and Resident #005 now reside. In addition, staff member #108 advised that Resident #002 would arrive at the main dining room before meals to assist with putting aprons on residents. Staff stopped this behavior when they realized Resident #002 was touching the residents' breasts under the aprons as they were providing assistance.

During an interview with Inspector #593 on August 20, 2014, staff member #115 advised that Resident #002 was moved to the other unit of the home so that staff could monitor their behaviours more closely, however staff are unable to stop them from sitting near other residents and staff would move them if they were inappropriate towards another resident. They further advised that there had been no inappropriate behaviour since transferring to the other unit, however Resident #002 is aware of when staff is watching them and will not do anything inappropriate at this time.

During an interview with Inspector #593 on August 21, 2014 staff member #110 advised that staff are required to monitor Resident #002 and that they were transferred to the other unit so that staff could more closely monitor them.

Inspector #593 made the following observations of Resident #002:

* Resident #002 was observed to be seated in a living area of the unit, there were two other residents observed to be sleeping in the area at this time. There were no staff members present in the area at this time.

* Observed a resident seated next to Resident #002 in the living area of the unit, there were no staff members present in the area at this time.

* Resident #002 was observed to be seated next to a resident in the living area of the unit while an activity was taking place.

* Resident #002 was observed to be seated between two other residents, there were no staff members present in the area at this time.

* Resident #002 was observed to be seated in the garden outside of the unit, Inspector #593 observed other residents in this area with no staff members present at this time.

As evidenced by documented progress notes, documented plans of care and staff interviews; Resident #002 was known to exhibit sexually inappropriate behaviours towards residents in the home including non-consensual touching of a sexual nature towards other residents, prior to the incident. Furthermore, Resident #002 was relocated to another unit of the home for closer monitoring however as evidenced by staff interviews and observations by Inspector #593; Resident #002 has been left unsupervised around cognitively impaired residents and as documented in Resident #002's progress notes, the sexually inappropriate behaviour has continued. The licensee has failed to protect Resident #001 from sexual abuse by a resident with known and documented sexually inappropriate behaviours towards other female residents. [s. 19. (1)] (593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 26, 2014

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

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 28th day of November, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Gillian Chamberlin

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