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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
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Bureau régional de services de Sudbury
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 3, 2014	2014_380593_0006	S-000333-14	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

Extendicare Maple View of Sault Ste. Marie
650 Northern Avenue SAULT STE. MARIE ON P6B 4J3

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): July 31st, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nursing Staff, Health Care Aide's (HCA)and Personal Support Worker's (PSW).

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

During the course of this inspection, Non-Compliances were issued.
- **2 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:

Critical incident 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 Resident also residing in the home.

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".

A review of Resident #002’s care plan at the time of the incident found that Resident #002 has inappropriate sexual behaviours towards other Residents. It is documented that Resident #002 is to be reminded daily by staff to keep their hand’s to themself, to stay away from other Residents and to not touch others. In addition, it is also documented that Resident #002 will seek out other Residents with intent and make sexual advances towards them as evidenced by touching them without consent when staff are not in the vicinity and attempts to push them to quiet areas such as the dining room or their own room.

During an interview with Inspector #593 July 31st, 2014 at 12:51 staff member #106 advised that they witnessed Resident #002 sexually abuse Resident #001. Staff member #106 was walking towards the communal dining area when they observed Resident #002 with the front of Resident #001’s shirt in their hand pulling Resident #001 towards themself, at this time they were licking and kissing the side of Resident #001's face. Staff member #106 believed that this physical behaviour towards Resident #001 was non-consensual and immediately removed Resident #001 from the situation. Shortly after, Resident #001 had returned to the dining room and Resident #002 was found to be licking and sucking Resident #001's hand, again staff member #106 believed this interaction to be non-consensual.

During an interview with Inspector #593 on July 31st, 2014 at 11:17 staff member #107 advised that staff member #106 reported to staff member #107 the initial incidence of sexual abuse immediately after the incident occurred. Shortly after staff member #107 was made aware of the incident, both staff member #107 and staff member #106 witnessed Resident #002 sexually abuse Resident #001 for the second time that evening. Staff member reported this incident to the Ministry of Health and Long-Term Care shortly after the incident occurred as they believed the interaction to be sexual abuse as Resident #001 did not consent to the touching of a sexual nature by Resident #002.

The sexual behavior documented in Resident #002's care plan was known by staff in the home and confirmed by staff during interviews conducted in the home:

During an interview with Inspector #593 July 31st, 2014 at 10:00 staff member #109 advised that Resident #002 has made sexual gestures towards other Residents and staff members in the home.

During an interview with Inspector #593 July 31st, 2014 at 11:17 staff member #107 advised that Resident #002 has a history of sexual behaviors towards other Residents and staff members.

During an interview with Inspector #593 July 31st, 2014 at 11:30 staff member #102 advised that Resident #002's inappropriate sexual behaviors started shortly after admission and had been present until approximately six weeks before the incident occurred. Due to this perceived improvement in Resident #002's behaviour, staff member #102 advises that Resident #002's libido reducing medication was reduced and they were discharged from the Behavioral Support Ontario program.

During an interview with Inspector #593 July 31st, 2014 at 12:51 staff member #106 advised that Resident #002 has a history of previous sexual behaviors including touching other Residents, trying to kiss other Residents as well as sexually inappropriate remarks and touching towards staff members in the home.

During an interview with Inspector #593 July 31st, 2014 at 15:00 staff member #103 advised that Resident #002 has shown sexual behaviors previously toward other Residents and staff members. Staff member #103 has witnessed Resident #002 try to grab at other Residents and coax Residents to come towards them with the intent of touching them without consent.

During an interview with Inspector #593 July 31st, 2014 at 15:00 staff member #104 advised that Resident #002 has shown sexual behaviors toward other Residents and staff members. Staff member #104 advised that the previous night July 30th 2014, Resident #002 asked staff member #104 to go to bed with them.

This history of sexual behaviors was also confirmed through review of Resident #002's progress notes which found that:

A day during 2014, when asked what Resident #002 wanted to do, replied with "I want to

kiss some girls".
A day during 2014, Resident #002 made inappropriate comments about getting hard whilst receiving care from a PSW.
A day during 2014, Resident #002 was touchy feely with a staff member whilst receiving care.
A day during 2014, Resident #002 attempted to touch another Resident's hand, was removed from the situation by a staff member whom the Resident then asked for a kiss.

Furthermore, non-compliance was previously identified under LTCHA, 2007 S.O. 2007, c.8, s. 6. During an inspection completed on March 3rd, 4th and 5th 2014 under inspection #2014_281542_0007 in relation to failing to ensure that the care set out in Resident #002's plan of care is provided to Resident #002 specifically relating to managing sexual behaviors towards other Residents which resulted in sexual abuse of another Resident.

As evidenced by documented progress notes, documented plans of care and staff interviews; Resident #002 was known to display sexually inappropriate behavior towards female Residents in the home including previous sexual abuse of another Resident in the home. Furthermore, previous interventions related to Resident #002's inappropriate sexual behaviours were reduced eight days prior to the sexual abuse of Resident #001 and on the evening that Resident #002 sexually abused Resident #001, Resident #002 was further left unsupervised allowing a second incident of sexual abuse occurred towards Resident #001. As such, the licensee has failed to protect Resident #001 from sexual abuse by a Resident with known and documented sexually inappropriate behaviours towards other 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:

During an interview with Inspector #593 July 31st, 2014 at 12:51 staff member #106 advised that they witnessed Resident #002 sexually abuse Resident #001. At the time, staff member removed Resident #001 from the situation. Shortly after, Resident #002 remained unsupervised and Resident #001 had returned to the dining room. Resident #002 sexually abused Resident #001 for the second time that evening.

A review of Resident #002's care plan in place at the time of the incident between Resident #001 and Resident #002 found that Resident #002 has inappropriate sexual behaviors towards other Residents and it is documented in Resident #002's plan of care that Resident #002 will seek out Residents and make sexual advances towards them thus Resident #002 is required to be monitored around other Residents and to be distracted when hovering around other Residents.

Resident #002's sexually inappropriate behaviors as documented in their plan of care were well known by staff members as confirmed by staff member #109, staff member #107, staff member #102, staff member #106, staff member #103 and staff member #104 during interviews conducted by Inspector #593 July 31st 2014.

On two occasions; Resident #002 was left unsupervised around other Residents during the evening allowing two incidences of sexual abuse to occur toward Resident #001. As such, the licensee has failed to provide the care to Resident #002 as specified in their plan of care. [s. 6. (7)]

Ontario

Ministry of Health and Long-Term Care

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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

Issued on this 16th day of December, 2014

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_0006
Log No. / Registre no:	S-000333-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 3, 2014
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	Extendicare Maple View of Sault Ste. Marie 650 Northern Avenue, SAULT STE. MARIE, ON, P6B-4J3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Johanne Messier-Mann

To EXTENDICARE (CANADA) 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

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 being alone with other Residents, seated near other 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. 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 October 17th, 2014.

Grounds / Motifs :

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

Critical incident 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 Resident also residing in the home.

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".

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A day during 2014, Resident #002 was touchy feely with a staff member whilst receiving care.
A day during 2014, Resident #002 attempted to touch another Resident's hand, was removed from the situation by a staff member whom the Resident then asked for a kiss.

Furthermore, non-compliance was previously identified under LTCHA, 2007 S.O. 2007, c.8, s. 6. During an inspection completed on March 3rd, 4th and 5th 2014 under inspection #2014_281542_0007 in relation to failing to ensure that the care set out in Resident #002's plan of care is provided to Resident #002 specifically relating to managing sexual behaviors towards other Residents which resulted in sexual abuse of another Resident.

As evidenced by documented progress notes, documented plans of care and staff interviews; Resident #002 was known to display sexually inappropriate behavior towards female Residents in the home including previous sexual abuse of another Resident in the home. Furthermore, previous interventions related to Resident #002's inappropriate sexual behaviours were reduced eight days prior to the sexual abuse of Resident #001 and on the evening that Resident #002 sexually abused Resident #001, Resident #002 was further left unsupervised allowing a second incident of sexual abuse occurred towards Resident #001. As such, the licensee has failed to protect Resident #001 from sexual abuse by a Resident with known and documented sexually inappropriate behaviours towards other Residents. [s. 19. (1)] (593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 03, 2014

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 3rd day of October, 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