Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ministère des Soins de longue durée
Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	☐ **Licensee Copy/Copie du Titulaire** ✕ **Public Copy/Copie Public**
Name of Director:	Andrew Wisdom
Order Type:	☐ Amend or Impose Conditions on Licence Order, section 104 ☐ Renovation of Municipal Home Order, section 135 ✕ Compliance Order, section 153 ☐ Work and Activity Order, section 154 ☐ Return of Funding Order, section 155 ☐ Mandatory Management Order, section 156 ☐ Revocation of License Order, section 157 ☐ Interim Manager Order, section 157
Intake Log # of original inspection (if applicable):	003803-21, 004719-21, 004754-21, 004761-21, 006461-21, 007570-21
Original Inspection #:	2021_886630_0019
Licensee:	Ritz Lutheran Villa 4118A Road 164, R.R. #5, Mitchell, ON, N0K-1N0
LTC Home:	Ritz Lutheran Villa 4118A Road 164, R.R. #5, Mitchell, ON, N0K-1N0
Name of Administrator:	Jeff Renaud

Background:

Ministry of Long-Term Care (MLTC) inspectors #569, #630 and #730 conducted an inspection with respect to Ritz Lutheran Villa (the Home) on March 29, 30, 31, April 1, 8, 9, 13, 14, 15, 16, 21, 22 and May 14 and 18, 2021.

The inspectors determined that the Licensee, Ritz Lutheran Villa (the Licensee) failed to comply with s.19(1) of the Long-Term Care Homes Act, 2007 (LTCHA). In response to this finding, pursuant to s.153(1)(a) of the LTCHA, the inspectors issued a compliance order (CO #001).

Following a review of CO #001 by the Director, CO #001 has been substituted with the Director's Order below.

Order #:	001

To **Ritz Lutheran Villa**, you are hereby required to comply with the following order by the date set out below:

Pursuant To:

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:

The licensee must be compliant with s. 19 (1) of the LTCHA. Specifically, the licensee must:

a) Ensure resident #004 and resident #005, and all other residents in the home, are protected from resident to resident sexual abuse.

b) Review and revise the home's policies and procedures related to sexual abuse as well as intimacy and sexuality to ensure they:
i) provides a clear description of consent;
ii)includes the processes for assessing a resident's cognitive capacity to consent to sexual activities;
iii) and meets the needs of all residents in the home related to the prevention of sexual abuse, including sexual exploitation.

c) Provide education to all staff in the home regarding the revised policies related to sexual abuse as well as intimacy and sexuality. A documented record of the education must be maintained in the home including the names of staff who participated and the content of the education.

d) Ensure the home's policies and procedures related to the assessment of a resident's cognitive capacity to consent to sexual activities are fully implemented as part of the prevention of sexual abuse program.

Grounds:

1. The licensee has failed to protect residents #004, and #005 from resident to resident sexual abuse by resident #003. Section 2(1) of the Ontario Regulation 79/10 defines sexual abuse to include "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."

There were multiple sexually inappropriate behaviours by one resident towards other residents in the home during a two-month time period. Several Critical Incident (CI) reports were submitted to the Ministry of Long-Term Care (MLTC) related to sexual responsive behaviours demonstrated by this resident towards other residents. Care plan interventions were identified and implemented but failed to be effective. Based on an assessment of the resident by an external care provider recommendations had been provided for the management of these behaviours. These recommendations were not fully implemented by the home.
The home failed to clearly demonstrate that they had protected residents from non-consensual sexual contact by this resident.

2. A Critical Incident (CI) report documented actions of a sexual nature by one resident to another resident on the home. There were at least four other documented incidents between these residents after this incident had occurred.

Inspector #569 asked staff if there had been leadership direction to allow sexual interactions between these residents, including the parameters for staff to follow during those interactions. Staff said they had been directed to allow sexual interactions between both residents provided both were willing, and in a public place and if the resident was safe. They also said they did not feel comfortable with the situation as they felt it contributed to one of the resident's responsive behaviours.

The Director of Care (DOC) and Administrator told Inspector #630 that the home had implemented a new policy titled "Intimacy and Sexuality" on April 27, 2021, which included direction for staff when responding to sexual interactions between residents. Prior to this policy being implemented there was not a specific process or assessment tool in place in the home to determine a residents cognitive capacity to consent to sexual activities. They said this policy was separate from the home's prevention of abuse and neglect policy, but the expectation was that the two would be used together when assessing resident to resident sexual activities or behaviours. The DOC said an assessment tool

was to be used by registered staff to assess a resident's cognitive capacity to consent to a sexual activity every time resident were found to be engaging in an activity of a sexual nature with another resident. Interviews with staff and management in the home found that there were differing understanding of when to use the assessment tool as well as the meaning of consent related to sexual activities. Staff and management in the home had inconsistent understandings of how to implement the policy.

The DOC said this "Intimacy and Sexuality" policy and assessment tool had not been implemented at the time of the sexual interactions between these two residents. The DOC said they realized, upon review of the incidents between the residents, that the resident's cognitive capacity to consent to sexual touching or behaviours should have been assessed differently. The DOC said some of the incidents, had not been reported to management and therefore they were not able to investigate or report it at the time.

In reviewing the interviews with the staff, it is evident to me that all necessary actions were not taken by the licensee to protect residents#004 and Resident #005 from sexual abuse by Resident #003. The licensee was aware that Resident #003 had previous incidents and that there was a pattern of inappropriate sexual behaviours and that the resident was continuing in that behaviour, and that residents #004 and #005 did not have the capacity to consent to the sexual behaviour and actions. The licensee did not ensure that immediately on identifying that the most effective intervention was one on one, that it was always in place, whether with the hired security guards or with assigned staff. It is not sufficient for the licensee indicate there is not sufficient staff or finances and allow Resident #003 or any other resident to sexually abuse resident.

Sources: The home's Intimacy and Sexuality policy dated April 2021; the home's Zero Tolerance Abuse and Neglect policy dated August2017; Critical Incident (CI) reports; progress notes and other clinical records; interview with a Personal Support Worker (PSW) and other staff.

An order was made by taking the following factors into account:

Severity: There was actual harm and risk of harm to resident #004 and #005 and other female residents related to non-consensual sexual contact by resident #003.

Scope: Of the five residents reviewed, there was sufficient evidence to show that two residents had experienced one or more incidents of non-consensual sexual contact from resident #003.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s.19 and one Compliance Order was issued to the home.

This order must be complied with by:	July 16, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007.* If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Long-Term Care Inspections Branch
1075 Bay St., 11th Floor, Suite 1100
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.

Issued on this 13th day of July, 2021	
Signature of Director:	
Name of Director:	Andrew Wisdom