Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 18, 2020	2020_831211_0015	005296-20, 016032-20	Complaint

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue Woodstock ON N4S 3V9

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

Caressant Care Bourget
2279 Laval Street P.O. Box 99 Bourget ON K0A 1E0

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

JOELLE TAILLEFER (211)

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): October 27, 28, 29, 2020 and November 2, 3, 4, 5, 6, 9, 10, 13, 16.

The following intakes were inspected:
- Log #005296-20 a complaint related to alleged resident to resident abuse.
- Log #005223-20 a critical incident Inspection (CIS) included in this inspection related to resident to resident abuse corresponding to the complaint (Log ##005296 -20).
- Log #016032-20 a CIS related to alleged resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Regional Director, Director of Nursing & Interim Director of Nursing (DON), Acting Director of Nursing (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Resident Assessment Instruments and Minimum Data Set RPN (RAI-MDS/RPN), Behavioural Supports Ontario PSW (BSO/PSW), Personal Support Workers (PSWs), Resident Support Worker (RSW), Maintenance, Clerk and a resident.

In addition, the inspector reviewed the residents' health care records, licensee's investigation notes, observed the provision of care to residents, observed residents' rooms and a common residents' area, observed resident to resident interactions and the policies and procedures related to resident Abuse and responsive behaviour management.

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.
- **8 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	Légende 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 protect two residents from a resident's abuse.

Section 2 (1) of the Ontario Regulation 79/10 defines sexual abuse as (b) “any non-consensual touching, behaviours or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.”

A complaint was received related to allegation of multiple abuse incidents from a resident toward resident #003.

A Critical Incident Report (CIR) was submitted indicating that resident #001 touched in a sexual nature resident #003.

Another CIR was submitted outlining touching in sexual nature between residents #001 and resident #002.

Multiple allegations of sexual gesturing and touching from resident #001 that occurred were documented in resident #001's progress notes.

Further discussion was held with multiple staff who stated that resident #001 had previously demonstrated sexual behaviors toward other residents but this behavior had been resolved for quite some time. Resident #003 and resident #002 would not be able to comprehend or provide consent to sexual activity.

The licensee has failed to protect these residents from allegation of sexual abuse from resident #001.

Sources: Residents #001, #002 and #003’s progress notes. Interviews with three staff. [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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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

Findings/Faits saillants :

The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #001 collaborate with each other in the development and implementation of the plan of care so that the different aspect of care are integrated and are consistent with and complement each other.

Several instances of sexual gesturing and touching were documented in residents #001 and #003's progress notes and in the "24 hours Resident Condition Report".

The licensee has failed to ensure that the staff and others involved in the different aspect of care of resident #001 who was exhibiting sexual behavior toward resident #003, collaborate with each in the development and implementation of resident #001's care plan before a certain date. As such, resident #001 was still exhibiting sexual behavior toward resident #003 on different dates.

Sources: Residents #001 and #002's progress notes and the Behavioral Support Ontario-Dementia Observation System (BSO-DOS) Data Collection Sheet. Interview with a staff. [s. 6. (4) (b)]

2. The licensee has failed to ensure that the provision of the care set out in the plan of care are documented for residents #001 and resident #002.

Resident #001's progress notes indicated to initiate the BSO-DOS monitoring. The half hour monitoring of the BSO-DOS sheet was not documented for multiple different dates and times.

Resident #002's progress notes indicated to initiate the BSO-DOS monitoring for an amount of days. The half hour monitoring of the BSO-DOS sheet was not documented on a certain date and times.

The licensee has failed to ensure that the provision of the care set out in the BSO-DOS Data Collection Sheet were documented every half hour for certain dates for residents #001 and #002.

Sources: Residents #001 and #002's progress notes and the Behavioral Support Ontario-Dementia Observation System (BSO-DOS) Data Collection Sheet. Resident #001 and #002's POC in the Point Click Care. [s. 6. (9) 1.]

3. The licensee has failed to ensure that resident #001 was reassessed and the plan of care revised at any other time when, care set out in the plan has not been effective.

Multiple allegations of sexual gesturing and touching were documented in residents #001 and #003's progress notes and in the "24 hours Resident Condition Report". Resident #001's care plan was initiated and interventions were put in place after several allegation of sexual gesturing and touching from resident #001 toward resident #003. Resident #001 continued to demonstrate responsive behaviors and attempted to sexually touch resident #003 after interventions were put in place.

The licensee has failed to ensure that resident #001 was reassessed and the plan of care revised when resident #001 kept demonstrating responsive behaviors. Furthermore, the BSO-DOS's half hour monitoring was last documentation on an identified date. As a result, resident #001 was able to sexually touch resident #003.

Sources: Residents #001 and #003's progress notes and the Behavioral Support Ontario-Dementia Observation System (BSO-DOS) Data Collection Sheet and resident #001's care care [s. 6. (10) (c)]

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 policy to promote zero tolerance of abuse of residents was complied with.

Specifically, staff did not comply with the licensee's policy "Abuse and Neglect-Resident to Resident" dated September 2018, under the section "Reporting" as followed:
-All cases of suspected or actual abuse must be reported immediately to the DOC/Executive Director. In the absence of management staff, concerns should be reported immediately to the Charge Nurse, who will notify management staff on call.
-After receiving notice of the abuse, the DOC/Manager on call will immediately notify the Executive Director of the initiation of an investigation.
-The Executive Director/DOC or delegate shall notify the police immediately of any alleged, suspected or witnessed incident of abuse or neglect that may constitute a criminal offence.
-The Executive Director/DOC who has reasonable grounds to suspect that any of the following has occurred or may occur must immediately report that suspicious and the information upon which the suspicion is based to the Director appointed by the Ministry of Health and Long Term Care: b) Abuse of a resident by anyone, or neglect of a resident by the home or its staff, that resulted in harm or a risk of harm to the resident.
-The Executive Director or delegate upon becoming aware of the incident will immediately report to the Director using the MCIS form under the mandatory reporting section, or after hours by calling Service Ontario at 1-888-999-6973.

Several allegations of sexual gesturing and touching from resident #001 occurred towards residents #003 and #002.

ADOC stated when the staff suspected sexual behavior or harm from a resident toward another resident that occurred after-hours, the nurse should notify immediately the manager on call for guidance.

As such, the licensee failed to comply with their licensee's policy under the section "Reporting" when there was allegation of sexual abuse from resident #001 towards residents #003 and #002.

Sources: Review of residents #001, #002 and #003's progress notes. Review of the licensee's policy "Abuse and Neglect-Staff to Resident, Family to Resident, Resident to Resident, Resident and /or Family to Staff". Interview with ADOC #102. [s. 20. (1)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of sexual abuse of residents #002 and #003 from resident #001 by anyone that the licensee knows of, or that was reported to the licensee was immediately investigated and appropriate action was taken in response to every such incident.

Resident #001's progress notes indicated that resident #001 tried to touch in a sexual manner resident #003.

The licensee has failed to immediately investigate and take appropriate actions in response to the allegation of sexual behavior when resident #001 attempted to sexual touch resident #003 that the licensee knew and reported.

Sources: Residents #001, #002 and #003's progress notes. 24 hours Resident Condition Report. Interviews with the ADOC and a RN. [s. 23. (1) (a)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident had occurred shall immediately report the suspicion and the information upon which it is based to the Director.

The licensee submitted two Critical Incident Reports (CIRs) within a period of five months. One CIS indicated that resident #001 touched in a sexual nature resident #003 and the other CIS outlined touching of sexual nature between residents #001 and resident #002. The staff were unable to determine if resident #002 had the cognitive capacity of decision making at the time of the incident.

The licensee has failed to ensure that a staff who has reasonable grounds to suspect that residents #003 and #002 was sexually abused by resident #001, immediately report the suspicion and the information to the Director.

Sources: Residents #001, #002 and #003's progress notes. Interview with DOC #104 and ADOC #102. [s. 24. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's monitoring and internal reporting protocols was developed to meet the needs of resident #001 with responsive behaviors for a period of times.

The BSO-DOS's half hour monitoring was last documented after a certain date.

The "24 hours Resident Condition Report after a certain date indicated that resident #001 keep going in an area of the home and tried to sexually touch resident #003.

Resident #001's progress notes indicated that resident #001 was observed touching sexually resident #003.

The "24 hours Resident Condition Report on a specific date indicated that resident #001 went again in the area of the home and stand very close to resident #003. An intervention was put in place and a 15 minutes safety checks monitoring was started in the point click care (POC) for resident #001.

The licensee has failed to ensure that resident #001's BSO-DOS's monitoring sheet and internal reporting protocols was developed to meet the needs of resident #001 with responsive behaviors within two days. As a result, resident #001 was observed sexually touching resident #003. [s. 53. (1) 3.]

WN #7: 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 the resident's substitute decision-maker was notified immediately upon the licensee becoming aware of alleged incident of sexual abuse from resident #001 toward resident #003 and between residents #001 and #002 that causes distress to the resident that could potentially be detrimental to the resident's health or well-being.

The Ministry of Long-Term Care Home received a complaint related to allegation of sexual assault incident from resident #001 toward resident #003. The concern was that resident #003 POA's was not informed of the allegation of sexual abuse from resident #001 towards resident #003 until the next day. Furthermore, resident #001 had previously attempted to sexually touched resident #003.

Resident #001's progress notes for two different dates indicated that residents #001 attempted to sexually touch resident #003. Five days later, resident #001 sexually touched resident #003. Interview with ADOC #102 and review of resident #003's progress notes indicated that resident #003's SDM was contacted and informed the next day of the allegation of sexual abuse.

Resident #002's progress notes indicated that resident #001 was observed sexually touching resident #001 and resident #002's Power of Attorney (POA) was informed the next day.

The licensee has failed to ensure that resident #002's POA and resident #003's SDM were immediately notified when there was allegation, suspected or witnessed incidents of sexual abuse that causes distress to the resident that could potentially be detrimental to the resident's health or well-being.

Sources: Residents #001, #002, and #003's progress notes. Interviews with ADOC #102 and another staff. [s. 97. (1) (a)]

WN #8: 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 has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse of sexual nature from resident #001 toward resident #003 for specific dates that the licensee suspects may constitute a criminal offence.

The Ministry of Long-Term Care Home received a complaint stating that they were notified the next day related to an allegation of sexual abuse from resident #001 toward resident #003. They were also concerned that they were not contacted on previous dates when resident #001 exhibited sexual behaviors toward resident #003.

Resident #001’s progress notes outlined several subsequent incidents of sexual gesture and touching from resident #001 towards resident #003 and #002.

Resident #001’s progress notes indicated that the police force was notified the next day of the allegation of sexual abuse from resident #001 toward resident #003.

Resident #002’s progress notes indicated that the resident was observed exhibiting sexual behavior with resident #001. DOC #101’s documentation indicated that the police force was not informed as there was no resistance between residents #001 and #002. Thereafter, DOC #101 wrote that the staff was unable to determine resident #002’s cognitive capacity of decision making at the time of the incident.

Interviews with two staff stated that the police should have been notified immediately when they suspected or witnessed resident #001 exhibiting sexual behaviors toward resident #003. ADOC #102 stated that the police force should have been notified immediately when residents #001 and #002 were exhibiting sexual behaviors since resident #002 didn't have the comprehension to understand the gesture as a sexual interaction, thus resident #002 was unable to consent.

The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed of sexual behaviors from resident #001 toward residents #003 and #002.

Sources: Resident #001, #002 and #003’s progress notes. Interviews with the complainant, DOC #104 and ADOC #102 [s. 98.]

Issued on this 4th day of January, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JOELLE TAILLEFER (211)
Inspection No. / No de l'inspection :	2020_831211_0015
Log No. / No de registre :	005296-20, 016032-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 18, 2020
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, Woodstock, ON, N4S-3V9
LTC Home / Foyer de SLD :	Caressant Care Bourget 2279 Laval Street, P.O. Box 99, Bourget, ON, K0A-1E0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pamela Richmond

To Caressant-Care Nursing and Retirement Homes Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 # / No d'ordre : 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 :

Specifically, the licensee should prepare, submit and implement a plan to ensure that residents #002 and #003 or any other residents are protected from sexual abuse from resident #001.

The plan must include, but is not limited to:
1. A training refresher to all staff on how to identify and report resident to resident alleged, suspected or witnessed abuse in accordance with their policies which also includes:
• prompt action taken to effectively protect all residents from abuse,
• notify the manager on call during business after-hours for guidance,
• begin an immediately investigation,
• immediate notification of the appropriate police force of any alleged, suspected or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offense.
• immediate notification to the Director, under the LTCHA, 2007, as per section 24(1) of the same Act, when a person who has reasonable grounds to suspect abuse of a resident that resulted in harm or risk of harm to the resident,
2. A system is developed whereby the Director of Care and/or delegate is reviewing all documentation and communication from the front-line staff at least daily to determine if any alleged, suspected and witnessed resident's abuse has occurred in the home.
3. A system is developed whereby when there is a resident with responsive behaviours, that the resident is assessed, interventions are developed and implemented immediately. These interventions are to be documented into the resident's care plan and revised as needed after each responsive behavior.
4. A system is developed to communicate to the team on each shift when resident #001 exhibited sexual responsive behavior to prevent further incidents.

Please submit the written plan to achieving compliance for inspection # 2020_831211_0015 to Joelle Taillefer, LTC Homes Inspector, MLTH, by fax at 613-569-9670 by December 30, 2020.

Grounds / Motifs :

1. The licensee has failed to protect residents #002 and #003 from sexual abuse from resident #001.

Section 2 (1) of the Ontario Regulation 79/10 defines sexual abuse as (b) "any

non-consensual touching, behaviours or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

A complaint was received related to allegation of several sexual incidents from resident #001 toward resident #003.

Two Criritical Incident Reports (CIRs) within five months were submitted indicating that resident #001 touched in a sexual nature residents #003 and resident #002.

Several allegations of sexual gesturing and touching from resident #001 towards residents #003 and #002 that occurred were documented in resident #001's progress notes.

Further discussion was held with multiple staff who stated that resident #001 had previously demonstrated sexual behaviors toward other residents but this behavior had been resolved for quite some time. Resident #003 and resident #002 would not be able to comprehend or provide consent to sexual activity.

The licensee has failed to protect these residents from allegation of sexual abuse from resident #001.

Sources: Residents #001, #002 and #003's progress notes. Interviews with four staff.

The licensee failed to comply with:
1. LTCHA 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. (Refer to WN #3)
2. LTCHA s. 23. (1) Every licensee of a long-term care home shall ensure that, (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone. (Refer to WN #4)
3. LTCHA 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: 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. (Refer to WN #5)
4. 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. (Refer to WN #8)
5. LTCHA s. 6 (4) (b). Every licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.
LTCHA s. 6 (9) 1. The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. (Refer to WN #2)
7. LTCHA s. 6 (10) (c) The licensee shall ensure that the resident is reassessed, and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan has not been effective. (Refer to WN #2)
8. O. Reg 79/10 s. 53. (1) 3. Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours 3. Resident monitoring and internal reporting protocols. (Refer to WN #6)
10. O. Reg 79/10 s. 97. (1). Every licensee of a long-term care shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (a) ae notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect or 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. (Refer to WN #7)

An order was made by taking the above following factors into account.

Severity: Two residents were allegedly sexually abuse by resident #001. This resulted was an actual risk of harm for residents #002 and #003 has the staff didn't observed any significant change in condition for both residents after the incidents.
Scope: This issue was a pattern has resident #001 was able to sexually touch

once both residents after three observed attempts to sexually touch resident #003.
Compliance History: A Voluntary Plan of Correction (VPC) was issued for LTCHA s. 19 (1) and a Written Notification (WN) for LTCHA s. 24 (1) related to the Prevention of Abuse, Neglect and Retaliation in the past 36 months. (211)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 01, 2021

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 18th day of December, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Joelle Taillefer

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