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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Jun 29, 30, 2017	2017_618211_0010	023042-16, 026648-16, 027379-16, 032156-16, 009125-17	Critical Incident System

Licensee/Titulaire de permis

CITY OF OTTAWA
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

CENTRE D'ACCUEIL CHAMPLAIN
275 PERRIER STREET VANIER ON K1L 5C6

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): May 31, 2017 and June 1, 2, 5, 6, 7, 8, 12, 14, 2017.

During the inspection the following logs were inspected:

Log # 009125-17: Critical Incident: resident to resident alleged abuse,
Log # 023042-16, log # 026648-16, log # 032156-16: An incident that occurred causing an injury for which the resident was taken to the hospital
Log # 027379-16: Critical Incident: improper transfer incident

During the course of the inspection, the inspector(s) spoke with the Administrator, Program Manager of Resident Care, Program Manager of Personal Care, RAI-MDS Coordinator, Staffing Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping aides and residents.

During the course of the inspection, the inspector(s) conducted a tour of the resident care areas, reviewed residents' health care records, relevant licensee policies and procedures, staff work scheduled and routines, observed resident rooms, the delivery of resident care and services and staff to resident and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

4 WN(s)
4 VPC(s)
0 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. 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).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. 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.

This finding is related to Log # 027379-16 Critical Incident Report dated on an identified date and submitted to the Director on the next day, indicating that resident #003 sustained an identified altered skin integrity injury to an identified body area during a transfer on an identified date. The next day, an identified staff discovered two other body areas with identified altered skin integrity injury on resident #003.

Resident #003 was admitted to the home on an identified date and diagnosed with cognitive impairment and other medical health conditions.

On June 6, 2017, Inspector #211 observed a pictogram posted on the resident's wall above the bed indicating to use a specified equipment for transfers. On the same wall, Inspector #211 observed a sheet with a picture of the identified transfer equipment with specific instructions.

On an identified date during the evening, the resident health care progress notes indicated that the resident sustained an altered skin integrity injury to an identified body area during the transfer. The notes indicated that the resident was agitated during the transfer and his/her identified body area was caught between an identified area from a specific chair.

The resident's written plan of care on an identified date, indicated under the nursing

diagnosis that resident #003 has specified behaviours with identified interventions.

Inspector #211 reviewed an identified note written by RPN #132 to the Program Manager of Resident Care sent on an identified date, indicated that an investigation was started immediately on the evening of the incident, after the resident sustained an injury to the identified body area during the transfer. The note indicated that both identified PSWs who were interviewed individually stated they found the resident sitting in the identified chair in his/her room. They started preparing the resident for the transfer by putting an identified transfer device behind the resident while sitting in the identified chair. While putting the transfer device, the resident started to be agitated, moving his/her identified limbs and the other part of the body. The resident was hitting one of the identified body part toward the identified chair. Then, they attached the transfer device to the identified transfer equipment and put both resident's identified limbs together. However, the resident's identified limbs continued to move while transferring the resident into the bed and they observed the resident's altered skin integrity injury to the identified body area. The note indicated that both PSWs indicated that there was a moment where the resident's identified limb was between an area from the identified chair and they thought the altered skin integrity injury may have happened during that time. The note indicated that PSW #138 and PSW #141 received education related to the resident's transfer. The education included the following:
• Safety of the resident during care,
• To post-pone a resident's care until the resident is calm and not agitated,
• To read the instruction posted into the resident's room.

During an interview with RN #104 on June 6, 2017, indicated that the resident becomes nervous during the transfer and the resident need to be explained the procedure while being transferred to prevent sudden movement or to prevent the resident from holding the staff's hand or the identified transfer equipment.

During an interview on June 6, 2017, RN #132 stated that PSW #141 indicated that she did not read the instruction on the wall related to the resident's transfer precaution.

During an interview with PSW #138 on June 7, 2017, indicated that the resident was agitated and moving while putting the transfer equipment device on the resident's chair and when they were transferring the resident into the bed. PSW #141 indicated that she was putting the resident's identified limbs together, but the resident was repeatedly uncrossing them. PSW #141 acknowledged that she was not holding the resident's identified limbs all the time during the transfer and then she observed the injury to the

resident's identified body area. PSW #141 stated that the resident was not hitting his/her other identified body part when the transfer device was applied nor during the transfer.

During an interview with PSW #141 on June 7, 2017, indicated that resident #003 was very agitated during the transfer. PSW #141 indicated that the resident's mood fluctuated and we should have waited until the resident was calm to transfer the resident. PSW #141 stated that she tried to hold the resident's identified body areas but the resident was so agitated and moving his/her identified limbs everywhere that she was unable to hold both resident's identified limbs together.

During an interview with the Program Manager of Resident Care on June 7, 2017, indicated that an investigation was completed and indicated that the PSWs transferred the resident with the identified transfer equipment in an unsafe manner. The Program Manager of Resident Care stated that the investigation validated that resident #003 was refusing to have his/her clothes changed while sitting in the identified chair and the resident was exhibiting resistance to care behaviours during the transfer. The Program Manager of Resident Care indicated that the resident was already agitated, aggressive and hitting his/her specified body part when he/she was sitting in the chair and the staff should not have proceeded with the transfer while the resident was still agitated at the time. The PSWs should have notified the nurse that the resident was too agitated to be transferred. The signage instruction related to the resident's transfer posted on the resident's wall was not followed as directed by both PSW. The signage instruction indicated to hold both resident's identified limbs during the transfer with the identified equipment to prevent injury.

The licensee has failed to ensure that the care set out in the plan of care for resident #003 was provided to the resident as specified in the plan. [s. 6. (7)]

2. The licensee has failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

This finding is related to Log # 009125-17 Critical Incident Report on an identified date and submitted to the Director on the same day that indicated an alleged sexual abuse from resident #004 toward resident #006. The intake indicated that an identified staff found resident #004 holding resident #006 with one hand and the other hand in resident #006's identified clothes while in the resident 004's room on the identified date.

Inspector #211 reviewed the resident #004's health care progress notes indicating that the resident was admitted to the home on an identified date on a specific floor and was transferred to another floor at a later date.

Review of the resident #004's written plan of care under the nursing diagnosis: Communication-inappropriate sexual behaviour identified specific interventions.

Review of the geriatric psychiatry consultation, dated ten days after the incident, indicated specific recommendations for resident #004.

During an interview with PSW #125 on an identified date, indicated that resident #004 never exhibited sexual behaviours and she was not aware that this resident had exhibited verbal and physical sexual behaviours while on another unit. Moreover, PSW #125 indicated that she is working full time on the identified floor and she was not aware that resident #004 had demonstrated sexual behaviours since he/she was admitted to the home.

Inspector #211 and PSW #125 went searching on an identified date for the resident's plan of care on the identified unit. PSW #125 indicated to Inspector #211 that the resident's modified plan of care (Kardex) was not available in the binder titled Assigned sheet to verify specific resident's care. When inspector #211 asked PSW #125 if she was able to visualize the longer version of the resident's written plan of care, PSW #125 stated that she was not able to enter the computer to see resident's Kardex or the written plan of care.

During an interview with RN #124 on an identified date, showed inspector #211 that the resident #004's written plan of care was available in the computer and that a hard copy of the modified plan of care (Kardex) for the PSWs should be left in a binder titled Assigned Sheet Group. RN #124 confirmed that the Kardex was not available in the specific binder for the PSW to view.

During an interview with the Resident Assessment Instrument-Minimum Data Set Coordinator (RAI-MDS Coordinator) identified that resident #004's hard copy of the written plan of care was not in the unit binder titled Residents' Care Plan Binder and the modified hard copy of the written plan of care (Kardex) was not available in the other binders titled Assigned Sheet Group. The RAI-MDS Coordinator indicated that the staff probably forgot to bring the hard copies of the resident's written plan of care and the Kardex from the previous unit. The RAI-MDS Coordinator acknowledged that there was a

breakdown of the communication at different levels related to resident's past alleged sexual behaviours and the PSW should have been informed.

The licensee has failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident 004's plan of care and have a convenient and immediate access to it. [s. 6. (8)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure:
-that the care set out in the plan of care is provided to the resident as specified in the plan,
-that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a restraining of a resident by a physical device may be included in a resident's plan of care only if a physician, registered nurse in the extended class or other person provided for in the regulation has ordered or approved the restraining.

The Long Term Care Homes Act 2007 defines a physical restraint as all devices used by the home that restrict freedom of movement or normal access to one's body. A resident

may be restrained by a physical device if the restraining of the resident is included in the resident's plan of care. The use of a physical device from which a resident is both physically and cognitively able to release themselves is not a restraining device.

This finding is related to Log #023042-16

The Critical Incident (CIR) indicated that resident #001 sustained an injury to two body areas on an identified date, after the resident was seen by an identified PSW, falling forward from the wheelchair. The resident was sent to the hospital and diagnosed with an injury to another body area two days after the incident. The CIR indicated that a staff forgot to apply the two physical devices on the resident's chair.

Review of resident #001's health record indicated that the resident was admitted on an identified date and diagnosed with cognitive impairment and other multiple health issues.

Review of the resident's current written plan of care under the Nursing Diagnosis identified specific interventions.

On June 1, 2017, Inspector #211 observed resident #001 sitting in a specific type of chair with the two physical devices applied to the chair. On June 2, 2017, Inspector #211 observed the resident sitting in the specific chair with the two physical devices applied to the chair in the dining room.

During an interview with RPN #115 on June 1, 2017, indicated that the two identified physical devices are considered a restraint because the resident is unable to remove them since he/she doesn't have the physical strength. RPN #115 indicated that the resident's physical devices were applied going back to at least an identified date. RPN #115 indicated that she was unable to locate resident #001's restraint's order prior the resident's fall on the identified date and the only documented restraint's order is dated approximately six weeks later. RPN #115 stated that one of the physical device is also used to prevent the resident from sliding down from the specific chair and the other physical device is used to prevent the resident from putting his/her limbs outside of the chair. RPN #115 acknowledged she only noticed that one of the physical restraint was approved by the physician six weeks later after the resident's fall. RPN #115 revealed the use of the specific type of chair and the two identified physical devices are indicated in the section Repositioning Nursing Diagnosis and under the ADLs Nursing Diagnosis.

During the interview with the PSW #116 on June 1, 2017, indicated that the resident's restraints are to prevent the resident from falling when sitting in the chair since the resident can move himself/herself within the specific type of chair. She indicated that the two identified physical devices are considered restraint as the resident is not able to remove both.

During the interview with PSW #118 on June 2, 2017, indicated that both identified physical devices are always applied when the resident is sitting in the chair.

The form tilted Medical Directive Prescription-Contentions signed by the physician on the identified date, indicated to use one of physical device when the resident is sitting in the chair.

Review of the quarter Physician's Order Review documented for approximately fourteen months doesn't include that the resident's restraint was ordered or re-ordered.

During the interview with the Program Manager of Personal Care on June 2, 2017, indicated that both resident's physical devices are considered restraints.

The Program Manager of Personal Care indicated that the quarterly Physician's Order Review documentation did not indicate an order to apply a restraint to resident #001. One of the resident's restraint was not ordered by a physician or a registered nurse in the extended class for approximately fourteen months and the other type of restraint was not ordered.

The licensee has failed to ensure that one of the resident #001's physical device was ordered by a physician or a registered nurse in the extended class and the other resident's physical restraint was not ordered for approximately fourteen months. [s. 31. (2) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a restraining of a resident by a physical device may be included in a resident's plan of care only if a physician, registered nurse in the extended class or other person provided for in the regulation has ordered or approved the restraining, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

This finding is related to Log # 027379-16 Critical Incident Report submitted on an identified date, indicating that resident #003 sustained an altered skin integrity injury to

an identified body area during a transfer on an identified date.

Resident #003 was admitted to the home on an identified date and diagnosed with cognitive impairment and other medical health conditions.

The resident’s progress notes on the identified date during the evening shift, indicated that the resident sustained a altered skin integrity injury to an identified body area during the transfer. The notes indicated that the resident was agitated during the transfer and the identified body area was found between an area in the identified chair. The altered skin integrity injury was cleaned and an identified dressing was applied.

On the following shift after the incident, the resident’s notes indicated that the resident slept well during the night and the dressing was still in place on the resident’s identified body area. On the day shift, the notes indicated that an identified PSW reported she found the resident with an injury to another body area. RPN #142 documented that the physical assessment identified an injury behind the other body area with a small amount of edema and redness, the identified body area injury found on the day of the incident not covered with a dressing and a bluish green bruise to another body area. RN #104 documented that the physical assessment of the resident indicated old multiple bruises to two identified other body areas, recent bruise to another body area and an identified shape of the altered skin integrity to the identified body area found on the day of the incident. Also, RN #104’s documentation indicated that the physical assessment identified a specific size of the opening to the resident’s other identified body area with slight redness and dry blood.

Three days later during the evening shift, the nursing progress notes indicated that the area surrounding the altered skin integrity injury of the resident’s identified body area found on the day of the incident was red and warm.

The next day, RPN #142 documented in the notes that the resident’s altered skin integrity injury to the identified body area was still red and warm and the physician ordered an antibiotic.

Four days later, the resident's health care progress notes indicated that the resident’s altered skin integrity injury to the identified body area, an injury to the resident's other body area and the bruise to another body area were healing well.

Eleven days later, the health care progress notes indicated that the resident’s identified

body area was re-evaluated and there was presence of scar.

Six days later, the health care progress notes indicated that a scab over the resident's identified body area was removed and the area was bleeding slightly. The area was cleaned with normal saline and two identified dressings were applied to prevent the resident removing the scab.

Review of the physician's notes on an identified date (six days after the incident), indicated that the resident sustained an altered skin integrity injury to the identified body area, antibiotic was started, a specific infection to the above body area was observed, the area was dry with no edema today and to continue the antibiotic.

During an interview with RN #132 on June 6 and 7, 2017, indicated that she was informed by RPN #139 on the identified date of the incident during the evening shift that resident #003's identified body area sustained an injury during the transfer from the identified chair to the resident's bed. RN #132 indicated that the identified staff told her that the resident's identified body area got stuck between two areas of the identified chair. RN #132 stated that she only saw one injury. RN #132 indicated she didn't complete a whole assessment of the resident's body because the staff did not mentioned an injury or an incident to the other parts of the resident's body. RN #132 indicated that there was no evidence of blood or other injury to the resident's body. RN #132 stated that the resident's identified body area with the altered skin integrity injury was bleeding and she covered the wound with a specific dressing. RN #132 indicated that when a resident has an altered skin integrity, an assessment sheet must be completed and she did not remember if the assessment sheet titled "Wound Assessment Tool" was initiated and completed.

During an interview with RN #104 on June 6 and 7, 2017, indicated that she received a call from RPN #142 the next day during the morning shift related to resident #003's injuries. RN #104 indicated that RPN #142 reported that the resident's injuries may have occurred during a identified equipment transfer on the previous evening, on the identified date. RN #104 stated that she made a complete assessment of the resident's body and she observed the following:
• A specific measurement of the altered skin integrity injury of resident's identified body area,
• A specific measurement of another body area injury with dry blood.
RN #104 indicated that she applied a dressing to the resident identified altered skin integrity's body area on the identified date.

RN #104 indicated that when a resident sustained a wound, the nurse should initiated an assessment and complete the Wound Assessment Tool but this tool is not required when a resident sustained this particular altered skin integrity injury. However, the nurse should document in the progress notes and initiate a nursing diagnosis in the resident's written plan of care when a resident sustained this kind of altered skin integrity injury. RN #104 showed Inspector #211 that a nursing diagnosis for wound related to the resident's identified altered skin integrity injury was initiated five days later.

During an interview with RPN #139 on June 8, 2017, indicated that a sheet titled Wound Assessment Tool is required when a resident has sustained this kind of skin injury, wound or other altered skin integrity. RPN #139 indicated that she did not complete the sheet titled Wound Assessment Tool since RN#132 initiated the resident's identified body area assessment and treatment.

During an interview with the Program Manager of Resident Care on June 7, 2017, indicated that the sheet titled Wound Assessment Tool should have been initiated on the day of the incident, when the nurse assessed the resident's altered skin integrity injury on the identified body area and the area should have been reassess and documented on the above tool weekly.

The licensee has failed to ensure that resident #003 exhibiting altered skin integrity to three identified body areas, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others.

This finding is related to Log # 009125-17 Critical Incident Report dated and submitted to the Director on the same identified day, indicated an alleged sexual abuse from resident #004 toward resident #006. The intake indicated that an identified staff found resident #004 holding resident #006 with one hand and the other hand in resident #006's identified clothes while in the resident 004's room.

The Ontario Regulation 79/10 r. 2 (1) (b) under the Long-Term Care Homes Act, 2007, sexual abuse means,
(a) Any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or

(b) 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.

Resident #004 was admitted to the home on an identified date and diagnosed with cognitive impairment and other health conditions. On admission resident #004 was admitted to an identified floor.

Resident #006 was admitted to the home on an identified date and the resident's health care records identified the resident with cognitive impairment and other health conditions.

Inspector #211 reviewed resident #004's admission progress notes on an identified date, that indicated that the family members reported the resident never demonstrated responsive behaviours. The nursing progress notes indicated that the resident did not socialize with other residents and did not demonstrate agitation nor aggressive behaviours. The resident was identified has having difficulty with his/her memory characterized with two identified deficiencies.

The nursing progress notes on an identified date indicated that the resident preferred to withdraw from the activities and stayed lying in his/her bed.

Four weeks later, the nursing progress notes, indicated that identified individuals reported to an identified RN that the resident had demonstrated physical and verbal sexual behaviours toward them.

The next day, the nursing progress notes indicated that the resident exhibited verbal inappropriate sexual behaviours toward the staff and the PSWs were notified to be cautious.

Ten days later, the nursing progress notes indicated that the resident was seen by a physician for a physical and mental condition status. The physician had no current issues.

Fourteen days later, the nursing progress notes indicated that RN #104 requested to have resident #004 included on the Behavioural Support Ontario (BSO) list and the resident was on the transfer waiting list to another unit.

Six days later, resident #004'and #006's progress notes written by RN #124 indicated

that resident #004 had an inappropriate sexual behaviour toward resident #006. An identified employee heard screaming from a resident's room and found resident #004 standing behind resident #006. Resident #004 was holding resident #006 with one hand while the other hand was inside resident #006's identified clothes. Resident #004 stopped holding the resident #006 when the identified staff entered the resident's room and asked resident #004 to ceased holding resident #006. Resident #006 left the room. The progress notes indicated that resident #004 told RN #124 that resident #006 always comes into his/her room. Resident #004 was informed that this aggression toward a resident was inacceptable and the resident replied that it will not happened again.

Two days later, resident #006's progress notes written by RN #124 as a late entry indicated that a physical evaluation was not completed on the day of the incident for resident #006, despite several attempts since the resident refused to be brought to his/her room to have complete physical evaluation, however it was noted that the resident's two identified body areas were uninjured.

On the same above day, resident #004's progress notes written by RN #104 indicated the resident was referred to the psychogeriatric team related to his/her alleged sexual behaviours.

Review of the resident #004's written plan of care under the nursing diagnosis: Communication-inappropriate sexual behaviour dated two days after the incident, identified specific interventions.

Nine days after the alleged sexual behaviour incident, the resident #004's progress notes written by RN #104 indicated that the resident was transferred to another unit and the notes specified that the resident walked independently with a identified equipment and socialized with other people on the unit.

Review of the geriatric psychiatry consultation dated ten days after the alleged sexual behaviour incident, indicated specific recommendations for resident #004:

Review of the Physician's Order on an identified date, indicated to decrease an identified medication for resident #004.

Review of the resident #004's medication administration record (MAR) for an identified month, indicated that the identified medication was decrease on an identified day.

The only documented evidence in the resident #004's health care record that indicated that the licensee has followed the geriatric psychiatry consultation was the decrease of resident's identified medication.

During an interview with the housekeeping aide on June 13, 2017, indicated that on the identified alleged sexual behaviour incident, he/she heard a loud scream from resident #004's room. When he/she entered the room, he/she observed resident #004 holding resident #006 and having his/her hand inside resident #006's identified clothes. Resident #006 was completely dressed and he/she was not able to establish if resident #004 was touching resident #006's identified area. The housekeeping aide stated that he/she observed resident #006 struggling to escape from resident #004's arms, but when he/she told resident #004 to release the resident, resident #004 immediately stopped holding resident #006. The housekeeping aide indicated that he/she immediately informed the nurse in charge of the unit.

During an interview with RN #124 on June 6 and 12, 2017, stated that she spoke with resident #004 related to his/her inappropriate sexual behaviour toward resident #006. RN #124 indicated that the resident #004 replied he/she would never exhibit this behaviour again. RN #124 stated that resident #006 did not demonstrate emotionally upset behaviours related to the incident and the resident refused the physical examination. RN #124 indicated that she was not aware that resident #004 had demonstrated inappropriate sexual behaviour on two previous dates.

During an interview with the Program Manager of Personal Care on June 12, 2017, stated that she was aware that resident #004 had demonstrated verbal sexual behaviour toward the staff prior the alleged sexual behaviour incident. The Program Manager of Personal Care indicated that when resident #004 had verbally exhibited sexual behaviours toward the staff, the interventions were not necessary at that time since the resident did not demonstrate physical sexual behaviours toward residents.

Interview with the Program Manager of Resident Care on June 14, 2017, indicated that she was not aware of resident #004 previous physical and verbal sexual behaviours incident toward identified individuals on an identified date. The Program Manager of Resident Care acknowledged that she was aware of resident verbal sexual behaviours toward staff members on an identified date, but she was only informed of the incident one to two weeks later. The Program Manager of Resident Care indicated that resident #004's verbal and physical sexual behaviours should have been integrated in the resident's written plan of care after the two previous alleged sexual behavious incidents

and specified interventions should have been put in place to ensure that the resident was properly monitored and that the staff had the accurate information on how to care for resident #004's alleged sexual behaviours.

The licensee has failed to ensure that:
• Procedures and interventions were developed and implemented after resident #004 exhibited two previous sexual behaviours prior the alleged sexual behaviour incident toward a resident,
• All direct care staff were advised at the beginning of the shift of resident #004's sexual behaviours requiring heightened monitoring because his/her behaviours could pose a potential risk to the resident or others.

Also, it was noted that the geriatric psychiatry consultation recommended interventions related to resident #004 were not completely implemented to minimize and assist residents who could be potentially at risk of harm. [s. 55.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that,

(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others., to be implemented voluntarily.

Issued on this 20th day of July, 2017

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

Original report signed by the inspector.