Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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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 16, 2015	2015_284545_0013	O-002251-15	Critical Incident System

Licensee/Titulaire de permis

NEW ORCHARD LODGE LIMITED
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE WEST END VILLA
2179 ELMIRA DRIVE OTTAWA ON K2C 3S1

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

ANGELE ALBERT-RITCHIE (545)

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): June 10 and 11, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Dietary Manager, a Registered Nurse (RN), several Registered Practical Nurses (RPN), several Personal Care Workers (PSW), RAI Coordinator, Office Manager, and Resident #001 and Resident #002.

The inspector also reviewed residents' health records, staff schedules, the home's Resident Abuse by Persons Other than Staff policy (ref #: OPER-02-02-04, version November 2013), reviewed the home's investigation report, observed Residents' rooms and common areas on two units and observed delivery of Resident care and services.

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)
2 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. 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 has failed to ensure that a person who had reasonable grounds to suspect that a sexual abuse of a resident by anyone that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director.

In accordance with O.Reg. 79/10, section 2, sexual abuse means, 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 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 Critical Incident Report (CIR) was submitted to the Ministry of Health and Long Term Care on a specific date in June 2014 regarding a sexual abuse between Resident #001 and Resident #002 that occurred the previous day; 19 hours post incident.

On June 10 and 11, 2015 Resident #001 and Resident #002 were interviewed by the Inspector. Both Residents have moderate to severe cognitive impairment. During interviews, neither Resident was able to recall the incident.

Progress notes, written 30 minutes following the alleged sexual abuse, were reviewed by the Inspector. In both Resident’s health records, the notes indicated that the PSW

reported that she had observed Resident #001 in Resident #002's room. Resident #002 had no pants on and was on top of Resident #001, this one's top was pulled up to the shoulders. The note indicated that the Residents were preparing for intercourse and that Resident #002 had touched Resident #001's chest, and that both Residents were willing participants. In Resident #001's health record, the note also included that Resident #001 was angry when separated from Resident #002 and Resident #001 was seeking out Resident #002 after they were separated.

On June 10, 2015, the Inspector interviewed 3 staff members who were present on the date that Resident #002 was found naked on top of Resident #001 (also naked) in Resident #002's bedroom. PSW #S109 and RPN #S105 indicated that Resident #001 and Resident #002 were observed, for the first time that shift, walking on the unit holding hands. Both staff members indicated that Residents #001 and #002 would not have been able to provide consent to having sex, as they both have moderate to severe dementia. RPN #S105 indicated she notified the RN in charge, of the alleged sexual abuse and assumed that RN contacted the Manager On-Call, the families of Resident #001 and #002, the Police and the Director (MOHLTC). RN #S110 indicated that he reported the alleged sexual abuse to the Manager On-Call immediately, but did not notify the Director (MOHLTC).

During an interview with the Dietary Manager on June 11, 2015 she indicated that she was the Manager On-Call on a specific shift of a specific date in June 2015. She indicated that RN #S110 reported the incident to her 30 minutes after the Residents were found naked in Resident #002's bedroom. The On-Call Manager indicated that she did not report the alleged sexual abuse to the Director (MOHLC), added that she left a voice message to the Assistant Director of Care (ADOC) describing the situation and asking for advice. The On-Call Manager added that upon arrival to the home at 6:30AM the following day, and in discussion with the ADOC, it was determined at that time that a sexual abuse between Resident #001 and #002, had occurred the previous day. She indicated that she did not at that time report the sexual abuse to the Director (MOHLTC).

During an interview with the ADOC on June 10, 2015, she indicated that both Residents on the specific Unit had cognitive impairment and were unable to make an informed consent in regards to behaviour of sexual nature, therefore the encounter must be considered a sexual abuse, added that a sexual abuse requires to be immediately reported to the Director and the Police. The ADOC indicated that she did not report the sexual abuse to the Director (MOHLTC).

On June 11, 2015 during an interview with the Director of Care (DOC), she indicated that she reported the sexual abuse between Resident #001 and #002 by submitting a Critical Incident Report (CIR) to the Director the day after the incident of sexual abuse occurred, after initiating the investigation. The DOC indicated that she was aware that she needed to report immediately, any suspicion of sexual abuse of a Resident by anyone that results in harm or risk of harm, and the information upon which it was based, to the Director.

On June 11, 2015 the Administrator indicated to the Inspector that she was informed by the ADOC of the alleged sexual abuse via a text, just before she arrived at the home the next day. She indicated that the ADOC had already been to the specific unit to ensure staff was made aware of the situation and need to continue 1:1 with the male Resident and as well, to continue hourly monitoring of the female Resident. The Administrator indicated she was aware that any person who had reasonable grounds to suspect sexual abuse that resulted in harm or a risk of harm to the Resident, needed to report immediately to the Director. The Administrator further indicated that the home did not ensure that those who had reasonable grounds to suspect that a sexual abuse between Resident #001 and Resident #002 that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

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 person who has reasonable grounds to suspect that a sexual abuse of a resident by anyone that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #2: 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 or neglect of a resident that the licensee suspects may constitute a criminal offence.

A Critical Incident Report (CIR) was submitted to the Ministry of Health and Long Term Care (Director) on a specific date in June 2015 regarding a sexual abuse between Resident #001 and Resident #002 that occurred the previous day, more specifically 19 hours before.

On June 10, 2015, during interviews with the designated representatives of the Licensee on a specific shift of a specific date in June 2015, such as the RN in-charge and the On-Call Manager, they both indicated that the police was not immediately notified of the alleged sexual abuse between Resident #001 and Resident #002 that occurred on a specific date in June 2015.

On June 11, 2015, during an interview with the Director of Care (DOC), she indicated that she was responsible to investigate the alleged sexual abuse between Resident #001 and Resident #002 which she reported to the Director (MOHLTC) 19 hours later, via a CIR. She indicated she had not notified the police, of this alleged sexual abuse, as per legislation.

On June 11, 2015 the Administrator indicated to the Inspector that the appropriate police force was not notified of the alleged sexual abuse that occurred on a specific date in June 3, 2015 between Resident #001 and Resident #002, as per legislation. [s. 98.]

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 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, to be implemented voluntarily.

Issued on this 17th day of June, 2015

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

Original report signed by the inspector.