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
Apr 12, 2016	2016_280541_0009	002078-16	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF HASTINGS
1M Manor Lane Box #758 BANCROFT ON K0L 1C0

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

HASTINGS MANOR HOME FOR THE AGED
476 DUNDAS STREET WEST P.O. BOX 458 BELLEVILLE ON K8N 5B2

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

AMBER MOASE (541)

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): March 23, 29, April 1 and 4, 2016

This inspection was for two critical incidents related to two allegations of resident to resident sexual abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, the Assistant Director of Nursing, Registered Nurses, Registered Practical Nurses, Personal Support Workers, an Activity Aide and Residents. In addition the Inspector observed resident to resident interactions, reviewed resident health care records and reviewed relevant policies.

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.
- **6 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non- respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to protect residents #004, #005 and #006 and several other unidentified residents from alleged sexual abuse by resident #003.

On a specified date an inspection began for critical incident an allegation of resident to resident sexual abuse. The critical incident was as follows:

On a specified date resident #003 was observed by an RPN inappropriately grabbing resident #004 while they were sitting in a common area. Resident #004 was trying to strike out to stop resident #003 from touching him/her. The critical incident report indicates resident #004 was upset at the time of the incident but settled once resident #003 was out of the vicinity.

O. Reg. 79/10 s. 2(1) b defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed, towards a resident by a person other than a licensee or staff member.

Upon entering the home, Inspector #541 reviewed resident #003's progress notes which reflected multiple incidents of behaviours of sexual nature by resident #003 directed towards co- residents dating back several months. The incidents are documented in resident #003's progress notes as follows:

On a specified date: Resident #003 found in room of resident #006, with behaviours of sexual nature.

On a specified date: At a specified time resident #003 found in a room with co-resident and resident #003 was non-consensually touching the resident. Progress note does not reflect who the co- resident is.

On a specified date: Resident #003 found with a co-resident. Residents were kissing and touching of each other.

On a specified date: Resident #003 found in a room with resident #006, with behaviours of a sexual nature.

On a specified date: Resident # 003 found in a common area with a co- resident, both partially dressed. When resident #003 saw PSW the resident began re-dressing. Resident #003 had to be redirected 3x after, again was found sitting beside co-resident with co-resident being partially dressed.

Progress notes indicate on or around a specified date, the home implemented an intervention related to resident #003. During an interview ADON #100 indicated the intervention was due to resident #003's behaviours of sexual nature directed at resident #006.

On a specified date: Resident #003 found holding a co-resident's hand and touching of a sexual nature. Resident #003 asked if there was a room for the resident and co-resident. Resident #003 then asked staff where resident #004's room was.

On a specified date: Resident #003 found in a common area with resident #005. Resident #003's partially dressed and resident #005 was touching sexually resident #003.

On a specified date: Resident #003 sitting beside co-resident touching the resident's leg. Progress note does not reflect who co-resident is.

On a specified date: Resident #003 found in co-resident's room, touching with a sexual nature resident #005.

On a specified date: Resident #003 found hanging onto co-resident's hand, trying to touch in a sexual way the resident. Progress note does not reflect who co-resident is.

On a specified date: At a specified time resident #003 was trying to get a co-resident to touch him/her in sexual way. Approx 12 hours later resident #003 was touching co-resident inappropriately in a common area. Progress note does not reflect who co-resident is.

On a specified date: At a specified time, resident #003 found with co-resident in a common area inappropriately touching the resident. Approximately 8 hours later, resident #003 had behaviours of a sexual nature in a common area.

On a specified date: Resident #003 observed stroking a co-resident's leg and was redirected to another area. 20 minutes later, resident #003 was sitting beside co-resident in a common area and was trying to touch and tickle the resident. Resident #003 was spoken to; resident apologized and repeated 5 minutes later. 10 minutes after this resident #003 was observed to be whispering to co-resident and then touching co-resident. Progress notes do not indicate who any of the co-residents are.

On a specified date: Resident #003 observed sitting beside a co-resident and inappropriately touching co-resident. Progress note does not reflect who co-resident is.

On a specified date: Resident #003 observed sitting beside co-resident in a common area inappropriately touching co-resident. Progress note does not reflect who co-resident is.

On a specified date: Resident #003 observed inappropriately touching a co-resident. Progress note does not reflect who co-resident is.

On a specified date: Resident #003 was touching, with a sexual nature, a co-resident. Progress notes do not indicate who co-resident is.

On a specified date: Resident #003 and resident #005 observed sitting in a common area prior to a meal service, inappropriately touching each other.

On a specified date: Resident #003 was trying to kiss a co-resident and was almost got slapped across the face by the co-resident as the resident did not appreciate it. Progress note does not indicate who co-resident is.

On a specified date: Resident #003 found in co-resident #005's room partially dressed. Witnessing staff member was unsure of how long the residents had been together.

On a specified date: Resident #003 observed sitting in a common area with a co-resident. Resident #003 has arm around co-resident, touching the resident and kissing the resident on the cheek. Staff also overheard resident #003 making remarks of a sexual nature to and towards the co-resident. Progress notes do not indicate who the co-resident is.

On a specified date: Resident #003 holding hands with co-resident. Witnessing staff observed resident #003 attempting to kiss and touch co-resident.

On a specified date: Resident #003 trying to hold hands with 2 different co-residents at different times. A co-resident was walking by the resident and resident #003 pushed co-

resident's brake on the resident's walker so the resident would have to stop. When the co-resident stopped, resident #003 stated "Your brake just fell".

On a specified date: Resident #003 and #005 observed kissing in a common area. Both residents inappropriately touching each other.

Interventions: Both separated and removed from room. Resident #003 was very upset to not stay with resident #005.

On a specified date: Resident #003 witnessed inappropriately grabbing resident #004, to which resident stated "no". A Critical Incident Report was submitted.

On a specified date: Resident #003 observed with an arm around resident #005's shoulder and inappropriately touching the resident; resident #005 not showing any signs of distress. Residents were re-directed and a few minutes later resident #005 was observed inappropriately touching resident #003.

During the inspection the home was unable to provide Inspector #541 any documented assessment to demonstrate that consent was provided in any of the above documented incidents of alleged sexual abuse.

PSW #102 and RPN #104 both indicated to Inspector #541 during interviews that the only strategy to manage resident #003's behaviours of a sexual nature is to "keep an eye on the resident" or re-direct when the behaviour is witnessed.

The licensee failed to comply with:

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 #003)

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 #004)

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 #005)

O. Reg 79/10 r. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible, (b) strategies are developed and implemented to respond to these behaviours, where possible; (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. (Refer to WN #002)

O. Reg 79/10 r. 97(1)(b) 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 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. (Refer to WN #006) [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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible; (b) strategies are developed and implemented to respond to these behaviours, where possible; and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented

Over a specified period of time, there were multiple documented incidents of behaviours of a sexual nature by resident #003 directed at multiple co-residents. (Refer to WN#001).

ADON #100 indicated during an interview with the inspector that resident #003 was demonstrating sexual behaviour directed at a specific co- resident. An intervention was implemented. Subsequently, resident #003 started to exhibit sexual behaviour directed at co-resident #005.

Inspector #541 reviewed resident #003's current care plan. There are no triggers identified related to resident #003's ongoing sexual behavior and there are no interventions in place to direct staff how to manage this behavior.

Resident #003's sexual behavior was first documented on a specified date and continued over a period of time. During this time, the only intervention in place to manage resident #003's sexual behavior on a daily basis was to "monitor every 20 minutes." Resident #003 continued to demonstrate the sexual behavior and the intervention of "monitoring every 20 minutes" was not reassessed despite over 20 incidents of alleged sexual abuse of

multiple co-residents over the specified period of time.

On March 29, 2016 ADON #100 was asked by Inspector #541 what strategies have been implemented to keep co-residents safe from resident #003 and ADON #100 indicated "frequent monitoring." When asked how staff are to know to do this ADON #100 indicated it would be in the resident #003's kardex. Resident #003's current kardex was provided to inspector #541 by DON #101 upon entering the home. There are no interventions in the kardex to direct staff to frequently monitor resident #003.

PSW #102 who works full time on the unit where resident #003 resides indicated during an interview with Inspector #541 that resident #003 does not have any increased monitoring in place and staff just have to be aware of where the resident is.

The home did not assess resident #003 for any potential triggers to sexual behaviors; they did not identify any strategies other than monitoring and this was not effective based on several progress note entries and they did not reassess resident #003 when the sexual behaviours continued and the one intervention was not effective. [s. 53. (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, for resident #003 demonstrating responsive behaviours, (a) the behavioural triggers for the resident #003 are identified, where possible; (b) strategies are developed and implemented to respond to these behaviours, where possible; and (c) actions are taken to respond to the needs of resident #003, including assessments, reassessments and interventions and that resident #003's responses to interventions are documented, to be implemented voluntarily.

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 there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

Over a specified period of time, there were multiple documented incidents of behaviours of a sexual nature by resident #003 directed at multiple co-residents. (Refer to WN #001).

Inspector #541 was provided with policy #F-20 titled "Zero Tolerance of Abuse and Neglect Program" as the home's policy to promote zero tolerance of resident abuse and neglect.

Page 4 of the policy states: "The DON/delegate shall make a report to the MOHLTC Director with the results of every investigation conducted under this policy, and any action the Home takes in response to any incident of resident abuse or neglect."

During an interview with ADON #100 Inspector #541 asked for any documentation into an investigation of the above mentioned allegations of resident to resident sexual abuse. Inspector #541 was provided with two completed investigation forms titled: "Internal Reporting of an Alleged, Suspected or Witnessed Abuse or Neglect of a Resident" for incidents that occurred on two specified dates.

The MOHLTC Director was not notified about either of these investigations. [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 that the licensee knows of, or that is reported is immediately investigated:
(i) Abuse of a resident by anyone.

Over a specified period of time, there were multiple documented incidents of behaviours of a sexual nature by resident #003 directed at multiple co-residents. (Refer to WN #001).

ADON #100 was identified as the person in charge of the home's responsive behaviour program and was interviewed on March 29, 2016. When Inspector #541 asked what was done in regard to each incident to determine if the interaction was consensual or who the co-resident was in each incident, ADON #100 provided Inspector #541 with the following:

- Form "Internal Reporting of an Alleged, Suspected or Witnessed Abuse or Neglect of a Resident" completed following one specified incident.
- Form "Internal Reporting of an Alleged, Suspected or Witnessed Abuse or Neglect of a Resident" completed following one other specified incident.

When asked by Inspector for the investigation into any of the remaining incidents, ADON #100 was unable to provide any documentation to reflect the incidents were investigated.

On March 31, 2016 Inspector #541 verified with the Administrator that there was no investigation completed into any of the remaining incidents of sexual behaviour by resident #003. [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 has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director?
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Over a specified period of time, there were multiple documented incidents of behaviours of a sexual natures by resident #003 directed at multiple co-residents. (Refer to WN#001).

PSW #102 works full time on the unit where resident #003 resides. PSW #102 indicated that when resident #003 is demonstrating sexual behaviour towards a co-resident, the behaviour is to be stopped and resident #003 is to be redirected.

RPN #103 stated during an interview with inspector, that if resident #003 is observed touching resident #005, the interaction is to be stopped and the residents are to be re-directed.

RPN #104 stated that she was of the understanding that neither resident was able to consent to the sexual activity due to their cognitive impairment and therefore any sexual behaviour or activity between the two should be stopped.

On March 29, 2016 Inspector #541 interviewed the home's Director of Nursing (DON) #101 and Assistant Director of Nursing (ADON) #100 and confirmed that the Director was not notified of any of the incidents apart from the incidents on a specified date.

DON #101 was asked why the incident on a specified date was reported to the Director and no other incident were, she indicated that because resident #003 frequently touched or had sexual behaviour directed towards resident #005 that it was ok as the behaviour was sometimes reciprocated by resident #005. DON #101 further stated that resident #005's family was ok with the incidents.

When ADON #100 was interviewed regarding why the incidents were not reported to the Director, she indicated it was because resident #005 did not appear upset and sometimes participated in the interaction. ADON #100 was unable to clarify why a form titled alleged abuse was completed for the two incidents yet the incidents were not reported to the Director.

The home failed to notify the Director of multiple incidents of alleged sexual abuse by resident #003 of residents #004, #005 and #006 as well as other unidentified co-residents. [s. 24. (1)]

WN #6: 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 SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Over a specified period of time, there were multiple documented incidents of behaviours of a sexual nature by resident #003 directed at multiple co-residents. (Refer to WN#001).

Inspector #541 asked ADON #100 to provide a copy of investigation into the above mentioned incidents of alleged sexual abuse.
For the incident that occurred on a specified date at a specified time Inspector was provided with a form titled: "Internal Reporting of an Alleged, Suspected or Witnessed Abuse or Neglect of a Resident". The form indicates the Substitute Decision Maker (SDM) of resident #005 was notified on the day following the incident at a specified time which was more than 12 hours after the incident occurred.

For the remaining incidents Inspector #541 was unable to verify that the SDM for each resident was notified within 12 hours of each incident occurring. [s. 97. (1) (b)]

Issued on this 12th day of April, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMBER MOASE (541)
Inspection No. / No de l'inspection :	2016_280541_0009
Log No. / Registre no:	002078-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 12, 2016
Licensee / Titulaire de permis :	THE CORPORATION OF THE COUNTY OF HASTINGS 1M Manor Lane, Box #758, BANCROFT, ON, K0L-1C0
LTC Home / Foyer de SLD :	HASTINGS MANOR HOME FOR THE AGED 476 DUNDAS STREET WEST, P.O. BOX 458, BELLEVILLE, ON, K8N-5B2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Debbie Rollins

To THE CORPORATION OF THE COUNTY OF HASTINGS, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care h shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure the following:

- The members of the management team including Registered Nurses of the home are educated on the home's abuse policy # F-20 and responsive behaviour policy # J-110 focusing on the implementation of strategies to prevent, minimize or respond to responsive behaviors and incidents of suspected/alleged resident abuse.

- All staff are educated on sexual abuse with a particular focus on identification, reporting requirements, notification of SDM and the strategies to be implemented to respond to the safety needs of residents.

In addition, the home shall immediately ensure any resident including resident #003 currently exhibiting sexual behaviours is assessed and interventions are implemented to ensure safety of co-residents.

The plan is to be submitted via fax to Amber Moase at 613-569-9670 by April 19, 2016.

Grounds / Motifs :

- The licensee has failed to protect residents #004, #005 and #006 and several other unidentified residents from alleged sexual abuse by resident #003.

On a specified date an inspection began for critical incident an allegation of resident to resident sexual abuse. The critical incident was as follows:

On a specified date resident #003 was observed by an RPN inappropriately grabbing resident #004 while they were sitting in a common area. Resident #004 was trying to strike out to stop resident #003 from touching him/her. The critical incident report indicates resident #004 was upset at the time of the incident but settled once resident #003 was out of the vicinity.

O. Reg. 79/10 s. 2(1) b defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed, towards a resident by a person other than a licensee or staff member.

Upon entering the home, Inspector #541 reviewed resident #003's progress notes which reflected multiple incidents of behaviours of sexual nature by resident #003 directed towards co- residents dating back several months. The incidents are documented in resident #003's progress notes as follows:

On a specified date: Resident #003 found in room of resident #006, with behaviours of sexual nature.

On a specified date: At a specified time resident #003 found in a room with co-resident and resident #003 was non-consensually touching the resident. Progress note does not reflect who the co- resident is.

On a specified date: Resident #003 found with a co-resident. Residents were kissing and touching of each other.

On a specified date: Resident #003 found in a room with resident #006, with behaviours of a sexual nature.

On a specified date: Resident # 003 found in a common area with a co- resident, both partially dressed. When resident #003 saw PSW the resident began re-dressing. Resident #003 had to be redirected 3x after, again was found sitting beside co-resident with co-resident being partially dressed.

Progress notes indicate on or around a specified date, the home implemented an intervention related to resident #003. During an interview ADON #100 indicated the intervention was due to resident #003's behaviours of sexual nature directed at resident #006.

On a specified date: Resident #003 found holding a co-resident's hand and touching of a sexual nature. Resident #003 asked if there was a room for the resident and co-resident. Resident #003 then asked staff where resident #004's room was.

On a specified date: Resident #003 found in a common area with resident #005. Resident
#003's partially dressed and resident #005 was touching sexually resident #003.

On a specified date: Resident #003 sitting beside co-resident touching the resident's leg. Progress note does not reflect who co-resident is.

On a specified date: Resident #003 found in co-resident's room, touching with a sexual nature resident #005.

On a specified date: Resident #003 found hanging onto co-resident's hand, trying to touch in a sexual way the resident. Progress note does not reflect who co-resident is.

On a specified date: At a specified time resident #003 was trying to get a co-resident to touch him/her in sexual way. Approx 12 hours later resident #003 was touching co- resident inappropriately in a common area. Progress note does not reflect who co-resident is.

On a specified date: At a specified time, resident #003 found with co-resident in a common area inappropriately touching the resident. Approximately 8 hours later, resident #003 had behaviours of a sexual nature in a common area.

On a specified date: Resident #003 observed stroking a co-resident's leg and was redirected to another area. 20 minutes later, resident #003 was sitting beside co-resident in a common area and was trying to touch and tickle the resident. Resident #003 was spoken to; resident apologized and repeated 5 minutes later. 10 minutes after this resident #003 was observed to be whispering to co-resident and then touching co-resident. Progress notes do not indicate who any of the co-residents are.

On a specified date: Resident #003 observed sitting beside a co-resident and inappropriately touching co-resident. Progress note does not reflect who co-resident is.

On a specified date: Resident #003 observed sitting beside co-resident in a common area inappropriately touching co-resident. Progress note does not reflect who co- resident is.

On a specified date: Resident #003 observed inappropriately touching a co-resident. Progress note does not reflect who co-resident is.

On a specified date: Resident #003 was touching, with a sexual nature, a co-resident. Progress notes do not indicate who co-resident is.

On a specified date: Resident #003 and resident #005 observed sitting in a common area prior to a meal service, inappropriately touching each other.

On a specified date: Resident #003 was trying to kiss a co-resident and was almost got slapped across the face by the co-resident as the resident did not appreciate it. Progress note does not indicate who co-resident is.

On a specified date: Resident #003 found in co-resident #005's room partially dressed. Witnessing staff member was unsure of how long the residents had been together.

On a specified date: Resident #003 observed sitting in a common area with a co-resident. Resident #003 has arm around co-resident, touching the resident and kissing the resident on the cheek. Staff also overheard resident #003 making remarks of a sexual nature to and towards the co-resident. Progress notes do not indicate who the co-resident is.

On a specified date: Resident #003 holding hands with co-resident. Witnessing staff observed resident #003 attempting to kiss and touch co-resident.

On a specified date: Resident #003 trying to hold hands with 2 different co-residents at different times. A co-resident was walking by the resident and resident #003 pushed co-

resident's brake on the resident's walker so the resident would have to stop. When the co-resident stopped, resident #003 stated "Your brake just fell".

On a specified date: Resident #003 and #005 observed kissing in a common area. Both residents inappropriately touching each other.

Interventions: Both separated and removed from room. Resident #003 was very upset to not stay with resident #005.

On a specified date: Resident #003 witnessed inappropriately grabbing resident #004, to which resident stated "no". A Critical Incident Report was submitted.

On a specified date: Resident #003 observed with an arm around resident #005's shoulder and inappropriately touching the resident; resident #005 not showing any signs of distress. Residents were re-directed and a few minutes later resident #005 was observed inappropriately touching resident #003.

During the inspection the home was unable to provide Inspector #541 any documented assessment to demonstrate that consent was provided in any of the above documented incidents of alleged sexual abuse.

PSW #102 and RPN #104 both indicated to Inspector #541 during interviews that the only strategy to manage resident #003's behaviours of a sexual nature is to "keep an eye on the resident" or re-direct when the behaviour is witnessed.

The licensee failed to comply with:

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 #003)

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 #004)

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 #005)

O. Reg 79/10 r. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible, (b) strategies are developed and implemented to respond to these behaviours, where possible; (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. (Refer to WN #002)

O. Reg 79/10 r. 97(1)(b) 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 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. (Refer to WN #006) [s. 19. (1)]

The home's compliance history was reviewed for the past 3 years:

- In June 2015 a Written Notification (WN) was issued for LTCHA s. 20 (1) for failing to comply with their policy to promote zero tolerance of abuse and a WN for O. Reg 79/10 s. 104(1)2 failing to provide an accurate description of individuals involved in an incident of alleged abuse upon reporting it to the Director.

- In January 2015 a Compliance Order (CO) was issued for LTCHA s. 19(1) for failing to protect residents from abuse

The scope of the incidents was determined to be pattern and the risk was determined to be actual as resident #003 allegedly sexually abused three residents #004, #005 and #006 over a specified period of time. (541)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON M5S-
2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de
révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 12th day of April, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amber Moase

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